

Barrock Court Care Home Limited

Barrock Court Care Home

Inspection report

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Tel: 01697473765

Date of inspection visit:
15 January 2019
17 January 2019

Date of publication:
27 February 2019

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service: Barrock Court Care Home is a residential care home that provides personal care and support for up to 28 people. At the time of the inspection, 28 people were living at the service.

People's experience of using this service: People and their relatives were positive about the service, however we found a range of issues which needed to be addressed.

Medicines were not managed well. Including their administration, storage and recording.

Concerns had been raised over the care of people's skin. We found mattresses which were not fit to be used and pressure relieving equipment which was not always being used. We also observed people sitting for extended periods with no evidence of being moved.

Safeguarding systems and processes were in place, but these were not robust or monitored fully.

Audits and checks had not found what we had during the inspection.

The provider had not met their legal obligation to send the Care Quality Commission (CQC) all incidents which were notifiable. Staff had received training to protect people from various forms of abuse. Not all incidents had been recorded fully by staff or reported accordingly to the registered manager.

There was a registered manager in place, who was kind and caring. However, we had some concerns over their knowledge and ability to lead the service. They did not have a clear oversight of the care provided and there were mixed views on their visibility within the service.

We received mixed views from staff on the support offered by management. Staff said they felt supported, but that the registered manager did not always fully deal with issues arising.

The service was clean and tidy with no odours. However, we found urine soaked mattresses which were replaced after being found in need of renewal.

There was not enough staff in place to support people to meet their needs. Staff told us that safe recruitment procedures were followed when they applied to work at the service, including vetting checks and reference checks. Staff had received training in various topics, however further training had been organised to take place, including in connection with consent and skin management.

Care records were in the process of being fully reviewed, with new paperwork being implemented. In some cases, detail was missing or contradictory. Archived records were not secure or appropriately stored. We were unable to gain access to some records requested.

People's dietary needs were met, including those with special requirements. People were complimentary about the meals prepared.

There was a welcoming and homely atmosphere at the service and people and their relatives were happy and felt safe with the care provided and said staff were kind and caring.

A variety of activities took place at the service, but on occasions the activity coordinator was diverted to other duties to support the service which impeded on their availability.

We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in connection with safe care and treatment, safeguarding service users from harm and abuse, staffing and good governance. We also identified a breach in Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, notification of other incidents. We are dealing with this matter outside of the inspection process.

More information is in the full report below.

Rating at last inspection: Good (Report published on 27 September 2017).

Why we inspected: The inspection was brought forward due to information of risk and concern regarding poor care standards, we had received from the local authority and healthcare professionals.

Follow up: Following the inspection we referred our concerns to the local authority responsible for safeguarding. In addition, we requested an action plan and evidence of improvements made in the service. This was requested to help us decide what regulatory action we should take to ensure the safety of the service improves.

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 was not always safe.

Details are in our Safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring

Details are in our Caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our Well-Led findings below.

Requires Improvement ●

Barrock Court Care Home

Detailed findings

Background to this inspection

The 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.

Inspection team: This inspection was carried out by one inspector, a specialist advisor and one expert by experience. A specialist advisor is a member of the team with specialist knowledge in a particular area. This specialist was a tissue viability nurse specialist. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. This expert by experience was also a registered nurse.

Service and service type: Barrock Court Care Home 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.

Barrock Court Care Home accommodates 28 people across three separate units, each of which has separate adapted facilities. One of the units specialises in providing care to people living with dementia.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The inspection was unannounced.

What we did: Before the inspection we looked at all the information we held about the service including statutory notifications that the provider had sent to us about certain incidents that have occurred within the service. Due to the earlier planning of the inspection we had not requested information we require providers 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 contacted the local authority commissioning and safeguarding teams and the local Healthwatch.

Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services. We also contacted local community nursing teams. Any comments received supported the planning and judgements of this inspection.

During the inspection, we spoke with 14 people who used the service, four relatives and three visitors. We spoke with the regional director, quality assurance manager, registered manager, deputy manager, activities coordinator, three senior care staff, five care staff, the chef, administrator and one domestic. We spoke with four members of the community nursing team, a local GP and an occupational therapist.

