

Bupa Care Homes Limited

Barton Brook Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Good ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

We carried out this unannounced inspection of Barton Brook Care Home on 12 and 14 July 2017. This was the first inspection of Barton Brook Care Home since it had been re-registered with the Care Quality Commission in January 2017. The re-registration had taken place as a business entity to reflect changes to the providers named responsible people. This did not create any changes to the overall registration of the home.

Barton Brook Care Home is a large care home with 120 beds operated by Bupa. The home consists of four different units, each with 30 beds. Each of the units are known internally as Moss (Residential Dementia), Irwell (Nursing and Intermediate Care), Brindley (General Nursing) and Monton (General Residential). The home is situated in the Eccles area of Salford, Greater Manchester and at the time of the inspection, there were 119 people living at the home.

At the time of the inspection the home had 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.

The feedback we received from staff and some visiting relatives was that staffing levels were not sufficient to meet the needs of people living at the home, particularly on the Brindley, Irwell and Moss Units. We were told there were enough staff on Monton unit. We have made a recommendation about staffing levels in the detailed findings of this report.

We found the home to be clean with appropriate infection control processes in place, with the home achieving a score of 93% during their last audit from Salford City Council. All of the toilets and bathrooms contained appropriate hand hygiene equipment and guidance, with personal protective equipment (PPE) readily available and worn by all staff when necessary.

Each person we spoke with told us they felt safe. Relatives were also satisfied with the safety of their family members, commenting positively on the good standard of care provided. The home had detailed safeguarding policies and procedures in place, with clear instructions on how to report any safeguarding concerns to the local authority. Staff were all trained in safeguarding vulnerable adults and had a good knowledge of how to identify and report any safeguarding or whistleblowing concerns.

The home had systems in place for the safe storage, administration and recording of medicines. The completion of the medication administration records(MAR) was done consistently and the home had effective systems in place for the administering of topical medicines. Staff authorised to administer medicines had completed the necessary training and had their competency assessed. Safe systems of working were also in place with regards to the administration of controlled drugs.

All staff demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which is used when someone needs to be deprived of their liberty in their best interest. We found DoLS applications were not always made in a timely manner when staff had identified that people lacked the capacity to make their own choices and decisions. This presented the risk of people being detained or restricted without lawful authority.

Overall, staff were complimentary about the training provided by the home, regarding both induction and on-going refresher sessions. An online system was available which allowed staff to complete additional training in their own time. Staff told us they received reminders when refresher training was required to keep their skills and knowledge up to date.

Staff on the Brindley unit told us due to the care needs of two people living on the unit who presented with mental health needs, that training in this area would be beneficial to them and other staff working on the unit. We noted this was not an area covered on the homes training matrix. This would enable them to gain more of an understanding in this area and provide appropriate care in response. We have made a recommendation about training in the detailed findings of this report.

Staff confirmed they received supervision and appraisal as part of their on-going development. We looked at a sample of these records during the inspection and found they were completed with good detail about the discussions that had taken place.

Meal time observations showed these to be a positive experience, with people being supported to eat where they chose such as in their bedroom or in the main lounge. Both the Brindley and Irwell House units had a dedicated 'hostess' who assisted people at mealtimes as necessary, giving extra to help to care staff as needed.

We found people received enough to eat and drink, however accurate records regarding people's food and drink intake were not always maintained by staff.

People told us they received enough to eat and drink and were offered a good choice of meal options, with alternatives available. We saw nutritional assessments were in place and special dietary needs catered for.

The people we spoke with and their families told us a good standard of care was provided at Barton Brook. People said they felt treated with dignity, respect and that staff promoted their independence as necessary.

We looked at 17 care files which contained accurate and detailed information about the people who used the service and how they wished to be cared for. Each file contained detailed care plans and risk assessments, along with a range of personalised information which helped ensure their needs were being met and the care they received was person centred.

The home employed several activity coordinators, who planned and oversaw the activities completed within the home. Activities were scheduled throughout the week and were displayed on a notice board on each unit, informing people what was coming up. The activity coordinator also took people out into the local community if they were able to.

There were systems in place to seek and act on feedback from people living at the home such as satisfaction surveys, staff/residents meetings and a complaints procedure. The home maintained a record of compliments in addition, where people had expressed their satisfaction with the service provided.

The home had a range of systems and procedures in place to monitor the quality and effectiveness of the service. Audits were completed on a daily, weekly and monthly basis and covered a wide range of areas including medication, care files, infection control and the overall provision of care. Random spot checks were also undertaken on each of the units. This involved either a the unit, or registered manager arriving at the unit out of hours and conducting observations.

We saw evidence of action plans being implemented to address any issues found. Additionally the provider completed monthly inspections of the home, providing a detailed report, along with positive feedback and areas for improvement.

