Bupa Care Homes Limited

Branston Court Care Home

Inspection report

Branston Road
Burton On Trent
Staffordshire
DE14 3DB

Tel: 01283510088

Date of inspection visit:
24 July 2017

Date of publication:
21 August 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Branston Court Care Home provides accommodation and nursing care for up to 45 older people living with dementia. The accommodation is provided over two floors. The Trent unit is on the ground floor and the Dove unit on the first floor. Both floors have their own lounge and dining area. There were 41 people living at the home on the day of this inspection.

We inspected this service on 24 July 2017 following concerns received about people's safety and the management of the service. This inspection was focused and only covers the domains, safe, responsive and welled. We previously inspected this service in February 2017 and rated the service as Good.

This report covers our findings in relation to the identified concerns. It also covers related information gathered as part of this inspection visit. You can read the report from our last comprehensive inspection visit, by selecting the 'all reports' link for Branston Court Care Home on our website at www.cqc.org.uk

The registered manager that was in post at our last inspection was no longer employed and was in the process of cancelling their registration. 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. At the time of this inspection the regional support manager was managing the service and had been in post since the 10 April 2017. The regional director confirmed a new manager had been appointed and would undertake their induction with the support of the regional support manager.

Improvements were needed to ensure that when people required medicines to be hidden in food or drink, their capacity regarding this was clearly recorded. Other areas regarding medicines management were needed to ensure clear records were maintained to demonstrate that people received their medicine as prescribed or if not the reason why. People's prescribed medicines were not always made available to them as prescriptions were not sent to the pharmacy in a timely way. Records were not consistently recorded to ensure room and clinical fridges were maintained at the recommended temperatures for storing medicine.

Staff understood their role in protecting people from the risk of harm. We saw that actions had been put in place to monitor and protect people from harm. However, this required further improvement to ensure people that were cared for in bed were protected from other people that used the service that may enter their bedrooms. The provider had acknowledged this and actions were being taken to provide a secure area for people that were at higher risk of harm from others living at the home.

Some people demonstrated behaviours that put themselves and others at risk. The provider was using agency staff to enable sufficient staffing levels to be maintained but some agency staff were not always reliable in turning up for their agreed shifts. The regional support manager was addressing this issue with

the agency used at the time of this inspection. We saw that other staff employed were used, such as housekeeping staff that were trained to provide care, when there was a deficit in the staffing levels. A recruitment drive had been undertaken to increase the staffing levels in place and new staff were on induction at the time of this inspection. Safe recruitment practices were in place to check staff were suitable to support people.

People were supported by staff who knew them well but their therapeutic needs were not always met to enhance their well-being. The provider was taking action to address this with the support of specialists in dementia care that were employed by them.

The environment did not support people living with dementia. Plans were in place to improve the environment and specialist advice was being sought to achieve this. Additional training and guidance had been organised for staff regarding supporting people with dementia and people that demonstrated behaviours that put themselves and others at risk. Staff confirmed that clear improvements had been made under the management of the regional support manager and told us they felt supported and listened to.

The quality assurance checks had not been effective in identifying where improvements were needed. Actions had been taken to address this and improvements were ongoing at the time if this inspection. People's representatives had been consulted regarding the areas that required improvement and were encouraged to share their opinions about the quality of the service to enable the provider to make improvements. People's representatives and the staff team told us the regional support manager was effective and approachable. The provider's complaints policy was accessible to people's representatives.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Improvements were needed to ensure clear records regarding people's medicine administration were maintained and that their prescribed medicines were available to them. People's welfare had been placed at risk and improvements were ongoing to address this and ensure people were safe. Care staff understood their responsibilities to report any concerns. Additional staff were in place to meet the needs of the people that used the service. Recruitment practices in place checked staff's suitability to work with people. Arrangements were in place to minimise risks to people's safety in relation to the premises and equipment.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

Improvements were needed to ensure people's therapeutic needs were met. This had been identified by the provider and actions were ongoing to address this. People were supported by staff who knew them. The provider's complaints policy and the procedure were accessible to people who lived at the home and their representatives.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The quality assurance checks had not been effective in identifying where improvements were needed under the previous management. Actions had been taken to address the concerns identified and improvements were ongoing. People were encouraged to share their opinions about the quality of the service to enable the provider to make improvements. People's representatives and the staff team told us the regional support manager was effective and approachable and staff felt supported and listened to.

Branston Court 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.

