Care Quality Commission

Zest Care Homes Limited

Bramley Court

Inspection report

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Yardley Wood
Birmingham
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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**

Overall summary

This report provides details from two separate inspection visits which took place months apart. The first inspection was in February 2015 and the second inspection visit was in August 2015. We were unable to provide a report from the first visit but felt it valuable to provide summaries of both visits together with the judgements from the most recent inspection visit in August 2015. Both visits were unannounced. Prior to the February visit we had last inspected this service in June 2014 and it was complaint with all the regulations we looked at.

Bramley court provides accommodation with nursing care and support for up to 76 older people who live with dementia. At the time of our August visit 71 people were using the service.

There was a registered manager in place. 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

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was away during our visit however we spoke with them afterwards.

People were kept safe from the risk of harm. Staff knew how to recognise signs of abuse and who to raise concerns with. People had assessments which identified actions staff needed to take to protect people from risks associated with their specific conditions, although some of these needed to be improved with additional information. Concerns raised at our first visit about medication and hoisting people safely had been addressed when we revisited.

People were supported by the number of staff identified as necessary in their care plans to keep them safe. Initial concerns about a lack of staff to support people to engage socially and respond to care needs had been resolved with action taken by the registered manager to decrease staff sickness and improved continuity of staff. There were robust recruitment and induction processes in place to ensure new members of staff were suitable to support the people who used the service

Staff had the skills and knowledge to ensure people were supported in line with their care needs and best practice. In response to previous concerns raised the provider had ensured that staff had the skills and knowledge to move and handle people safely.

The care manager and staff we spoke with were knowledgeable of the requirements of the Mental Capacity Act 2005. Staff sought consent from people before providing personal care. However the provider had not ensured consent had been sought from the appropriate people for the installation of camera surveillance equipment in people's bedrooms and the provider had not ensured that people would be safeguarded from misuse of the recordings obtained. You can see what action we told the provider to take at the back of the full version of the report.

When necessary, people were supported to eat and drink and access other health care professionals in order to maintain their health.

People had positive relationships with the staff that supported them and spoke about them with affection. The provider sought out and respected people's views about the care they received. Staff knew how to maintain people's privacy and dignity when delivering personal care.

The provider was responsive to people's needs and changing views. People were supported by staff they said they liked and care was delivered in line with their wishes. People could raise concerns and complaints and they were managed appropriately.

People were confident in how the service was led and the abilities of the management team. The provider had established processes for monitoring and developing the quality of the care people received. The registered manager had not ensured that overt surveillance equipment that was being installed at the service was going to be used in line with all the relevant legislation.

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?

Good

The service was safe. Staff were confident to take action if they suspected a person was at risk of abuse.

There were enough staff to keep people safe from the risks associated with their specific conditions.

The provider had taken steps to ensure medication was managed and stored safely.

Is the service effective?

Requires improvement

The service was not effective. The provider did not always take the appropriate steps to protect the legal rights of people and safeguarding information obtained through recordings and use of cameras and audio equipment.

Staff had the skills and knowledge needed to meet people's specific care needs.

People were supported to eat and drink enough to maintain their well-being.

Is the service caring?

Good

The service was caring. Staff spoke affectionately about the people they supported.

Staff took time to sit with people and promote social inclusion.

Staff knew how to support people's dignity and took action when there was a risk that people's privacy would be compromised.

Is the service responsive?

Good

The service was responsive. The provider responded promptly to changes in people's care needs.

People were supported to raise concerns and complaints and these were managed appropriately.

Is the service well-led?

Requires improvement

The service was not well-led. The registered manager had not ensured that overt surveillance equipment that was being installed at the service was going to be used in line with all the relevant legislation.

People expressed confidence in the management team to meet their care needs and there were robust processes in place to assess the quality of care people received.

The provider had not introduced robust systems to ensure the use of surveillance equipment did not breach current legislation.

Bramley Court

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.