We 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 reviewed a range of records including seven care records and all recent medicine administration records. We looked at records relating to the management of the service and the provider's policies and procedures.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Medicines were not managed safely.
- Unauthorised staff had access to medicines storage cabinets as keys were kept in drawers within the medicine room.
- People did not always receive their medicines as prescribed. For example, before food. One person with capacity was not asked if they wanted 'as required' pain relief during a medicine round (although we confirmed they could ask if needed). We asked the staff about this and they said, "I knew she didn't, you can tell by her face."
- Medicine administration records were not fully completed which meant we could not be sure that people had received their medicines as prescribed.
- Staff confirmed the temperature in the medicines room was not always maintained at appropriate levels. Staff told us it was often very hot in the medicine room during summer months.
- Staff had their competencies checked in medicines management, but this had proved ineffective.
- The provider's medicines policy did not always follow best practice and in some areas needed to be updated.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Staffing levels were not sufficient during the inspection and people were at risk of not having their needs met in a timely manner.
- People waited excessive times for call bells to be answered. We pressed one call bell and it took 14 minutes for staff to attend. One staff member told us, "The buzzer system doesn't work properly...they have changed it and the staff don't know how to use it." One person told us, "Waiting for the toilet is the worst thing. There are too many people wanting the staff. If it is a busy time, I wait a long time, a long time."
- We observed people were left in the same position for extended periods with no record to suggest they had been moved.
- The regional director told us during the inspection, "I cannot leave the lounge at the moment as there is no one to look over the residents."
- Safe recruitment procedures continued to be in place, including checks on staff suitability to work with vulnerable people.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Preventing and controlling infection

- Two mattresses were found to be soaked in urine beneath protective covers with a further two stained from dried urine. All were replaced during the inspection and after a review of all mattresses by the provider, a further three were replaced.

Failure to provide people with suitable clean bedding is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service was clean and tidy with no odours. We confirmed most staff had received infection control training.
- One visitor said, "I noticed after a few weeks that this place is really clean, it never smells."

Systems and processes to safeguard people from the risk of abuse:

- The provider did not have a robust system in place for protecting people from possible financial abuse. Although only small amounts involved, out of the three people's financial records we checked, all were incorrectly totalled and receipts were not always obtained and checked. The regional director said they would investigate this.
- Safeguarding systems, procedures and policies were in place. However, the provider had not reported all concerns or relevant incidents to the local authority safeguarding team or the Care Quality Commission in line with their legal responsibilities.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff knew about their responsibilities to report any concerns they had, but this was not always recorded and reported fully.
- Staff had received safeguarding training and were confident in their ability to identify any signs of abuse.

Assessing risk, safety monitoring and management

- People who were at risk of skin damage had not been fully supported as they had not been repositioned regularly or supported with equipment provided to them, in order to maintain their skin integrity.
- Healthcare professionals said the service was not always safe. Comments included, "We have lost some confidence in the home and are never 100% sure at the moment that any skin damage is being spotted and acted upon", "Some residents have developed pressure ulcers shortly after arrival here" and "The senior carer is really good here, she seems to follow through on our advice."
- Risk such as those in relation to people's medicines or those faced by staff had not always been assessed or adhered to, to minimise risk of harm.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Although we found issues with people's safety, the people we spoke with told us they felt safe.
- People were protected from falls, including having sensor mats in place to alert staff to movement when people were in their bedrooms.
- The environment was well maintained and health and safety, fire safety and equipment checks were carried out regularly.

- Emergency procedures were in place but some records were out of date in this area. These were updated immediately by the registered manager when we brought this to her attention.

Learning lessons when things go wrong

- Accidents or incidents were analysed to indicate if a pattern was forming.
- Investigations had taken place when medicine incidents had occurred, and lessons were learned and shared with all staff through meetings and discussion.
- Accident and incident forms were not always recorded. We spoke with the regional director who said this would be addressed.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Ensuring consent to care and treatment in line with law and guidance

- We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
- The registered manager followed the principles and guidance related to MCA and Deprivation of Liberty Safeguards (DoLS) authorisations and were working with staff to ensure they completed capacity assessments and best interest decisions appropriately.
- People were involved in decisions about their care; and staff knew what they needed to do to make sure decisions were taken in people's best interests. However, staff were not always documenting this clearly. The registered manager was working with staff to improve this with the introduction of new paperwork.
- Staff explained to people what they were about to do for them in order to gain consent. This included for example, personal care.
- Staff were not always clear which person had a lasting power of attorney (LPA) in place nor had copies of LPA been gathered to confirm any decisions were carried out legally when relevant. (LPA) is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself. There are two types of LPA; those for financial decisions and those that are health and care related.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff continued to receive an induction and ongoing training that the provider deemed as mandatory which included, for example, manual handling of people and health and safety.
- We noted that not all staff had received training in connection with the MCA and DoLS but this was booked to take place imminently.
- One healthcare professional said, "There are some training and staff development issues here but I think the care staff really do care."
- Staff told us they received regular support (supervision) sessions and annual appraisals with their line manager.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs had been assessed before moving into the service to ensure they could be met.
- Care had been planned to meet people's needs. Care records varied in how detailed they were. Where

people's needs changed their care plans had not always been updated.