We found the homes internal quality assurance systems had not been fully effective. For example, where DoLS applications had not been made in a timely manner and where accurate records had not been maintained with regards to people's food and fluid intake.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe, although we have made a recommendation with regards to staffing levels in the report.

The feedback we received from the majority of staff was that staffing levels were not sufficient. We have made a recommendation about this in the report.

Staff had a good understanding about safeguarding and how to report concerns. People living at the home felt safe.

Medicines were given to people safely.

Is the service effective?

Requires Improvement ●

Not all aspects of the service were effective.

Although we saw people received enough to eat and drink, accurate records about people's food and fluid intake were not always maintained.

We found DoLS applications were not always made to the local authority in a timely manner when staff found people to lack capacity.

Staff told us they received sufficient training to support them in their roles, however we have made a recommendation about enabling staff to have access to training related to mental health.

Is the service caring?

Good ●

The service was caring.

The people we spoke with and their relatives told us they felt good care was provided at the home.

People said they felt treated with dignity, respect and that staff promoted their independence as necessary.

We observed interactions between staff and people living at the home to be kind and caring.

Is the service responsive?

Good ●

The service was responsive

Staff had a good understanding about people's care needs and the assistance people required.

The home had appropriate systems in place to seek feedback from people who lived at the home.

People had detailed care plans in place meaning staff had access to information about people's care needs.

Is the service well-led?

Requires Improvement ●

Not all aspects of the service were well-led.

Quality assurance systems had not been fully effective and we identified breaches of the regulations.

Staff told us management were visible, approachable and could speak to them about concerns.

Staff meetings were held regularly across each of the units, giving staff the opportunity to speak about their work.

Barton Brook 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 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.

The inspection took place on 12 and 14 July 2017. The first day of our inspection was unannounced, however we informed the registered manager we would be returning for a second day to complete the inspection and announced this in advance.

We spent the first day of the inspection predominantly on the Moss, Irwell and Brindley units, whilst the second day of the inspection was spent on the Monton and Brindley units. During this time we carried out observations, reviewed care documentation and spoke with staff, visitors and people living at the home.

The inspection team consisted of three adult social care inspectors and a pharmacist inspector from the Care Quality Commission (CQC), a specialist advisor (SPA) with expertise in nursing care and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses health and/or social care services.

Before commencing the inspection we looked at any information we held about the service. This included any notifications that had been received, any complaints, whistleblowing or safeguarding information sent to CQC and the local authority. We also contacted other healthcare professionals involved with the service such as the local Safeguarding, Infection Control and Environmental Health teams based at Salford City Council. We also contacted the local Clinical Commissioning Group (CCG) and Salford Healthwatch. The feedback we received was used to inform our inspection judgements.

During the course of the inspection we spoke to the registered manager, the clinical services manager, each of the four unit managers, 21 care staff including nurses, 11 people who lived at the home and six visiting relatives.

We looked around each of the four units within the home and viewed a variety of documentation and

records. This included five staff files, 17 care plans, 32 Medication Administration Record (MAR) charts, meeting minutes, policies and procedures and audit documentation.

Is the service safe?

Our findings

Both people living at Barton Brook Care Home and the visiting relatives we spoke with said they felt the home was safe, with nobody raising any concerns about their general safety. One person said, "It's a nice place here and I feel safe. The staff have been there for me when I need them." Another person said, "It's definitely a safe place to live. They come straight away when I use my call bell." A visiting relative also said, "I feel it's a safe environment. My husband has had a few falls, but they always ring me and let me know what is going on."

We checked to see if there were sufficient numbers of staff available to meet the needs of people who lived at the home. The staffing numbers on Brindley unit consisted of a nurse and three care assistants at night, one of whom was providing one to one care at the time of the inspection and three nurses and four care assistants during the day. The staffing levels on Irwell unit included two nurses and five carers during the day and one nurse and three carers at night. Moss unit was staffed by a senior carer and two care assistants at night and a senior carer and three care assistants during the day. On Monton unit, there were two care assistants and a senior carer at night and a senior carer and three care assistants during the day. In addition, each unit had a 'unit manager', who was in charge of the day to day running and the monitoring of care staff and nurses.

The home used a dependency tool based on the care needs of people living at the home and we reviewed this during the inspection. We also viewed a sample of staffing rotas to ensure the agreed numbers of staff were consistently provided. We asked staff and visiting relatives if they felt enough staff were available. We were told there were enough staff on Monton unit, however on Brindley, Moss and Irwell, we were told there were not.

On Brindley unit, staff told us, "It is very hard on this unit. We need an additional member of staff at least really. One person is currently on one to one and when his behaviour is unpredictable, it is difficult to see to everybody else." Another member of staff said, "I feel people could receive their care a lot quicker on this unit. Today for example, it was nearly lunch time when we finished getting people up and it is a common thing, not just today." Another member of staff added, "They don't currently reflect the high dependency of the residents on the unit. Care needs are not getting met until late in the morning and staff are not getting their breaks as they should."