Our last inspection took place in June 2014 when the service met the regulations that we inspected. This report provides details from two separate inspection visits which took place months apart. The first inspection was in February 2015 and the second inspection visit was in August 2015. We were unable to provide a report from the first visit but felt it valuable to provide summaries of both visits together with the judgements from the most recent inspection visit in August 2015.

Both visits were unannounced. The first visit was carried out by two inspectors, a specialist advisor in moving and handling people and an expert by experience. The second visit consisted of one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed all of the information we held about the home. This included statutory notifications received from the provider about deaths, accidents and safeguarding alerts. A notification is information about important events which the provider is required to send us by law. 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. When we returned for our second visit in August, we reviewed the information we had obtained at our first visit in February. This helped us to identify if the provider had taken action in response to feedback given at our first visit.

During our first visit we spoke with 14 people that lived at the home about aspects of their care and the relatives of six people who used the service. We spoke with 21 staff members including care staff, nurses, unit managers and an activity co-ordinator. At our second visit we spoke to nine people who used the service and five people's relatives. We spoke to 15 staff members including the deputy manager. We spoke to the registered manager at both visits.

We were unable to speak with some people due to their limited verbal communication so we spent time at both visits observing people's care in the communal areas of the home and 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.

At our first visit we looked at parts of nine people's care records and at the second visit we looked at seven people's care records. We also looked at other records that related to people's care. This was to see if they were accurate and up to date. We also looked at medication records, staff employment records, quality assurance audits, complaints and incident and accident records to identify the provider's approach to improving the quality of the service people received.

Good

Is the service safe?

Our findings

People and visitors told us that they thought the home was safe. Their comments included: "I feel safe here, the building is secure and the staff are very kind," "[The home is] Absolutely safe" and "[Person's name is] Safer than [they were] at home."

At both visits the staff spoken with knew about the possible changes in people's behaviour that may suggest abuse. One staff member told us: "I have had training in safeguarding people. If I felt anyone was at risk I would report my concerns to the manager straight away." Staff told us they were confident that the manager would take action if people's safety was of concern. Staff told us that since our first visit in February they had received additional training in keeping people safe. They were clear about their responsibility to record what they had seen, found or heard and to report to a senior member of staff. The majority of the staff were aware of the agencies who may be involved investigating any allegation of abuse and would further report to these agencies if they continued to have concerns.

Since the last inspection we saw that action had been taken when safeguarding issues had been identified. For example the manager had undertaken unannounced night checks and had taken action when care concerns were identified at night. During our second visit the registered manager explained the actions they had taken in response to a recent safeguarding concern and we noted this was in line with local authority guidelines.

Since the last inspection we had received information about moving and handling practices that could put people at risk of harm. At our first visit we saw moving and handling practices that could have a detrimental impact for people over a period of time. For example, at that time all of the staff observed using hoists were not lifting people correctly when positioning hoist slings or failing to plan moves sufficiently by removing obstacles and ensuring batteries for hoists were charged.

At our second visit in August we saw moving and handling practices had improved. We observed staff lift people in line with good practice and use people's dedicated slings which were of the correct size. Staff informed people not to hold personal objects when being hoisted to prevent overbalancing. We did however observe a person being moved in a wheelchair with a missing footplate. This meant there was a risk that the person's foot could be injured if it dragged on the floor. We brought this to the attention of a senior member of staff who found an additional footplate and conducted a supervision meeting with the member of staff. Staff told us and records showed that they had received additional moving and handling training since our last visit. Peoples care records identified risks to people's health and welfare including moving and handling risks. These had been reviewed since our first visit and included enough detail to instruct staff's practice in the use of all of the equipment that was being used, such as slings and slide sheets.

At our first visit people and some visitors we spoke with told us that there were not always enough staff available to ensure people's needs were met in a timely way. One person said: "I do think the staff are stretched, they work hard but sometimes you have to wait for the call bell to be answered for ten minutes or so because they are so busy."

