Healthcare Homes Group Limited

Barking Hall Nursing Home

Inspection report

Barking
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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

The inspection took place on the 25 November 2015 and was unannounced. Barking Hall Nursing Home provides care and accommodation for up to 49 older people. There were 44 people living at the service on the day of our inspection.

The service has a registered manager. 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.

People spoke positively about the service and the approach of staff however they expressed concerns about staffing levels and how this impacted on their daily life. We found that staffing levels were not adequate and this meant that at times people had to wait unduly to receive support. The home was not fully staffed and permanent staff were being supported by agency staff, we were told that staff recruitment was underway to cover existing vacancies. The systems in place to recruit staff were thorough and provided protection to people. Staff had a good understanding of abuse and the steps that they should take to protect people.

Summary of findings

Risks to individuals such as those associated with tissue viability and falls were identified but not always managed in a proactive way which took into account best practice. Management plans would benefit from greater detail and more analysis.

Induction training provided new staff with the guidance they needed and staff told us that they were well supported when they started work at the service. Training to further develop staff skills and knowledge was not however effective as it did not ensure that staff had to knowledge they needed to meet people's ongoing health and support needs.

People were provided with a balanced diet but told us that they would like greater variety. The availability of staffing impacted on the serving of meals and meant that people had to wait to be served.

Care plans documented people's needs but varied in quality which meant that some people were at risk of receiving inconsistent care.

Activities were regularly provided but did not always meet people's needs and promote their wellbeing.

The manager was approachable and promoted an open culture. Staff knew what was expected of them and there were systems in place to drive improvement.

The service provided training in the form of an induction to new staff and comprehensive on-going training to existing staff. The senior staff in the service were knowledgeable with regard to Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The service had made referrals and worked with the Local authority to support people who used the service with regard to (MCA) and (DoLS).

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe. There were at times insufficient numbers of staff to meet people's needs.

Risks had been identified however the management plans were insufficiently detailed

Medication procedures did not always ensure that people received their topical medication when needed.

Staff had a good understanding of how to recognise and report any signs of abuse.

Is the service effective?

Requires improvement

The service was not consistently effective

Staff had not all received training which gave them the knowledge to meet people's needs.

Mental Capacity assessments were in place, although staffs understanding was variable

People were provided with a balanced diet but told us that they would like greater variety. The availability of staffing impacted on the serving of meals.

People had good access to health care support

Is the service caring?

Good

The service was caring.

Staff had developed positive relationships with people who used the service.

People were supported to express their views and make decisions about their care.

People had their privacy and dignity respected.

Is the service responsive?

Requires improvement

The service was not consistently responsive to people needs

Care plans were not always informative and sufficiently detailed to enable staff to meet people's needs in a consistent way

Some activities were planned in line with people's interests, but some people said they were unstimulated and lonely.

People's complaints were investigated and responded to

Is the service well-led?

Good

The service was well led

Summary of findings

There was an open culture.

The management team were approachable. They had systems in place to gather information which was used to identify shortfalls and drive improvements.

Barking Hall Nursing 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 was planned to check 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 inspection took place on the 25 November 2015 and it was unannounced. The inspection team consisted of two inspectors and a professional advisor who had specific skills in the area of nursing care and tissue viability.

Prior to the inspection we reviewed the information we held about the service including notifications of incidents that the provider had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law. We also looked at safeguarding concerns reported to us. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

There were 44 people living in the service. We spoke with twelve people, nine staff, the manager and the quality and compliance officer. We looked at staff records; peoples care records and records relating to how the safety and quality of the service was being monitored. We observed care practice, medication administration and the staff handover meeting.

Requires improvement

Is the service safe?

Our findings

People told us that there was not always sufficient staff to meet their needs promptly. One person told us, "At times the home seems short of staff. The response to bells can be a long time. Up to an hour on occasions." Another person said that they have had accidents as they had to wait to use the toilet. Another person said that when they ring to go to the toilet they are told, "Wait, wait, wait, I have got to go and find someone as I need two staff." The manager told us that they monitored the call bells and checked the response times. They said that sometimes staff forgot to turn the bells off when they went into people's rooms. However, a number of people told us that there was a very long wait if they rang the call bell. One person said, "The call bell is supposed to call staff but they don't come for a long time." Another person told us, "The staff sometimes say they'll only be a minute and it feels as if it's an hour."