- The provider was in the process of updating all care records with new documentation and full reviews were taking place.
- People's choices were recorded, including for example, people's preferred communication style, what they ate and how they liked to dress. One person said, "I can choose where I sit. Sometimes I eat in my room. The cook will always make something I like. Nothing is too much trouble."

Supporting people to eat and drink enough to maintain a balanced diet

- Food was of a good standard and all special diets were catered for.
- People and their relatives were positive about meals prepared. One person said, "The food is very good and well made. I really do enjoy my food." One relative told us, "The food looks lovely and (person) appears to enjoy it."
- During the lunch time meal staff provided encouragement to people to eat and drink where needed.
- However, in some cases people had more than three staff helping them with a single meal. This is not conducive to a positive mealtime experience. The operations director said this would be looked at along with staff deployment.
- People at risk of weight loss were monitored and supported by other healthcare professionals. Any concerns were acted upon, including giving people additional fortified milk shakes or other supplements.
- A GP confirmed, "I have no concerns for patient's nutritional or hydration needs."
- However, the checking of food and fluid intakes was not robust where people had been identified as needing their food and fluid intake monitored.

Adapting service, design, decoration to meet people's needs

- The premises were homely, and pleasantly decorated with various areas having been refurbished, including bathrooms and toilets with further work planned.
- The service was accessible to wheelchairs and people moved about freely in each of the three areas of the service, which included enjoying time with others in lounge and dining areas.
- People's rooms were personalised. One person said, "I like my room with all my bits and pieces."
- There was signage to support people to find their way around the service. This included signage on bathrooms and toilets.

Supporting people to live healthier lives, access healthcare services and support

- The service worked with other agencies and professionals to ensure people received effective care. However, communication within the service had declined and we saw evidence that healthcare professionals had been called to the service twice for the same issue because information had not been passed over between staff.
- People told us they had access to a range of healthcare professionals, including GP's, community nurse teams, speech and language therapists and hospital specialists.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; equality and diversity

- We found issues of concern during the inspection which we judged were not caring. These are detailed in other areas of the report, including people not always being supported well with their identified needs, particularly skin integrity, mealtime experiences, mattresses used and also not being protected appropriately from harm or abuse.
- People and their relatives or other visitors were overwhelmingly positive about the care provided at the service. Comments included, "The only way to describe the staff here are angels"; "This home is just perfect. The staff are just fantastic" and "My mother appears to be adjusting well to her environment and that is because of the good staff."
- Staff cared about the people they supported. A staff member told us, "I love working here; I have worked here for 18 months. I love the residents...It's the best part of the job. The worst part of the job is when a resident dies. It affects us all as we're close to everyone."
- People were well presented and looked comfortable in the presence of staff.
- Staff were patient and supported people in a friendly way. They had a good rapport with people.

Respecting and promoting people's privacy, dignity and independence

- Information of a personal and sensitive nature regarding people living at the service, including their previous addresses and GP details was contained within emergency procedural information in the reception area of the service. This did not protect people's privacy or dignity. We spoke with the registered manager about this and they told us this would be removed straight away.
- People told us staff promoted their independence. One person said, "The staff asked me if I wanted to change rooms, but I am happy with the one I have, so I chose to stay here."

Supporting people to express their views and be involved in making decisions about their care

- People and relatives were involved in planning how staff would provide care. People were involved in the care planning process as much as they were able. Records referred to what people wanted, and how specific aspects of care made them feel.
- Relatives said they were listed to and felt involved in their family members care.
- Information on advocacy services was available. Advocates help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- Care was planned around people's individualised needs and preferences.
- Care plans were in the process of being replaced with new paperwork to make them more person centred and up to date. We found that not all current care documentation was fully reflective of people's needs or reviewed regularly. For example, one person had fallen and their care plan and risk assessment had not been updated to reflect this information and change in their circumstances.
- The Accessible Information Standard is a framework which was put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Although the registered manager did not fully understand this standard, people were helped to wear hearing aids and reading glasses if they needed additional support.
- People told us they were generally happy with the activities available to them, although one person told us there could be more.
- The service had a bar area with dominos and TV for people to enjoy a drink in a familiar setting. There was also a shop and hairdressing salon. During the inspection there was no activity coordinator available and staff told us that they were expected to complete activities when this occurred. However, staff said, "We are too busy most days to do any more than care for people" and "The activities coordinator gets jobs to do in the office as well as her own job."

Improving care quality in response to complaints or concerns

- People and their relatives knew how to make a complaint. Relatives told us they would not hesitate to get in touch with the deputy or registered manager if they had any queries or concerns.
- There had been no complaints recorded since our last inspection.
- A complaints policy was in place and information on how to complain was on display within the service.