Several staff members identified that staff sickness affected the effectiveness of the staff team however, at our second visit in August, all the staff were spoke with told us that sickness levels and the use of agency staff had reduced and people were supported by permanent members of staff. They told us that the registered manager took immediate action when a member of staff failed to attend their shift in order to maintain sufficient staffing levels. We saw that staff were very busy at key points during the day such as early in the morning and at lunch time.

At our first visit we were concerned that at times staff were not appropriately deployed to ensure that people who were at risk of falling were constantly supervised in the lounges. At our second visit we saw that staff were present in the lounges however there was one or two occasions when no staff were present for a short period. We observed that staff were deployed to sit with people who were at risk of falling in their bedrooms. The registered manager told us that they calculated the number of staff required each shift, based on people's care needs, and that additional staff were also employed each shift to cover ad-hoc tasks resulting from changes to people's conditions.

We spoke with five staff members about how they were recruited. They told us that employment checks had been carried out before they started to work at the home such as police checks and taking up references. Six staff employment records we looked at confirmed this. We saw

Good

Is the service safe?

that the registered manager had taken action to seek additional information when it was missing from applications. This showed that the provider had taken steps to determine the suitability of applicants to work in the home before they were employed.

At our first visit we were concerned that on one floor the practices for administering and recording people's medicines were not consistent and improvements were necessary. These included ensuring people received their inhaled medicines as prescribed and that medicines were stored appropriately. At our second visit we saw this had improved. A person told us that they always got their time critical medicine on time and that nurses regularly checked their health condition. We observed that when nursing staff administered medicine, they did so patiently and people were offered fluids when necessary to help them swallow their medication.

We looked at nine people's medicine administration records and saw these were completed and up to date. There were regular medication audits. Any errors were found quickly and we saw that appropriate action had been taken. Since our first visit the registered manager had arranged with the pharmacy supplier for all tablet medication to be dispensed in blister packs. This supported people to receive their medication as prescribed and had reduced the risk of errors. Medicines were stored, and when necessary, disposed of appropriately. Good practice guides about the administration of medicines were available for nurses to refer to and staff had a good knowledge about the use of people's medicines.

Requires improvement

Is the service effective?

Our findings

We noted that the provider had installed overt surveillance equipment in people's bedrooms. The provider told us they had consulted with the local authority, residents, families and staff about implications of placing people under continual observation. However they could not demonstrate that they had permission from people who had the legal authority to consent to this being done. The registered manager switched off the surveillance system until permission had been received from the people who had the legal authority to consent on behalf of the people involved. Some relatives were assumed to have legal authority to make decisions about a person's care and treatment but the service was not showing that they were checking by having copies of these authorisations. The provider had recognised, since our first visit, that further clarity was required and we saw they had approached people for proof of their legal authority. During our second visit we observed a family member submit proof of their legal authority to consent to the care their mother received after being requested to do so by the provider.

The provider had not ensured that people using the service would be protected from the risk of unauthorised or improper use of images and information obtained from the surveillance equipment. The implications of handling information from any visual or audio recording had not been fully explored to ensure it complied with requirements to safeguard people from misuse of information obtained by the provider's use of such equipment. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The Mental Capacity Act 2005 (MCA) sets out what must be done to protect the human rights of people who may lack mental capacity to make decisions to consent or refuse care. At our first visit some staff told us they had completed MCA training, others had not. During both visits we saw that, with few exceptions, people were asked for their consent before any care was provided which showed staff had some understanding of the MCA.

At both visits we saw that assessments had been made of people's mental capacity to understand their day to day life and identify their communication needs. These assessments had typically identified when another person had the authority to manage a person's finances but not their general care needs. This had led to the risk that people may not receive care which was in their best interest. For example, at our first visit we observed one person, who could eat solid food, given a soft main meal prepared by pureeing it in a blender. Staff told us that this was not a recommendation by a health professional based on clinical need but a decision taken by a relative. We found no evidence of any discussion about what was in the person's best interests in relation to the food they were able to choose. However, at our second visit we saw evidence that the registered manager had arranged for staff to receive training in the MCA and staff we spoke with could explain the circumstances when they were required to consider a family member's wishes in order to promote a person's best interests.

Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for permission to deprive someone of their liberty in order to keep them safe. We were aware prior to this inspection that the provider had made numerous applications to the Supervisory Body as some people who lived in the home lacked mental capacity to understand the consequences of decisions regarding their safety and restricted movement. At the time of our August visit, one of the applications had been approved by the Supervisory Body and staff were able to explain how they supported the person in line with the requirements of the order.

We spoke with ten staff about their training and the care needs of specific people. A member of staff told us, "I feel that the training is relevant to the work I do." We found that staff had knowledge about individual people's care plans and what they needed to do to meet people's care needs. When we visited in August we saw that our concerns about staff moving and handling knowledge raised at our first visit had been addressed. Staff had received additional training and nursing staff had attended detailed training in order to maintain their professional registrations. We spoke to one of the two members of staff who were responsible for conducting lifting and handling training and they told us they were confident in their ability and the resources available to conduct the training.

Staff told us that on starting work they had three induction days and basic training. They had meetings to discuss their

Requires improvement

Is the service effective?

performance, training and any concerns they may have with a senior member of staff. All the staff we spoke with said they received sufficient training to meet people's care needs confidently.

Staff told us and we saw that they had appraisals and regular supervision to identify how they could best improve the care people received. Examples included improving staff awareness of good moving and handling techniques.

At our first visit, the people we spoke to and some relatives told us there was a good choice of food, there was enough food served and that it was well prepared. At that time, whilst observing support provided at breakfast we found that not all the choices available on the menu were offered to people. Where food had to be specially prepared relatives were unhappy with the meals provided. We saw that a pureed lunchtime meal was very runny and people were finding it difficult to eat because of its consistency. We raised our concerns with the registered manager that it could affect people's ability to get enough to eat.

When we returned in August we saw that the service had responded to our concerns and pureed meals appeared appetising and of the right consistency. We noted on one occasion however that a person was not given the appropriate equipment to help them eat which resulted in some of their food being spilt on the table. The provider had reviewed their menus in response to people's preferences and people told us they enjoyed the food offered. We noted however that on one day the menus did not reflect the meal choices available and there was confusion amongst staff about the time of the lunch meal. Staff told us that this had resulted in several people being placed at tables 45 minutes before their lunch was served. This could cause confusion and anxiety to people who live with dementia. We noted however that some people expressed a preference to sit at the dining table early.

We found that some people had been referred to appropriate professionals and when necessary in respect of concerns relating to eating and drinking and nutritional care plans were put in place. We checked the weights and nutritional assessments. We found that most people were maintaining their weight and where a person had been identified as losing weight there was a recorded reason for this and details of action taken.

We saw that drinks were offered to people at meal times and when snacks were given in the morning and afternoon. At our first visit we were concerned that people were not offered drinks between these regular times however at our second visit we saw people were constantly being offered drinks throughout the day. We saw evidence that people's fluid intake was reviewed each day and staff we spoke with could tell us the people who required prompting to take additional fluids to maintain their health.

People were support to access other health care services. Staff told us that the GP visited the home twice a week and reviews of people's health care and medicines were also undertaken three monthly by the GP. Two visitors we spoke with told us about how the service had responded well when their relative became ill suddenly. Records showed that people were regularly supported to meet their routine health care needs such as attending appointments with chiropodists, opticians and dentists.

Good

Is the service caring?

Our findings

People who were able to tell us said that they were mainly happy with their care and that staff were kind, courteous and polite. Amongst their comments were: “The care staff are good I know them by name and they are bright and cheerful and willing to oblige" and, “The staff are lovely, they seem to genuinely care about me.” A visitor told us: [Staff member’s name] is brilliant she kneels by the side of [relative’s name] and smiles and talks to him and he smiles back.”

