Hallmark Healthcare (Holmewood) Limited

Barnfield Manor Care Home

Inspection report

Barnfield Close
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected the service on 23 February 2018. The inspection was unannounced. Barnfield Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Barnfield Manor accommodates 39 people living with nursing needs, dementia and conditions related to old age. On the day of our inspection 22 people were living at the service.

At the last inspection, in 23 November 2015 the service was rated overall as 'Good'. At this inspection we found that the service remained 'Good'.

Since our last inspection there had been a change of registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were supported by a staff team who understood their role and responsibilities to protect them from abuse and avoidable harm. The registered provider had systems, policies and processes to support staff in safeguarding people. Staff had received appropriate safeguarding training.

Risks to people's safety, including the environment had been assessed and were monitored and reviewed.

People's medicines were administered, stored and managed safely.
The service was clean and hygienic and staff had received training in the prevention and control of infections and a policy and procedure was available to support staff.

People's needs had been appropriately assessed and staff had information of the support people required to effectively manage their needs. Staff had received induction, training and support. Some gaps were found in staff training, this had been already identified in some areas and training booked.

People received a choice of meals and drinks and their dietary needs were known and understood by staff. People were supported to access primary and specialist health services to monitor their health needs. Staff worked with external healthcare professionals to secure good outcomes for people. The internal and external environment was appropriate for people's individual needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice. This included how they wanted to spend the time towards and at the end of their life.

People were supported by a staff team that knew them. Staff were caring and provided a person centred approach. Independence was promoted, dignity and privacy respected and people were involved in their care and support. People had access to independent advocacy information should they have required this support.

Staff supported people with their interests and hobbies and people or their representative contributed to planning the care and support they received. People's communication needs had been assessed and planned for. The provider's complaints procedure had been made available for people and was presented in an appropriate format. People's end of life wishes had been discussed with them.

People, relatives and staff were positive about the leadership of the service. People received opportunities to share their experience about the service they received. Systems and processes were in place to monitor the quality and safety of the service people received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Barnfield Manor Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a comprehensive inspection that took place on 23 February 2018 and was unannounced. The inspection team consisted of one inspector, one specialist advisor who was a nurse experienced in caring for people with conditions related to ageing. One expert by experience, an expert by experience is a person who has personal experience of using or caring for someone who uses services for older people.

Prior to our inspection we reviewed information we held about the service. We used information the provider sent us in the Provider Information Return (PIR). This is information we require provider's to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We also used the Short Observational Framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at all or part of the care records of four people who used the service, medicines records, staff recruitment and training records, as well as a range of records relating to the running of the service including maintenance records and quality audits carried out by staff at the service.

We also reviewed information that we held about the service such as the last inspection report, notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. We also contacted commissioners (who fund people's care) of the service.

On the day of the inspection we spoke with six people who used the service, four relatives, the registered manager, the regional manager, the activities organiser, a nurse, a member of the housekeeping team and a maintenance worker. We looked at all or parts of the care records of four people, along with other records relevant to the running of the service. This included how people were supported with their medicines,

quality assurance audits, training information for staff, deployment of staff, meeting minutes, policies and procedures and arrangements for managing complaints and compliments received by the service.

Good

Is the service safe?

Our findings

People who used the service said they felt safe. One person said, "Yes I think I am safe it's nice being here they look after you." Another said, "Yes of course I'm safe here."

The provider continued to have processes in place to keep people safe. Staff were trained on this and they knew how to respond to any concerns relating to possible abuse. We saw information on how to contact the local authority safeguarding team was clearly displayed if anyone was concerned about people's safety or were concerned about any potential harm or abuse.

Staff followed people's comprehensive risk assessments. These were drawn up to mitigate risk to people and to assist staff to deliver safe care. Areas of risk assessment covered assisting people to move safely, maintaining skin integrity and ensuring good nutrition.

The risk assessments gave staff directions on how to reduce risk such as the safe use of hoists to ensure people's safety. The directions included details and a photograph of the correct sling to use while assisting people to move using a hoist. Risk was managed in a manner that endeavoured to promote independence, this meant accidents and incidents were recorded and monitored so the risk was understood and where possible actions were taken to reduce this risk. For example, ensuring people who had frequent falls were referred to a falls clinic to ensure they had optimum safety while moving about the home.

The registered manager also had systems in place to ensure lessons were learned from accidents and incidents. This was to avoid, where possible, reoccurrence of similar accidents and incidents. For example where there were reoccurring incidents, the risk assessments and care plans of effected people were re-viewed. In one recent instance this resulted in increased staffing levels to keep people safe.

We saw and people told us there was enough staff to respond to their needs. They said they did not have to wait too long for staff to assist them. One person said, "Well you can see there is always someone about." Another said, "Yes there is always someone about, it doesn't have to be a carer anyone will help you."