End of life care and support

- End of life care plans were in place for those people who chose to have them, detailing arrangements for, and after their deaths.
- The service had links with local GP's and community nursing teams and it was confirmed that a pain free passing would be sustained with this additional support.
- Do not attempt cardiopulmonary resuscitation (DNACPR) forms were in place for some people and staff were aware of the need to adhere to them if a cardiac arrest occurred.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding of quality performance, risks and regulatory requirements

- We had concerns about the competence, knowledge and oversight of the service by the registered manager and deputy manager. This was confirmed by healthcare professionals we spoke with who said the registered manager was not visible in the service. Staff we spoke with told us the registered manager rarely attended handover meetings.
- Staff said they generally felt supported, but said that the registered manager lacked confidence to address issues that had arisen and preferred to pass on to less senior staff to deal with.
- The registered manager told us they completed daily walkabouts around the service, however, records of this had only recently been completed.
- The registered manager had no understanding of the Accessible Information Standard (AIS) and did not realise that alcohol was easily accessible to vulnerable people at the service, including those living with dementia. AIS makes sure that providers are meeting the information and communication support needs of people living at their service.
- The registered manager had not always recorded or reported safeguarding concerns and incidents involving people using the service to the local authority for investigation, or CQC for monitoring purposes. We are dealing with this matter outside of the inspection process.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 notification of other incidents.

- Systems, including governance and quality assurance checks were not robust. Audits and checks had taken place but actions had not always been noted when issues had been found, nor followed up when they had been noted. These checks had not identified the failings we found during the inspection, which have resulted in the provider being in breach of five regulations.
- Robust mattress checks were not in place which allowed people to have unfit mattresses.
- The provider had completed visits to the home to monitor quality, but these were not effective, and for example, had not identified concerns regarding pressure care until this was raised by the healthcare professionals.
- Records were not always kept or completed appropriately. This included care records, turn (movement) charts, lasting power of attorney documentation and food and fluid charts. A list of people and their bedroom numbers showed four people incorrectly recorded as living in the same room.
- Archiving of people's care records and other documents relating to the service being delivered were not secure or easily accessible as some information we requested could not be found.

- The provider's website had misleading information, stating that the service was a nursing home. We brought this to the attention of the regional director who said they would address this.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- The regional director and quality assurance manager were very open with the inspection team and happy to discuss issues found and were keen to address concerns quickly.
- Staff had a willingness to provide person centred, high quality care, however, governance arrangements and oversight had hampered this from always occurring.
- Staff were open and kept relatives up to date with any concerns they had about their family member.
- When things went wrong or people came to harm, apologies were provided. We confirmed that the requirements of the Duty of Candour regulation had been met.

Engaging and involving people using the service, the public and staff

- People had been involved in completing surveys on the quality of the service, including in relation to food satisfaction.
- Meetings for people and their relatives had not been organised regularly. However, the registered manager told us they planned to hold a meeting soon.
- Staff attended team meetings and ad hoc meetings to discuss the service and any issues arising. Staff confirmed they had a chance at these meetings to ask questions.
- The provider's website provided an overview of activities occurring in their services and offered general information, including links to other organisations.

Working in partnership with others

- A weekly GP visit took place to support people and help reduce hospital admissions and promote better care.
- The registered manager told us they had good relationships with organisations such as local churches so that people could access information about how they could be supported with their faith.
- Healthcare professionals told us they used to work well with the service, but this had worsened. The registered manager and regional director told us they were keen to address this.
- The service had links with volunteers who were on placement at the service from local education providers. We spoke with one who said they really enjoyed their time working at the service.

Continuous learning and improving care

- The registered manager and regional director acknowledged that processes in connection with their submission of notifications to the Care Quality Commission was not fully robust. We directed the management team to guidance that would support them.
- The provider produced a 'Quality Matters' bulletin for all of their services. This included detail of best practice developments and guidance for staff to support continuous improvement.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered persons had failed to ensure the safe management of medicines.</p> <p>Risks had not always been assessed or mitigated to keep people safe.</p> <p>Equipment was not always appropriate or safe for people to use.</p> <p>Regulation 12 (1)(2) (a)(b)(e)(g)(h)</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>The registered person had failed to fully protect people as systems and processes were not robust and operated effectively to prevent abuse of service users.</p> <p>Regulation 13 (1)(2)(3)(6)</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The registered persons failed to effectively assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.</p> <p>Records were not always stored securely or</p>

kept fully up to date.

Regulation 17 (1)(2)(a)(b)(c)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

The registered persons had failed to ensure that enough trained and suitable numbers of staff were available at all times.

Regulation 18 (1)(2)(a)