We spoke with the registered manager about Brindley Unit. We were told that agreement had recently been given for an additional member of staff at night and an additional member of staff in the morning, due to the increased level of dependency on the unit.

On Irwell unit staff told us, "We have five care staff and two nurses per shift. Two carers cover one side, two the other with one floating, who stays in the lounge. I think people are left waiting a while for the toilet at times. We could do with one more, especially due to the number of people who require the assistance of two." Another member of staff said, "We have five carers, needs vary depending on the needs of the people on intermediate care. Sometimes we are fine, but when needs increase, we don't get extra staff, we just have

to manage." A third added, "Personally I don't think we have enough. There is a high level of dependency on the unit. The hospital will say someone requires the assistance of one, when actually they require two plus all our permanent residents require assistance of two staff. We need another carer ideally."

On Moss Unit, staff told us they felt staffing levels should be consistent all day and that it was difficult when a member of staff finished at 2pm. One member of staff said, "We could do with not losing a staff member in the afternoon. Care always comes first and paperwork second." Another said, "We would benefit from more staff. It's hard in the afternoon when we lose a member of staff. It puts pressure on us as a worker to keep everybody safe. Five all day would be better." A third member of staff told us, "It would be better if we could keep the extra member of staff from the morning in to the afternoon. People get restless as the day goes on." A relative also commented, "They haven't got enough staff to treat people on an individual basis, they do try. Wouldn't everybody benefit from more staffing though."

We recommend that the service re-evaluates the current dependency tool, to ensure there are sufficient and consistent numbers of staff available, to safely and responsively meet the care needs of people living at the home in response to the feedback we received.

We looked at the home's safeguarding systems and procedures. The home had a dedicated safeguarding file which contained guidance on identifying and reporting safeguarding concerns. This ensured that anyone needing to report a concern could do so successfully. We saw a tracker was in place for all referrals which ensured the correct procedures had been followed and necessary professionals and organisations notified, along with the outcome of any investigations. The training matrix showed us staff had received training in safeguarding adults, with a policy and procedure available if they ever needed to seek advice or guidance.

Staff we spoke with displayed a good understanding of safeguarding procedures and were clear about what action they would take if they witnessed or suspected any abusive practice. One staff member said, "Safeguarding is to do with people being abused. I have to report any issues to the nurse in charge." A second member of staff stated, "I would make sure people are safe, document what has happened and pass on to the unit manager, who would report this to the local authority." A third member of staff stated, "Safeguarding could be physical, financial, mental, emotional. It tends to be service user on service user on here. We intercept and diffuse it. If it was anything else, I'd speak with the person and refer to my line manager." A fourth added, "I did a full day safeguarding training before I started. It could be verbal, physical, mental, financial, neglect. If I had any concerns, I'd report them to the senior."

The service had recruitment procedures designed to protect all people who used the service and ensured staff had the necessary skills and experience to meet people's needs. We looked at five staff personnel files and found robust recruitment checks were completed before new staff commenced working at the home. The files included job offer letters, proof of identity, two references and a Disclosure and Barring Service (DBS) check. A DBS is undertaken to determine that staff are of suitable character to work with vulnerable people. These checks would ensure staff were suitable to work with vulnerable adults.

During the inspection we completed a walk round of the building, to look at the systems in place to ensure safe infection control practices were maintained and found the premises were clean throughout and free from any offensive odours, with the exception of Moss Unit which did smell of urine early in day, however this diminished later on when cleaning tasks had begun. Bathrooms and toilets had been fitted with aids and adaptations to assist people with limited mobility and liquid soap and paper towels were available, along with personal protective equipment (PPE) such as gloves and aprons. Upon arrival on the Irwell Unit, we found one toilet was soiled, with faeces on the seat and floor and the door wide open. We monitored the toilet for 15 minutes to see if staff noticed the issue and completed a full clean. As this had not occurred, we

spoke to the nurse in charge, so the toilet could be cleaned in case people using the service attempted to use it.

Infection control, food safety and environmental health practices were closely monitored by professionals from Salford city council. The most recent infection control audit had seen the home score 93% in June 2017, whilst the kitchen area had achieved a five star (the highest score) rating as part of the last inspection in April 2016 by environmental health.

We looked at how the home cared for people at risk of skin break down and pressure sores. Each person had a skin integrity care plan and corresponding Waterlow risk assessments in place. This provided staff with information about if people were at risk, if specialist equipment was needed such as pressure relieving cushions and mattresses and details about people's continence and nutritional needs which could impact on their skin. Nurses also maintained records of when dressings had been changed and if there were any concerns noted. Photographs of any wounds were also taken which is deemed to be good practice and these were stored within people's care records for staff to refer to as necessary and marked as being confidential.