Staff communicated well with people when supporting them with their care needs. We observed a member of staff explaining to a person what they were doing at each stage when they were moving them by hoist. The person said they were fine, and looking forward to sitting in an armchair. We also saw a person was given time to choose what clothing they wanted to wear and saw staff arranging for a person to have a snack different to what was on the menu. When we first visited in February we saw that staff on one unit did not have opportunities to spend time with people which placed them at risk of becoming socially isolated. At our second visit in August we saw this has improved. Staff told us they now had time to sit and talk with people. One member of staff told us they enjoyed speaking to a particular person who used the service and said they had learnt a lot from them about Birmingham’s local history.

People living in the home had their own single ensuite rooms which allowed them to have time in their own rooms privately if they wished. A visitor told us that staff maintained their relative’s privacy and dignity by asking the visitor to wait outside the room whilst they attended to their relative’s personal care. Staff spoke respectfully about the people they supported and were able to tell us how they maintained a person’s dignity when providing personal care. The provider was installing overt surveillance equipment in people’s bedrooms but had not ensured they had obtained consent from all the people who could be observed or identified how they would ensure any data obtained would remain private. This could compromise people’s privacy.

We observed that people were well groomed and care records contained information about how they liked to dress. We saw that people were dressed in accordance with these plans and a visitor confirmed their relative was supported to choose the clothes they wanted to wear. Staff we spoke to knew people’s preferred clothing and what jewellery their liked to wear. We saw a member of staff offer to wash and blow-dry a person’s hair which staff advised made the person happy. The member of staff told us they would enjoy doing this task as they knew it was something the person looked forward to.

People told us that they received care in accordance with their expressed wishes. One person told us, “I have been involved in planning my care. The staff know what I like and what my needs are.” Another person told us that they had been informed about their care plan. People’s care plans contained details of their life histories and preferences. When a person had been unable to express their preferences we saw evidence that family members and friends who knew the person well had been approached to provide these details.

During our first visit some people in the home were receiving end of life care. They were unable to talk to us about their care so we talked to staff and managers about this. One member of staff told us: “It’s a difficult subject for some people to discuss but we involve the family and try to ensure the person’s wishes are followed.” The manager was able to tell us how they supported people to eat and drink what they wanted, and how this aspect of care was managed to ensure people remained as comfortable and as safe as possible. We looked at the care records for four people who were receiving end of life care. We found discussions had been recorded with people approaching the end of their lives and where possible their relatives, about their wishes and preferences so that these could be respected.

Good

Is the service responsive?

Our findings

Staff we spoke with were knowledgeable about the people they supported. They knew about people's life histories, relatives and people important to them, likes, dislikes and preferences for receiving care. The provider responded appropriately to people's views about the service. For example when a concern had been raised about the gender of a staff member providing care, the registered manager checked that all the people who used the service were supported by the staff they wanted. People's care records were updated to reflect their preferred choices. A visitor we spoke with told us their relative's care had changed to reflect their changing abilities and health needs. We looked at care records and found there was a consistent approach to completing information about people's likes, dislikes and interests. We saw that this information had helped care staff provide support that was individual to the person.

People were supported to take part in hobbies and interest they said they liked. A person told us that staff came into their room to help them with their handicrafts. Another person told us that they had everything they wanted to keep them occupied in their own room. Some visitors told us that efforts were made to ensure people had time with the home's activity co-ordinators to pursue their individual interests. Their comments included: "[Staff's name] works their boots off trying to involve [people] especially if there is a religious event" and "[Relative's name] has been out to the park three or four times in the home's transport." We saw evidence that during the course of our inspection people were being supported to go out of the home. The activities coordinator told us that they worked with people on a one to one basis as they had found that people living with dementia found it difficult to manage group activities.