People were protected from unsafe or unsuited staff working in the service because the provider had systems in place to ensure staff were recruited safely. Staff records showed pre-employment checks were carried out before staff began working at the service. Proof of identity and undertaking criminal record checks with the Disclosure and Barring Service (DBS) took place. This meant people and relatives could be confident staff had been screened as to their suitability to care for people who used the service.

We reviewed the systems in place in relation to the administration of medicines and found they were managed in a safe manner which met with current guidance. People received their medicines as prescribed and accurate records were maintained of the medicines when they were administered. There were protocols in place to instruct staff when and how to administer 'as required' medicines. 'As required' medicines are prescribed to be given when they are needed rather than at regular intervals, for example the relief of people's pain or anxiety. Medicines were stored safely.

People were protected from the risk of infection by positive staff practices in relation to infection prevention. Staff used personal protective equipment (PPE) when providing care for people. Staff we spoke with showed a good understanding of preventing the spread of infection and we saw and they assured us they had the equipment they needed to keep the service hygienically clean.

Good

Is the service effective?

Our findings

The provider continued to have systems in place to ensure staff were trained to meet people's needs. Our observations, conversations with staff and people supported this.

Staff told us they received appropriate training which gave them the skills and confidence to carry out their roles and responsibilities. Training was on-going, a staff member said, "As well as the usual training we can go on any training we feel we need." Another said, "There is training we have to do as well as the training we want to do. I last did all my mandatory training and we covered caring for people with diabetes." Some gaps were found in staff training, this had been already identified in some areas and training booked. .

We saw staff were skilled in caring for people with complex needs. We saw they worked well as a team and were fully aware of the needs of all people they cared for. Staff were also aware of their own limitations in supporting people with complex needs and asked for support from other staff appropriately.

One visitor was very complementary about their relative's care. They told us the skills of the registered manager and skill and training of staff had given them and their relative the opportunity, missing for many years, to have a loving relationship. They were clear they considered this exceptional as their relative had lived in two other services that were not "nearly as good."

Staff felt listened to and supported by the management team and were able to give examples, such as, the registered manager observing their work practices. They said they were clearly told when they were doing something wrong and were given support and guidance to improve. They said it made them more confident and better able to meet people's needs.

Staff told us they received supervision on a regular basis. Supervision is recognised as a process to share success as well as identify areas for improvement and personal development.

Staff continued to work within the principles of the Mental Capacity Act 2005 (MCA) code of practice. They respected people's decisions and ensured they consented to the care provided where they were able to. When people did not have the capacity to consent, 'best interests' decisions were made on their behalf.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager had appropriately applied to the local authority for authorisation to deprive a person of their liberty when required to maintain their safety.

Through our observations and from talking with the registered manager and staff we found the service to continue to meet the requirements of the DoLS. Staff confirmed they had received training in MCA and DoLS and recognised the importance of following the Act. The manager showed us documentation which supported appropriate applications had been made to the supervisory body for independent assessment.

Lunch was a relaxed occasion with a staff member sitting at each table and eating with people. This created a pleasant atmosphere. The registered manager said people's food intake improved since introducing this. People were seen to eat well with gentle staff encouragement.

People were shown plated choices on offer for lunch so they could make an informed choice. This meant they could see and smell what was available and we saw people actively chose what they wanted to eat and the people we observed ate with obvious relish and finished all their meal. People with dietary needs were referred to the appropriate health care professionals.

People had access to health professionals when it was necessary. One person told us, "Yes I can see the GP whenever I like." A relative told us "[Name] has seen the chiropodist about every six weeks." Another relative told us, "[Name] has seen a chiropodist and he can see the doctor easily when he is ill, the doctor for the home, he has also had an eye test recently."

We saw records to support referrals had been made to appropriate health care professionals when specialist advice was needed. For example, referrals to the speech and language therapist had been made.

People had influence over how their rooms were decorated. We were told there were plans to extensively decorate the entire building. Adaptions, such as handrails to aid people with their mobility were also fitted when needed in the property. People's individual needs were met through the adaption of their premises when needed.

Good

Is the service caring?

Our findings

People continued to be cared for by kind, caring and compassionate staff who knew their needs and wishes. The staff cared for people in a manner that promoted their dignity and independence.

One person said the staff were, "Best girls in the world." Another said, "They know I like been dressed nicely and they always make sure I am." A relative said, "You couldn't want for more, they are the best."

The registered manager ensured all care delivered was what people wanted and met their needs and wishes. This was done by involving people and their relatives in care planning. People told us staff always got their permission before starting care. One person said, "Even though it's always the same, they always ask with a smile." One relative told us, "I am consulted on everything and was fully involved in planning [relative's] care. I can also see they do what they say they will do." Another relative said, "I am so involved I am here every day and when I leave my [relative] I know they will be taken care of how we both want."

Staff ensured people were cared for in a calm relaxed manner. This was created by smiling and chatting with people in an unhurried manner, giving people time to reflect on questions before expecting an answer. Staff had good communication skills and took time and care to ensure they knew people's wishes and needs. There was a relaxed relationship between staff and people.