Staff said that a few staff had recently left and there were some vacancies but the manager was in the process of recruiting replacement staff. They said that when the home was full they were able to have an extra member of staff on from 7-11am and 5-9pm to help over the busy periods. Staff said that the service could be short of staff at weekends if staff called in sick at short notice. They said that this could result in care becoming more task orientated. One member of staff said "People want conversation", but there is not always enough staff to enable them to spend time with people. Another member of staff said that they would like more time to chat to people, especially in the mornings. They described the morning shifts as feeling "a bit like a conveyer belt".

The manager said that they monitored the overall dependency levels in the home. They said that the staffing levels related to the dependency levels and the company were in the process of introducing a new dependency tool

During our inspection we observed that staff were busy and continued to assist people with personal care and their breakfast up until late morning. Call bells were ringing almost constantly. We observed staff making efforts to answer the bells but this meant that they were not always visible. Some people spent long periods unsupervised in communal areas. We sat in one lounge for 15 minutes before a carer appeared, the individuals in the lounge did not have an accessible call bell which would enable them to call for assistance. The manager told us that they monitored the call bells as part of the quality assurance system and during the period of our inspection 72% of calls were answered within 3 minutes.

The staffing shortfalls are a breach of Regulation 18 of the Health and Social Care Act 2008 (regulated activities) regulations 2014

We looked at the recruitment records for two staff who had recently been appointed. Application forms were in place and records showed that checks such as references and Disclosure and Barring Scheme (DBS) checks had been made prior to the commencement of employment. This was to ensure that they were safe to work with people.

People told us that they felt safe in the home. One person said, "I feel safe here." Another person told us, "This is one of the better care homes. I'm pretty comfortable and I feel safe here."

Risks were identified but not always managed in a proactive way. A range of assessment screening tools were used by staff to identify risks. The Malnourishment Universal Screening Tool (MUST) was used to identify individuals at risk of malnourishment and waterlow risk assessments were undertaken to identify those at risk of pressure damage. Where risks were identified there were plans in place to manage the risks, although these were not always robust as they did not clearly document how the risks should be managed. For example they did not document the settings of pressure relieving mattresses and we saw that one person was using a mattress which was not set at the correct setting for their weight. We raised this with staff who agreed to immediately address the issue. Pressure relieving cushions were being used however; these are not labelled for use by individuals. We observed that one very worn cushion was positioned on the floor, under the leg of a resident with a pressure ulcer which, is not appropriate and reflective of best practice. Records were in place to evidence that individuals were being repositioned on a regular basis

Risk assessments were in place for those individuals who had bed rails in place however these were not sufficiently detailed and did not evidence that a clinical assessment had been undertaken and other methods of falls prevention has been assessed. One person was using their bed rail as a means to move up the bed and it was agreed

Is the service safe?

that their independence could be better promoted by using alternative equipment. The manager told us that falls diaries were used for individuals who had more than two falls in any calender month.

Environmental risk assessment and fire safety records for the premises were in place to support people's safety. We saw that tests were undertaken on appliances and equipment such as electrical equipment, water temperatures and moving and handling slings to ensure that they were safe to use.

Medicines were not always consistently well managed. We observed the medication round as part of our inspection and noted delays in the administration of medication. The morning medication round was not complete until midmorning and this impacted on the timings of the afternoon administration. The manager agreed to review this with the nursing staff but told us that this was unusual and there was not normally a delay. During our observations we also noted that a member of staff signed to confirm that medication had been taken prior to administering it to the individual. This is not recommended practice as it does not take into account that the individual may change their mind.

People we spoke with were happy with the ways that staff managed their medicines. One person told us, "I get my pills at the right time and they always ask if I'm in pain." We observed that the nurse discussed each person's medicine with them and ensured they had a drink, as well as giving them time to take their medicines. Photographs were in place for identification purpose. There were protocols in place for medicines that were prescribed on an 'as required' basis.