On Moss Unit, we saw staff had been vigilant at reporting a concern and noted a person that had returned from hospital had a red area on their sacrum. Staff had informed the district nurse and we saw they visited the same day. A body map had been completed detailing the red scratch which meant the nature of the sore was documented to enable continued monitoring. When people had been identified at risk, we saw people had the required equipment such as cushions and air flow mattresses to provide a reduction in pressure on risk areas.

We checked to see that both the environment and equipment was adequately maintained. We found health and safety checks such as water temperature monitoring and legionella prevention were carried out on a regular basis. Fire risk assessments were evident along with a record of fire systems, emergency lighting and fire alarm checks. Regular checks of both gas and electrics were undertaken and had been completed within the necessary timescales. The home employed a maintenance man who was responsible for undertaking these checks and would ensure people living at the home were not placed at risk.

We looked at how accidents and incidents were managed at the home. A designated accident and incident file was in place which contained a detailed log, containing the specifics of each accident or incident, who was involved, and action taken. We saw where accidents had occurred, these had been investigated and preventative measures put in place to keep people safe.

We looked at how the home protected people deemed to be at risk of falls. Falls risk assessments had been completed and provided good detail about the level of risk presented to people and actions staff needed to follow. The assessments had been reviewed and updated each month by staff to ensure the information was still relevant. Where people had fallen from bed during the night we saw appropriate assessments had been completed to establish if bed rails were required to keep people safe. Where this had been the case we saw bed rails were in use, with staff also displaying a good understanding of people deemed to be at risk with regards to their mobility. The home had recently participated in a scheme called 'Pimp by zimmer' and this enabled people living at the home to design and decorate their own zimmer frame with colours or patterns of their own choice, making people want to use their zimmer frame more because it felt more personal to them.

People's care records contained identified areas of risk. Risk assessments were in place for a range of areas such as moving & handling, pressure care and choking. Each person also had a safety care plan in place,

which included information about any systems and equipment in place to maintain their safety.

We looked at the way medicines were managed and watched people being given their medicines on three units in the home (Moss, Irwell and Brindley). All the nurses and care staff we observed administered medicines safely and in a kind and patient way. Extra information to help staff decide when to offer a person their 'when required' medicine, (PRN protocols) were filed with the person's medication administration record (MAR). This helped ensure medicine was used safely and the person gained maximum benefit. Protocols were also in place for people prescribed a thickening powder for their drinks due to difficulty swallowing and risk of choking or aspiration.

We looked at the medicine administration records (MARs) belonging to 32 out of the 119 people living in the home. We found that records about medicines were carefully completed, with signatures provided by staff when medication had been administered. All MAR sheets had a photograph of each person and any allergies noted. A staff list was also available on file with sample signature records to demonstrate which staff were signing when medication had been given.

Medicines were kept safely and storage facilities were clean and tidy. The temperatures of rooms and refrigerators where medicines were stored were monitored and recorded to ensure that medicines were safe to use. Medicines that are controlled drugs (CD's) and subject to tighter legal controls because of the risk of misuse, were stored and recorded in the way required by law. Staff regularly checked CD stocks, which is good practice to prevent mishandling and to find any recording errors promptly. The stock balances of the sample of controlled drugs we checked were correct.

Is the service effective?

Our findings

All of the people we spoke with were content with their care and support, and felt the staff knew how to look after them properly. A relative said, "The staff are good. Excellent communication with relatives. They've phoned me straight away if there is trip or fall. They seek my opinion and ask if I want them to do anything more." Another relative added, "I feel I can go home. I know the staff would ring me if anything changes, there's good communication here. I feel I can ring them too if I just want to check on things."

We looked at how the home sought consent from people. Care plans contained a choices and decisions over care section, which included a mental capacity assessment to determine if each person had the capacity to consent to their care and treatment. Depending on the outcome, either the person themselves or their representative had signed the consent form. During the course of the inspection we observed staff knocking on people's doors and waiting for a response before entering, staff asked people if they wished to take their medication and would they like to participate in the activities on offer.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We asked staff about their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff confirmed they had received training and had an understanding of both areas. One staff member told us, "This is about whether a person can make decisions for themselves, we have done training in this." Another member of staff said, "MCA is about whether a person has got the capacity to say what they need." A third added, "I have heard of this [Name] has a DoLS in place, it's about having capacity to make decisions."