Throughout our visits we saw people being individually supported with activities they liked and observed staff chatting to people and playing people's chosen music. One occasion we observed a member of staff supporting a person to access the internet and order craft materials so they could pursue their interest in model making.

We spoke to visitors and staff, looked at information we had received and looked at the home's complaint records. We saw that there was information available for visitors to raise concerns if they wished. Some visitors told us that either they had not had reason to complain or that when they had raised complaints that these had been dealt with appropriately.

Requires improvement

Is the service well-led?

Our findings

All the people we spoke with were happy to be supported by the service and expressed no concerns with how it was managed. Relatives of people who had been at the service for several years said they had seen general improvement in the quality of the service, particularly in the management team and staff consistency. A friend of one person who was visiting said that the care had improved enormously from how it had been two to three years ago. They commented upon the improved arrangement of the dining furniture for meals and the general increase in standard of care. The relatives of two people who had moved in between our two visits said they were pleased with how their parent had settled in.

Staff we spoke with all said they enjoyed working at the service and that the registered manager and the deputy manager were supportive. A member of staff told us, "They are old school. They don't mess about [when action is needed] but they are fair." Staff said the management team were quick to respond to concerns and take action to support staff deliver care effectively. This included taking robust action to ensure staffing levels were maintained and equipment was purchased which supported people's care needs.

People we spoke with and relatives told us they were encouraged to express their views about the service and felt involved in directing how care plans were developed. Relatives gave us examples of how they were approached to support people who could not express their views of the service so they received care in line with their known preferences. When an investigation of a compliant had identified that errors had occurred the registered manager had, in most occasions, offered an apology and taken measure to resolve issues raised.

When people lacked capacity, the registered manager was taking action to identify those people who had the legal right to consent on people's behalf so they could be involved in making decisions which were in people's best interests. The registered manager had not ensured that overt surveillance equipment that was being installed at the service was going to be used in line with all the relevant legislation. They had however sought the views of people who used the service and their relatives, which were in support of surveillance.

The service had a registered manager who understood their responsibilities. This included informing the Care Quality Commission of specific events the provider is required, by law, to notify us about and working with other agencies to keep people safe. The deputy was also able to explain their responsibilities to the commission when acting up when the registered manager was absent. A social worker told us they felt the registered manager provided honest and timely responses to safeguarding concerns in line with their duty of candour.

The service had a clear leadership structure which staff understood. The provider had recently reviewed their management structure and replaced the senior nurse role on each unit with one overall deputy manager covering both units. Staff told us this system was an improvement because it promoted consistent leadership and good practices to be shared between units.

Staff told us the management team was approachable and receptive to their views. A member of staff told us, "The managers are very good. You can talk to them about things." There was an "on-call" system so staff could receive leadership and guidance from the management team when required and staff told us that senior managers were always available for support. The registered manager and deputy manager told us that calls from staff out of hours had substantially reduced since the new management structure was introduced and staffing levels were being maintained.

There were processes for monitoring and improving the quality of the care people received. The provider conducted regular visits to the service to assess the quality of care and the registered manager conducted regular audits to ensure the care people received and the environment met people's specific needs and kept them safe. Recent audits had identified a lack of hot water on occasions and we saw that the provider was taking action to resolve this. During both visits we saw that registered manager had maintained appropriate records of complaints to prevent similar incidences from reoccurring.

The registered manager had conducted a recent survey to capture people's views which had been well responded to. Comments were generally positive and the registered manager was able to explain the actions they had taken to ensure this information was used to improve the care people received.

Requires improvement

Is the service well-led?

There were systems in place to review people's care records and check they were up to date and identified people's current conditions. This was effective as all the care records we looked at had been reviewed and information was current. The staff had access to information which enabled them to provide a quality of care which met people's needs.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established and operated effectively to prevent abuse of service users. Regulation 13 (2) The provider had not taken reasonable steps to make sure that people who use services were not subjected to any form of degradation. Regulation 13 (4)(c)