The medicine trolley was kept locked when unattended. Two staff signed the Medication administration records when changes to prescribed medications were made. We checked samples of Controlled Drugs (CD) and saw that they were appropriately signed for and the quantities in stock tallied with the CD register.

According to the records in people's rooms staff were not applying their topical cream on a regular basis. There was no record of the condition of people's skin on the cream record or in the daily records we looked at. One person had extremely dry and scaly legs. They told us, "Staff only put cream on my legs occasionally." A member of staff we spoke with told us that they would ensure this person received the right cream on a regular basis.

Staff received training in a range of safe working practices. This included safeguarding vulnerable adults. Staff had an understanding of the different types of abuse that could occur. They said that they felt confident about reporting abuse or poor care practices to senior staff and managers within the home. They were aware of the whistle blowing policy. Although some staff were less confident about how they would report concerns to outside authorities if this was necessary.

Requires improvement

Is the service effective?

Our findings

Training was provided but it did not always equip staff with the knowledge that they needed to carry out their role. Staff told us that they that they had undertaken induction training when they had first started to work at the service; this included a range of areas including safeguarding and moving and handling. Staff also shadowed a more experienced member of staff until they felt confident to work on their own. One member of staff said that they had worked with another member of staff for two weeks before they worked independently. We saw that some of the training such as moving and handling and medication included an assessment of competence before undertaking these duties.

The majority of the ongoing training was eLearning or through social care television and not classroom based. This meant that staff were not able to gain greater understanding by discussing the training and relating it to people's specific needs in the home. We found that there were some gaps in training, nursing staff had not undertaken training on falls management. A significant number of staff had not undertaken training in dementia and staff thought that this would be helpful. Care staff did not receive any training related to people's medical conditions. Staff knowledge about people's medical conditions was very variable and tended to be better if they had received training in a previous care role with another provider. One person was on insulin and at times their diabetes was unstable. However, some staff did not know the signs to look out for if a person with diabetes had a low or a high blood sugar. The service had a number of people living with Parkinson's disease. However, some care staff did not understand the link between their medicines and their ability to move. Although the home provided regular care for people at the end of their lives none of the care staff had received end of life care training.

Staff told us that they were supported by the management team. We looked at the records of supervision and saw that while they had been undertaken regularly in the past there were gaps in recent months. The manager told us that they had attended a number of handover meetings to ensure that key messages were delivered.

Mental capacity assessments had been carried out and demonstrated that some people had capacity to make day to day decisions about their food and their personal care but could not always make more complicated decisions about medical care or any financial decisions. One assessment we looked at stated the person may need, "A little extra time….but can communicate decisions." Care staff had received Mental Capacity Act training but they had a variable understanding of its application to their role. Some care staff had an understanding of how the Mental Capacity Act was important and how people should always be assumed to have capacity unless there was proof to the contrary. All of the care staff we spoke with stressed the importance of involving people in decisions and giving them choices. They were able to give examples of how they encouraged and supported people to maintain their abilities and independence for as long as possible. We saw that people, and their relatives where appropriate, had been consulted about decisions on their care and treatment at the end of their lives. Applications had been made to the appropriate professionals for assessment when people who lacked capacity and needed constant supervision to keep them safe. This met the requirements of the Deprivation of Liberty Safeguards (DOLS.)

People were generally happy with the quality of the food but felt that it lacked variety. One person told us, "The food is reasonable but it's a bit repetitive. It would be improved if there was more variety." Another person said, "You get choices but they are often the same choices." People told us that they could ask for snacks at any time and there were sweet and savoury snacks and fruit in all the communal rooms. A person said, "The food is very good but it's sparse, I'm used to bigger helpings. They don't ask me if I want some more. I'm getting used to the smaller amount." The manager agreed that they would discuss portion sizes with the individual. People very much appreciated that they were offered an alcoholic drink before meals and we saw a number of people enjoyed a drink of shandy with their lunch.

People told us that they were encouraged to go to the dining room far too early and had to wait to be served their food. One person said, "I don't like going down to lunch and sitting there for ages." Another person told us, "I can wait an hour for food in the dining room. That's my worst moan." On the day of our inspection lunch was delayed and people sat in the dining room for a significant period before staff were available to serve them.