We checked to see if DoLS applications were made by staff across each of the units of the home when required. We found this was being done in a timely manner on the Moss and Irwell Units. On Brindley Unit, we identified two people who had been deemed to lack capacity to make complex decisions during mental capacity assessments in January 2017 and were unable to retain and use information as part of the process. One of these people was nursed in bed and unable to weight bare, with bed rails in use. We raised this with a nurse on the unit who said the expectation would be that DoLS applications should have been made where people lacked capacity, although had not yet been done. The nurse said they felt they needed to get 'up to speed' with them on the unit. The registered manager informed us these applications had been submitted on the day of the inspection, however the home's own internal quality assurance processes should have identified that these applications should have been made sooner.

This meant there had been a breach of regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Safeguarding service users from abuse and improper treatment.

People living at the home told us they enjoyed the food and received enough to eat and drink. One said, "You can choose what you eat; if you don't like what's on the menu you can always have a baked potato or an omelette." Another person said, "The food's pretty good and I do enjoy it." A third person added, "It's nice, the food." When we asked a fourth person about the food, we were told, "I have a good breakfast every morning."

We looked at how people were supported to maintain good nutrition and hydration. We observed the meal time experience during the first day of inspection on Moss, Irwell and Brindley units and saw that it was positive for people using the service. We observed lunch and breakfast on Monton unit during the second day of our visit. Each unit had its own dining area, which people were encouraged to use, however people's individual needs and choices were also respected, and we saw people eating in both the lounges and their bedrooms. Dining tables had been set properly prior to meal times, with each containing tablecloth, napkins, cutlery and condiments. Menus were clearly displayed for breakfast, lunch and evening meals, they also included 'night bite' options, should people be hungry in the evening. Each unit had a dedicated 'hostess' who assisted people at mealtimes as necessary, giving extra to help to care staff as needed.

We found people had eating and drinking care plans which informed staff about the support they needed to provide and if people were deemed to be at risk. Each person had a Malnutrition Universal Screening Tool (MUST) in place; this is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. We saw these had been completed and updated regularly to reflect people's changing needs. Staff had made referrals to external agencies such as Speech and Language Therapy (SaLT) and dietitians as necessary and their guidance and advice was available in the care plans we looked at, such as if people required soft or pureed diets and thickened fluids if they were deemed to be at risk of aspiration.

We reviewed the care plan of one person living on Monton Unit, who had previously been referred to the dietician due to weight loss, however staff on the unit said they had been discharged in February 2017, but still followed the actions as advised in the action plan from the dietician. This included adding fortified milk to cups of tea, having one glass of milk a day and adding extra cream/custard to puddings. The unit manager said these actions should be documented within the daily notes, however we saw these weren't being done consistently to show that these actions advised by the dietician service were being carried out by staff.

Similarly, on Brindley unit, a second person had also been referred to the dietician due to weight loss. The dietician team had again sent a nutritional action plan to be followed by staff. This included ensuring snacks and milk based drinks were offered and to keep a record of all snacks, including amounts. When we checked food intake records, these interventions were not being consistently recorded by staff to demonstrate they were being done in either the food intake records, or in the daily notes. We raised this issue with both the clinical services and registered manager who said they would speak with staff on the units to ensure the information was captured consistently following advice from other health care professionals.

We found food and fluid monitoring was not completed consistently on Irwell unit. On both sets of documents, we noted gaps in recording, or fluids being put on the food diary and not the fluid chart, which was left blank. This meant actual amounts of fluid provided and consumed was not documented. Our observations during the day showed drinks were given, everyone had water or juice in their rooms, had drinks at meals times and whenever they requested, however the people's monitoring charts did not reflect

this.

This was a breach of regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Good Governance.

We saw the service worked closely with other professionals and agencies to meet people's health needs. Involvement with these services was recorded in people's files and included general practitioners (GP), chiropodists, district nurses, tissue viability nurses (TVN) and speech and language therapists (SaLT).

We saw evidence that the Care Certificate was in place at the home which was available to staff who may not have previously worked in a job delivering care. An internal induction was also provided by Bupa, which staff told us they undertook when they first started working at the home. Topics covered during the induction included moving and handling, safeguarding, health and safety, first aid and infection control. One member of staff said, "Induction training lasted a week. It was very good and taught me a lot." Another member of staff said, "I had a week of induction training from Monday to Friday and was also able to spend time on the unit."

We asked staff for their opinions on the training provided by the home. One told us, "We get lots of training, both e-learning and face to face. I've done fire, COSHH and training related to topical creams. We have yearly updates including manual handling. If we miss two training sessions, then we can't continue working until we've done it." Another stated, "Our training gets updated, we get asked to do this. We've just recently completed a session in managing challenging behaviour."

A third said, "The training is good here and we are always reminded if something is coming up that we need to do." A fourth told us, "They are quite accommodating with training. I've raised with the manager previously if I feel I need more training and it is being looked at."

Staff on Brindley unit told us due to the care needs of two people living on the unit who presented with mental health needs, that training in this area would be beneficial to them and staff working on the unit. We noted this was not an area covered on the homes training matrix. This would enable them to understand this area in more detail and provide appropriate care in response.