People's independence was encouraged and promoted where possible. For example a mobile clothes shop was arranged every season so people could choose their own clothing as well as having a fashion show. This gave people control over what they wore. People spoken with appreciated this and looked forward to it.

Staff respected people's right to privacy and dignity by knocking on doors prior to entering and checking if everything was alright. When people were been assisted to move staff did this with respect and promoted people's dignity by ensuring they walked along side they and staff allowed people to set the pace of movement.

There was information displayed at the service to inform people and relative that advocacy services were available for them if required. Advocates support people who are unable to speak up for themselves.

Care had been taken to ensure people looked their best, for example a hairdresser visited on a regular occasion.

Good

Is the service responsive?

Our findings

People continued to have their needs recognised and met because the provider had involved them or their representatives in drawing up their care plans. By doing this the registered manager and staff knew what was important to people. We saw and relatives told us they were involved in care planning. One relative told us they were fully involved in their relatives care. They said, "While I consider the staff to be the experts they never think they know best they always check."

The care plans were signed to indicate people's involvement. Care plans were personalised to identify and meet people's needs and wishes. Staff were also involved in care planning and said they felt their knowledge of people's changing needs were used in care planning so people received care that changed with people's needs and wishes.

End of life care was explored in care plans. People were offered the opportunity to discuss the care they wanted at the end of their lives. This included if people wanted to go to hospital or be cared for at Barnfield Manor. Staff caring for people at the end of their lives, were aware of the need for pain relief and the registered manager and staff worked closely with health care professionals to ensure medicines were available to ensure optimum pain relief. Accommodation was offered to relatives over this period.

We noted that staff understood the importance of promoting equality and diversity. This included arrangements that had been made for people to meet their spiritual needs. Furthermore, the registered manager recognised the importance of appropriately supporting people's sexual identity and cultural needs and wishes.

The registered manager fulfilled their duty under the Accessible Information Standard. The Accessible Information Standard ensures that all people, regardless of impairment or disability, have equal access to information about their care and support. For example, they had ensured a person who at times struggled to settle in and understand what was happening to them had the support they needed to ensure their communication methods were recognised and met.

The registered manager and staff understood the importance of ensuring people were offered stimulation. People we spoke with told us they have plenty to occupy them. There was an activity organiser in post. There was a comprehensive range of activities available to people. These included board games, bowling, singing sessions, baking, pizza making and arts and crafts. Relatives were encouraged to bring in pets and they recently had a birds of prey display. People we spoke with said they liked this.

A newsletter outlining events was published and distributed on a monthly basis. This reminded people of the activities available. Relatives had recently been involved in upgrading an area of the grounds to make it more wheel chair friendly. People said they were looking forward to using it in better weather.

There were arrangements to ensure that people's concerns and complaints were listened and responded to in order to improve the quality of care. Records showed that when complaints had been received these had

been investigated and resolved to the satisfaction of the complainant.

When we spoke with people they told us they knew how to raise concerns. One person told us "I've no complaints it's good here." Another person told us, "I can't think of anything I would complain about." A relative said, "The staff would understand if you had any issues, you can talk to them". At the time of our inspection there were no on-going complaints and previous complaints had been resolved according to the provider's complaints policy. There were a high number of compliments from relatives on the care provided to their relatives.

Good

Is the service well-led?

Our findings

The service is required to have a registered manager and one was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider continued to ensure the service was managed in the best interests of people. The registered manager had an open and inclusive way of managing the service. People told us they knew the manager and saw them as very approachable, easy to talk to and available. We saw people, staff and visitors to the service chatted to them. Staff views were respected and their knowledge of people used in care planning.

The registered manager kept up to date on people's needs by spending time with people and staff. This meant they could see people's needs and any risk posed to them first hand and see if their care plan was fit for purpose and up to date. By taking this approach to managing the service the registered manager was also able to monitor and direct staff on how they delivered care.

The registered manager was knowledgeable on how to care for people living with dementia. They kept up to date on good practice. An example of this was the training of all staff in the service in the care of people living with dementia. This meant people could get assurance from any staff member and put people's care at the centre of the service.

Staff told us they appreciated this and said if they were doing something wrong or could improve the registered manager discussed this with them. Staff told us they were well supported and this was evident in the good staff morale.

There was a quality review system in place to evaluate all aspects of care delivery and to ensure the safety of people. Care plans and risk assessments were reviewed; falls and incidents were monitored and actions put in place to mitigate risk. Also there were systems in place to ensure the environment was safe.

The registered manager ensured the service was person centred. For example a member of the maintenance team had a good relationship with one person. The registered manager ensured they had time together. On the day of our inspection visit we saw they had lunch together.

The registered manager was aware of their responsibilities and ensured statutory notifications were sent to the Care Quality Commission when required this included displaying their current rating from CQC. Statutory notifications are changes, events or incidents providers must tell us about.

The registered manager worked in partnership with a range of local health care professionals to support people's care so they were able to provide consistent care. These included GP surgeries, dietary professionals and social care professionals.