The meal served on the day of the inspection looked and smelled appetising. One person with communication

Requires improvement

Is the service effective?

difficulties had not eaten their lunch. Staff were very patient when finding out what alternative they wanted, using their preferred method of communication. People received the support they needed to eat the meal. For some people this was cutting up their food and one person had a plate guard so that they could eat independently. We observed staff assisting people to eat, this was undertaken sensitively and staff sat alongside individuals and chatted with them. The support provided was appropriately paced.

Records were in place to evidence that people's food intake was being monitored but these were not working effectively. New documentation had recently been introduced for individuals identified as being at risk however there was not enough room for staff to give details of the food actually eaten or the types of drinks taken. We also saw an example were staff were 'over optimistic' in their recording and recorded that one individual had eaten more that we observed. The nurse on duty agreed to address with the member of staff. However we concluded that it was not possible from the records to assess whether people were getting adequate nutrition to prevent or reverse weight loss.

People were supported to maintain their health and access on going health support. People told us that they were able to access GP support and we saw that appropriate referrals were made . We saw that people were weighed regularly and referrals were made to the dietician when concerns were identified. We saw that one person had been assessed by the speech and language therapist (SALT) about the consistency of the food and drink it was safe for them to have. The therapist had given instruction for the safest position for them to eat and drink in order to reduce the risk of aspiration. Staff confirmed that they followed these instructions.

People told us that they saw the chiropodist on a regular basis. The manager told us that people kept their own optician if they wished or saw the visiting optician. Some people visited a local dentist and a community dentist also provided dental care at the home if needed.

Good

Is the service caring?

Our findings

People were complimentary about the staff and the support they received. One person told us, “The staff are very friendly and treat me with respect. They help me get up in the morning. I’m happy with the care.” Another person said, “I get on well with all the staff. I think the staff are very good. They give me a shower if I want and help me in the way that I like.” A third person told us, they keep me warm, we’re well fed and it’s like being in a private hospital’.

Our observations of interactions were that they were generally caring and compassionate. People were spoken to in a kind and patient way and staff took their time to explain to people what they were doing and why. Staff knew individuals well and spoke knowledgeably about individuals needs and preferences

People generally looked well cared for and we saw that there was a hairdresser who visited regularly. However we did note that some people had facial hair and it was not clear from their records if this was their choice and whether this was important to them to have it removed. Some individuals who could not cut or clean their nails also needed more regular nail care

We could see that care plans were developed with peoples preferences in mind and on occasion relatives had been consulted. We were told of, ‘Resident of the day’, whereby everything relating to the person was reviewed. We were told that the person themselves was involved and saw this process in action on the day of our inspection.

Relatives told us that they were enabled to visit when they wished and the staff communicated well with them. One person said, “The staff phone and let us know when the Dr has been and if there has been any changes to (their relatives) care.”

We saw that meetings were held with individuals and relatives on a monthly basis. The minutes of the last meeting had been well attended, and people were encouraged to share their views, opinions and ideas.

Staff were respectful in how they addressed people and were mindful of confidentiality, ensuring personal matters were spoken about quietly. Privacy was respected and doors closed when needed. Staff spoken with gave good examples of how they encouraged people to maintain their independence.

Requires improvement

Is the service responsive?

Our findings

We saw that preadmission assessments were undertaken before people moved into the service and this information was used to develop a plan of care. People's views were sought as part of this process, however we found that the care plans varied in quality. Some were person centred and gave staff a good impression of people's abilities, needs and preferences; others were extremely brief and gave very little information. In some instances the care records were contradictory and key information was omitted. One person's care plan stated that they needed mouthwash twice a day but their oral hygiene assessment stated that they needed four hourly mouth care. Another individual had two eye infections in a six month period however; they were not receiving regular eye care that might help to reduce the risk of further infections. There was no mention of their eye infections in their care plans. Another person had had a number of falls but we could not see evidence that they had been referred to a falls prevention service.

Care plans did not adequately detail how wounds were being managed, the status and size of the wounds being treated. The nurses on duty said that wounds should be measured weekly and put in the care plan but this level of detail was not in place. In one case, a wound is described as being on the left foot when, it was actually on the right foot. Photographs were not being taken at suitable intervals as there was nothing in the care plans to advise when these needed to be taken. The same applied to the measuring of wounds. Photographs and measuring of wounds are key practices in determining the healing and/or deterioration of wounds.