We recommend that home sources appropriate training in relation to caring for people with mental health needs to ensure staff are supported to undertake their role effectively.

Staff told us they received supervision and appraisal as part of their role. We looked at a sample of supervision records and saw topics of discussion included goals/priorities, personal development, training and overview of how things were progressing on the unit where the member of staff worked. One member of staff said, "We get supervision every two to three months, plus an appraisal. They are useful, it's a good opportunity to talk. We can have our say anyway and if we need to step up on something, we are told about it." Another member of staff said, "We have regular supervision but the registered manager's door is always open for you too; I feel lucky. I've been well supported."

Is the service caring?

Our findings

All the people we spoke with described staff as helpful, caring, compassionate, kind and rated the care either good or very good. Each person we spoke with looked clean, well presented and well cared for. Whilst speaking with people who lived at the home, some of the comments we received included, "I've no complaints about the care; If I wanted anything, they do it," and "The unit manager will do anything for you," and "They make sure you're always looked after."

Relatives told us they were happy with the care provided to their loved ones who lived at the home. One relative said, "The staff are great. It's hard work and must be frustrating but you wouldn't know. I have no concerns at all. I think the staff on here are amazing. I'm always here so I know how people are treated and it's wonderful." Another relative said, "I have been coming here for three and a half years now and I feel it is such a great place. I come in and bath my husband each day and we have such amazing support here. The care is absolutely excellent. I think it's very good and I am very pleased with how he is looked after." A third relative added, "We think that the staff are amazing. We looked around at a lot of homes and some were awful. We visit at all different times of the day and night and it's always good. It always smells lovely and clean and fresh. We don't worry. They let us know things. She is looked after in the way that we would care for her."

Over the course of the inspection we spent time observing the care provided on each unit of the home. Staff interaction with people was friendly and caring and people appeared calm and relaxed in the presence of staff. Staff acknowledged people on entry to the lounge area, wishing them a good morning and enquiring how the person was. People were offered choice and staff accepted and acted on their wishes. We did not observe anybody looking unclean or unkempt. People's hair was tidy and people we spoke with had clean teeth and finger nails. Appropriate physical contact by the staff was observed, such as hand holding or placing their arm around someone whilst speaking discreetly with them. Throughout the inspection people responded positively to the interactions with staff and care being given.

During the inspection we observed staff treating people with dignity and respect. One person approached a staff member and asked them if they could help them get changed. They told the staff member they needed some help because they'd had an accident. The staff member responded with, "No problem, we'll go and get sorted." They asked another staff member to cover the lounge discreetly and said, "I'm just helping [person] with something." Another person had attempted to remove their clothing items and leave their bedroom inappropriately dressed. Staff maintained people's dignity by responding promptly but sensitively so not to draw attention to the person. For example staff guided one person back to their room and said they'd go and make them a cup of tea whilst they got themselves 'sorted out.' We observed the staff member returning with the cup of tea and put their thumb up to the person in a positive/supportive way as they were getting dressed.

The staff we spoke with were aware of how to treat people with dignity and respect. One member of staff said, "When changing pads, tell people what you are doing first and explain. Cover people with a towel in between washing and make sure people are covered up." Another member of staff said, "Make sure curtains

and doors are closed and cover people with a towel. Encourage people to do what they can for themselves."

Staff promoted people's independence as necessary. For example, we observed one person asking staff throughout the day for the toilet. Staff pointed out the toilet but let the person orientate themselves following the verbal instruction, however staff watched the person to make sure they had got there safely.

The staff we spoke with displayed an awareness and understanding of how to promote people's independence. One said, "Ask people if they need help. Some can wash and dress themselves, so ensure you encourage this. It's about support and encouraging people to do things for themselves." Another member of staff said, "We encourage people to remain mobile and make sure they have got their frame."

People's end of life care was dealt with in a sensitive way. When appropriate, and where people had chosen to, documentation was in place to ensure their end of life wishes were considered. This included decisions around resuscitation, which was clearly documented and reviewed by a GP where appropriate. Certain staff were end of life care champions, and had completed the 'Six steps to success North West end of life care programme for care homes'. These certificates were displayed on a notice board in the corridors.

During our inspection we looked to see how the service promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights through good person-centred care planning. Support planning documentation used by the service enabled staff to capture information to ensure people from different groups received the help and support they needed to lead fulfilling lives, which met their individual needs.

Is the service responsive?

Our findings

All of the people we spoke to felt that they had person-centred care. People said they were asked what was important to them and received care when they wanted or needed it. People said they could have baths or showers when they wanted and although they could stay in bed if they wished, choose not to.