This inspection focused on three of the key questions within our inspection model, safe, responsive and well led. This inspection visit was unannounced and took place on 24 July 2017 following concerns identified by the local authority regarding the safety of people using the service. The local authority commenced a large scale investigation in June 2017. People's relatives and representatives had been made aware of the concerns and had been included in the discussions regarding the actions the provider was taking to make the improvements.

At this inspection we saw that actions had been put in place to address the concerns identified by the local authority and these actions were ongoing. This meant that although the safety of people had improved further improvements were needed.

We checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan.

On this occasion we did not ask the provider to complete 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. However we offered the provider the opportunity to share information they felt relevant with us.

The majority of people that used the service had communication difficulties and were unable to talk with us about the support they received. To enable us to understand the experiences of people, we observed the care and support provided to people and how the staff interacted with them.

We spoke with four people's visitors, the maintenance person, the cook, one of the activities coordinators, five members of the care staff team, two nurses and the deputy manager. We also spoke with the regional manager who was currently managing the service, the regional director and an admiral nurse. The provider employs admiral nurses, who are specialists in the care of people living with dementia and provide advice and guidance to the home on how improvements can be made. These discussions enabled us to gain people's views about the care and to check that standards of care were being met.

We looked at four people's care records to see if their records were accurate and up to date and reflected the care they received. We looked at how medicines were managed and records relating to staff recruitment and the management of the service.

Requires Improvement

Is the service safe?

Our findings

The stock and storage of medicines was not always accurate to provide clear information to support the administration of medicines. For example, two people on one occasion had not been given their medicine and the reason why was not recorded. We saw that for two other people their prescribed medicine was not available to them. One person had not received a medicine that was used to treat the symptoms of Alzheimer's disease as it was out of stock. Another person had medicine that had been prescribed to be given 'as required'; this medicine was used to treat anxiety. We saw the prescription was made six days earlier and had not been followed up so that the person could commence receiving the medicine. The nurse confirmed the prescription had only just been sent to the pharmacy to be dispensed.

We saw that clinical fridge temperatures were not always recorded on daily basis as required to ensure medicines requiring cold storage were stored at the correct temperature. The temperature of the rooms where medicines were stored was not always recorded each day, to ensure they were stored at the recommended room temperature.

Some people required their medicines to be hidden in food or drink. This is known as covert administration. This practice is only undertaken when a person refuses their medicine and they do not have the mental capacity to understand the health consequences of not taking this medicine. We saw a capacity assessment and best interest decisions had been undertaken, however these were not decision specific regarding covert administration. This meant that clear assessments were not in place to demonstrate why people may require their medicines to be administered in this way. The regional support manager confirmed this had been identified and action was being taken to address this.

Some people required medicine patches for their pain relief. We saw that body maps were used to identify where the patch had been placed. However, we saw for one person this had not been completed therefore we could not be sure the patch was administered correctly.

These issues constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff confirmed that only nurses administered people's medicines. We observed people being supported by the nurses on duty to take their medicine at lunch time and this support was provided in a safe and respectful way. The nurse dispensed each person's medicine separately and took this to them. We saw the nurses spent time with each person and stayed with them until they had taken their medicine before signing to confirm it had been taken.

The provider had taken action to support people that demonstrated behaviours that put themselves and others at risk, whilst they awaited confirmation of funding arrangements. The provider had additional staff on each shift that were provided by an agency, however these staff were not always reliable. On the day of the inspection one agency carer had not arrived for their shift. The regional support manager told us that

this was an ongoing issue and took immediate action to cover the shift with a member of the housekeeping team who was also trained to provide care. The regional support manager confirmed that additional staff had been recruited and were undertaking their induction at the time of the inspection.

The regional manager had implemented a 'tag' system to ensure a member of staff was available within the two lounge areas when they were occupied during the day. This involved staff on lounge duty passing the 'tag' to another member of staff when their lounge duty ended. We saw this worked well throughout the inspection to ensure a member of staff was present in each lounge to support people's safety.

Although the safety of people was monitored in lounges, we saw that staff were not always available to support people as needed that were not in the lounge areas. During the inspection one person spent time walking between the two corridors of the floor they lived on and after several minutes entered another person's bedroom and lay down on their bed. The person who occupied this room was sitting in their room in an armchair. We alerted a staff member who supported this person to rest on their own bed. Another person was heard shouting and we found the person wheeling themselves along the corridor, near to their bedroom seated on a commode. We alerted staff who supported this person. This demonstrated that staff were not always available to effectively support people.