Activities were provided but did not always meet people's needs. People were not enthusiastic about the activities in the home and told us that none were available at the weekend. One person told us, "There could be more activities." We asked another person about activities and how they occupied themselves during the day. They said, "I sit in the sitting room all day, that's all I do. I used to enjoy sewing and knitting but I've lost the ability." Another person told us, "They don't have any activities that are right for me personally." One person told us that they were lonely and they only, "Saw people walking past their door but really only saw people at mealtimes."

We saw that there was an activity diary in place and a sherry club took place in the mornings in one of the lounges. There was a planned exercise class one morning each week and crafts or bingo in the afternoons. We observed the morning session in one of the lounges. A small group of people were in attendance and after they were offered a sherry, the two staff members spent time with them looking at some photographs of the summer fete. The atmosphere was relaxed and those participating enjoyed talking about what they could see.

The manager told us that they had started a new "Buddy" project which they hoped would prevent social isolation and tailor activities to individuals.

The majority of people told us that they had not needed to make any complaints. One person said, "I've complained about the waiting times before meals. They know we're fed up with it but it hasn't improved." They added, "But on the whole it's a very good home. It's pretty good all round."

We looked at the records of complaints and this showed that complaints had been investigated and responded to. Where shortfalls or learning was identified the manager was able to demonstrate that actions were taken to address the concerns raised.The manager told us that they had received complaints about delays in the response times and this had been investigated and call bell response times were monitored. The feedback from individuals on the day of the inspection did not indicate that this had been fully resolved. Records of compliments were also maintained and used to encourage good practice. One person had written, "You are top of the tree for always going the extra mile for everyone."

Good

Is the service well-led?

Our findings

People told us that although they had raised concerns about shortfalls in staffing levels, they thought the home was well managed. One person told us, “This is the best place I could find.”

Staff spoke about the home in a positive way. One member of staff described the service as “homely.” Another member of staff said, “The staff are friendly. We all get on and work well as a team.” We observed the handover between staff on the day of the inspection and found that it was informative and ensured that all staff were aware of any changes to people’s needs before they came on duty.

Staff told us that they felt well supported by the management team and received regular supervision. Staff said the managers were very approachable. One member of staff said that the managers were supportive at organising their rota in a way that helped them meet their family commitments. One described very good support following bereavement. We saw that a number of staff had recently been given long service awards, reflecting their long service and commitment.

The manager said that they encouraged reflective practice and a questioning attitude amongst the staff. They supported staff who reported any mistakes they made and used this to drive quality improvements. They encouraged staff to learn from their mistakes. We saw the minutes of staff meetings where the duty of candour had been discussed and the importance of being open and honest when things go wrong. We saw examples of where the manager had taken suggestions from staff on board and was trialling different ways of doing things such as recording.

The manager was accessible and visible. We observed them working alongside care staff to deliver care at busy periods. They were knowledgeable about the needs of the people who lived in the service. We observed the manager directing staff and addressing issues in a positive way. The manager understood their responsibilities around key areas such as safeguarding and we saw that they had taken advice appropriately. They also demonstrated their knowledge of their legal responsibilities for notifying CQC of deaths, incidents and injuries which effected people who lived in the service.

The manager had systems in place to check the quality of the care provided and drive improvement. Weekly meetings were held with head of departments and regular meeting with the deputy manager and nursing staff. There was also oversight of the daily handovers as well as collection and oversight of data on areas such as falls, weight loss and accidents. This information was used to identify any concerns which required escalation to prevent a reoccurrence. The manager showed us external audits which had been undertaken by the pharmacy and the clinical commissioning group.

The provider had arrangements in place to monitor the quality of care. The manager completed a range of information on areas such as medication, infection control and record keeping each month and forwarded this to the provider to review. Provider audits were available and we saw that these included observations on how care was delivered and people supported. The reports provided to the manager highlighted areas of good practice as well as suggestions for improvement

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There was at times insufficient numbers of suitably trained staff deployed to meet people's needs.**