The people we spoke with told us they liked living at Barton Brook and felt staff at the home were responsive to their needs. One person said, "I can have a bath or shower every day if I want and it's usually in the morning." Another person said, "I have my hair done weekly. It's important to me and that is what I want."

On both days of our inspection, we arrived at the home at approximately 6am. The reason for this was to determine if people living at the home were able to choose when they got up in the morning, or if this was dependant on the workload of staff. On Brindley unit, although several people were up and seated in the lounge areas at this time, night staff told us this was normal for them and that there was never an expectation to wake people up if they preferred to have a lie in. One person said, "I could stay in bed if I wanted to, but I choose to get up." A member of staff added, "The morning routine on here varies. We encourage people to stay in bed at night but it is their choice. We promote sleep and do the best we can. We'll get them a brew and a biscuit, it calms them and they might settle again. People have their own routines, on odd nights they may get a bit more sleep and that's great."

On Irwell unit, two people were already up and dressed and sat in the lounge. One person was asleep in their chair, with another watching television. We spoke with this person who stated it had been their choice to get up and they had always been an early riser. We spoke with the nurse in charge, who stated this person had been up since 2am and despite encouragement had refused to go back to bed, preferring to sit in the lounge. The unit manager on Monton House told us one person liked to get up at 4am each day because they had always got up at this time for work earlier in their life and wanted to continue doing so now they were at Barton Brook.

We saw that people received care that was personalised and responsive to their individual needs and preferences. Each care file contained a pre-admission assessment, and although this was a standardised document to ensure all relevant information was captured, contained additional information specific to each person. This information was then used to assist with care planning so that staff could establish the care people required.

We found a range of care plans in place for each person covering all aspects of care. Care plans contained further evidence of personalisation, as they explained people's ability and level of functioning in each area, along with their likes and dislikes, what they were able to do for themselves and what support they required. The care plans people had in place covered areas such as capacity, eating and drinking, mobility, skin, communication and personal care. This ensured staff had the information necessary to meet people's needs in a way they both wanted and needed.

We saw evidence of a person-centred approach within the main care files. At the front of each file was a 'my

day, my life, my portrait' document which included information about 'what's important to me at this time.' The document provided information about the person's background, family tree, memories, favourite things, hobbies, interests and where they liked to be during the day. This personalised information was supplemented by other sections in the care file. Each person also had a 'what does a normal day look like' document, which covered a range of areas including lifestyle, choices, skin care, safety, washing, dressing, eating and drinking. The document included key safety risks for each area and provided staff with detailed information about how to care for each person. This would ensure staff had access to information of importance about people so that they could respond accordingly.

We asked staff how they aimed to deliver person centred care based on people's like, dislikes and preferences. One member of staff said, "Read the care files or just talk to people and find out from them." Another said, "Ask people speak to people and listen to them." A member of staff added, "Chat with people and they will tell you."

As part of the inspection we looked at the activity programme provided by the home. The home employed two activity coordinators, who worked across each of the four units at the home. Activity schedules were in place, with a board on display detailing the activities for that week and things that had been planned for people to take part in described as 'dates for your diary'. These included arts/crafts, board games, dominoes, pamper mornings, home made cake making and bingo. Trips and outings were also scheduled for those that wanted to or were able to take part and participation records of activities were maintained in people's care records.

We asked people for their views and opinions of the activities provided. One person said, "Yes, we have outings. For example we went to Blackpool and we go to bingo." Another person said, "I have enough to do. Oh yes they're very kind. There's bingo and other things, but I don't like dominoes." A member of staff also added, "We have quite a few, staff play games, quizzes, dominoes with people, we have artists who come into the home." Another said, "There is a co-ordinator who does this so there is quite a bit going on." A visiting relative told us,, "The events organiser is very good but they are covering four houses. People on here need one to one time and the staff haven't got time to do it. They have musical afternoons, 50-60's music playing. People get up dancing. Reminiscence mornings. Last year we went to Blackpool."

We looked at how complaints were managed. There was a complaints policy and procedure in place which had contact numbers for CQC and the local authority. The procedure was also displayed in the entrance area of each house. People told us they had never had reason to make a complaint but would feel confident in doing so. We were informed of several complaints which were active at the time of our inspection and the registered manager told us that formal responses were in progress.

The home maintained a record of compliments where people had expressed their gratitude with the service they received. We looked at a sample of these, some of which read; 'Thanks to all the staff for taking care of my brother. He was very happy here at the end of his life,' and 'To all the staff at Barton Brook; 'Thank you for looking after mum and for your respect, dignity and kindness whilst in your care,' and 'Thank you to all the staff for taking such good care of my dad. He was very content during his stay with you.'

The home had systems and processes in place to seek feedback from people living at the home There were a number of 'you said...we did' boards on display, providing details of action taken to address people's requests or concerns. For example, on Brindley House, people had asked for the quiet room to be transformed into a special area for those living at the home and their relatives. In response, a tea room had been created which was nicely decorated with specific objects and memories people would be able to relate to. People were also asked for their opinions about strengths and weaknesses with the home and in

response, an action plan had been created detailing how any issues were to be addressed.

Residents and relatives meetings took place across each of the units which provided the opportunity to raise any concerns or issues so that management could respond accordingly. We were told attendance at these meetings varied across each of the units, depending on whether people wanted to be involved or not. From the meeting minutes we reviewed, we saw topics of discussion included updates about new staff, activities, new care plan documentation and plans for the upcoming care home open day.

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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 home had a clear management structure in place. The registered manager was supported by a clinical service manager (CSM) and an area manager who we were told visited the home on a regular basis from BUPA. The CSM assisted in overseeing the daily running of the home on each of the four units, feeding back issues to the registered manager. Each of the four units also had a unit/house manager in place, who oversaw the day to day running of their particular unit. In addition to these management arrangements, the staffing structure consisted of nurses, senior carers, care assistants and staff worked in the kitchen, laundry and undertook domestic tasks.

Overall, staff told us the home was well-led and managed and they felt supported. One member of staff told us, "The manager is always there and you can talk to her. The manager makes an effort to come on the unit each day and talk with staff and residents." Another said, "I feel it's good and because I am relatively new, they are giving me time to get used to the job." A third stated, "I would say it's excellent, if you have a problem they are always there to listen." A fourth member of staff added, "Yes, it's good. It's useful to have a clinical manager as well as it's very good support to us."

We asked staff what the culture was like at the home and if they enjoyed working at Barton Brook. One member of staff said, "It's going alright. We have ups and downs, but I feel we work together and that there is good team working." Another member of staff said, "It's okay and I am enjoying it. I like all of the staff and residents." A third member of staff said, "I feel there is a nice culture definitely." A fourth added, "I do enjoy it; atmosphere here is quite good."

The home used a range of systems to assess the quality and effectiveness of the service. Bupa have a filing system in place called 'operational essentials', with a large proportion of the files linked to a specific area of auditing, monitoring or governance. The system ensured every area of care provision was being monitored and audited, with issues identified and action points generated.

We saw monthly compliance inspections were carried out at the home by the provider. Each area received a rating of either red, amber or green along with feedback on positive areas of practice observed and issues which needed to be addressed.

Clinical 'walk rounds' were completed each day the CSM which allowed them to observe the provision of care on each unit. Each 'walk round' was documented and looked at a number of areas including a review of the handover, any people with clinical concerns such as falls issue or safeguarding concerns, medication administration and documentation, nursed in bed checks and also ensured the 'resident of the day' process had been completed and documented correctly. For any issues identified, we saw an action plan had been

generated with details on who was responsible for completing and when.

The home had a 'resident of the day' programme in place which involved the completion of a comprehensive review of a person's programme every day on a rolling rota basis, with the person central to this. The schedule was based on room numbers and would be done on the 1st of the month or on a date around this time. This process ensured people's care was meeting their needs and their wishes were being met.

We found the homes internal quality assurance systems had not been fully effective. For example, where DoLS applications had not been made in a timely manner and where accurate records had not been maintained.

This was a breach of regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Good Governance.

Weekly clinical risk meetings were held with the home manager from each unit, during which nine areas were discussed including admissions, safety, nutrition and hydration, medical conditions which could impact on care and any incidents that had occurred. Heads of department meetings were also held, with staff responsible for areas such as the kitchen, laundry and maintenance. Action points were generated along with who was responsible and date for completion.

Staff told us regular team meetings were held both day and night staff. Topics of discussion included communication, staff changes, recruitment, training, cleanliness and equipment. We also saw records from reflective discussions that had taken place following on from incidents and actions taken to promote learning. One member of staff said, "Yes, we have these every month. We can bring stuff up and discuss any issues we have." Another member of staff said, "These are held once a month, we can bring things up in there that we want to discuss."

The home's policies and procedures were stored electronically and included key policies on medicines, safeguarding, MCA, DoLS, moving and handling and dementia care. Policies were updated at provider level; this meant that the most up to date copies were always available. Staff told us they had access to these and had their own username and password so they could access them securely. This meant staff could seek advice and guidance as required.

The home had developed several links within the local community. This included a local dementia centre, local schools where children often visited and sang songs to people living at the home.

Providers are required by law to notify CQC of certain events in the service such as serious injuries, deaths and deprivation of liberty safeguard applications. Records we looked at confirmed that CQC had received all the required notifications in a timely way from the service.

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	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Appropriate systems were not in place to ensure people living at the home were not detained or restricted without unlawful authority.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Appropriate systems were not in place to ensure accurate, complete and contemporaneous records in respect of each service user were maintained. Appropriate systems were not always in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.