We saw that people that were able walked around the unit independently. Systems were in place to alert staff if a person entered another person's bedroom that was cared for in bed. However these systems had not always proved effective in recent months in maintaining people's safety. The provider was taking action to address this by creating two safe corridors for people that were cared for in bed. This would ensure that people who walked independently around the home would not have access to these areas The call system was also in the process of being updated at the time of our visit. We saw that assessments had been undertaken to determine each person's ability to use a call bell and care plans had been updated to reflect the support each person required and the technology needed to alert staff when support or assistance was needed. The regional support manager confirmed that work to make these improvements had been agreed and would be completed within the next few weeks.

On the day of the inspection nine people went out for the day with the support of care staff and the two activities coordinators. We saw that risk assessments had been completed regarding this trip to guide staff and support people's safety. The maintenance person confirmed that wheelchairs had been checked the previous day to ensure they were safe for people to use. The care staff that supported people on the trip had not impacted on the staffing levels in the home, as these staff had come in on their day off to provide this support.

The staff we spoke with knew about people's individual risks and explained the actions they took and the equipment they used to support people safely. We saw that all of the equipment used was serviced and maintained as required, to ensure it was in good working order and safe for people. Staff understood how to support people to move with the aid of equipment such as a hoist. We saw staff were attentive and spoke to people whilst supporting them. One member of staff told us "We have moving and handling training and know about each person's support needs. Now we also have these new handover forms which we have to carry with us at all times. They include each person's moving and handling needs and how many staff they need to support them." The regional support manager confirmed that training in moving and handling had recently been provided to all staff and this training included assessing the staff's competency. Additional 'real life' competency was also due to be undertaken by the trainer who would be attending the home to assess the staff's skills when supporting people.

We saw that plans were in place to respond to emergencies, such as personal emergency evacuation plans.

The plans provided information on the level of support a person would need in the event of fire or any other incident that required the home or areas of the home to be evacuated. We saw that the information recorded was specific to each person. This provided staff with the right information to enable them to support people's individual needs.

The majority of visitors we spoke with told us they had seen improvements and felt that positive changes were being made at the home. One visitor told us, "I think there is a definite improvement and the [regional support] manager is very good. The staff are very good with people too, even when they are being difficult or noisy. They know people really well and genuinely do their best for them."

Staff did not always feel they had the skills to enable them to manage people who demonstrated behaviours that put themselves and others at risk. We saw the plans lacked information for staff on the techniques to be used to manage people's behaviours. This was because the staff were waiting for training on managing people's behaviours. The regional manager confirmed this training had been booked and was due to commence. Staff told us they welcomed this. One member of staff said, "We are getting behaviour management training which will be really helpful as I don't feel we have the skills to manage behaviour at present." Another member of staff told us, "Since [the regional support manager] has been here things have improved. They have listened to us and the support we are getting is so much better."

Staff we spoke with knew and understood their responsibilities to keep people safe and protect them from harm and knew the procedure to follow if they identified any concerns or if any information of concern was disclosed to them. One member of staff told us, "We had safeguarding training not that long ago. We know to report to the manager or nurse if we have any concerns." Another member of staff said, "Any incidents including falls are reported to the person in charge and recorded. The deputy or the regional support manager makes the safeguarding referral."

We saw that the provider had checked staff's suitability to deliver personal care before they started work. Staff told us they were unable to start work until all of the required checks had been completed. We looked at the recruitment checks in place for three staff. We saw that they had Disclosure and Barring Service (DBS) checks in place. The DBS is a national agency that keeps records of criminal convictions. The three staff files seen had all the required documentation in place. This showed us that the provider understood their legal responsibilities regarding safe staff recruitment.

Requires Improvement

Is the service responsive?

Our findings

People were not always provided with stimulation to support their needs. Although nine people had gone out; the people that remained in the home were not provided with sufficient stimulation throughout the day. The regional support manager had identified this at the morning meeting. The regional manager directed that a film should be shown in the afternoon. The meeting was held every day with heads of services to review any issues or actions required. We attended this meeting on the day of the inspection and saw that everyone exchanged information on any areas for improvement and ongoing work being undertaken. This was a positive approach to ensuring the daily tasks were identified and provided the manager with an overview of the home for the day.

We saw there was limited interaction between the staff and people using the service. We observed that care staff, although present in lounge areas spent a considerable amount of time completing care records which afforded them little time to interact with people. However we did observe that permanent staff knew people well and did when time was available; discuss people's life histories with them.

We spoke with the admiral nurse who agreed that staff responsiveness could improve to increase the interactions provided to people. For example, we observed one person who was sat in the lounge and appeared withdrawn with little interaction between them and the staff team. Their visitor arrived and gave the person a newspaper. The immediate change in this person's well-being was apparent as they began to read the paper out loud. The admiral nurse told us that the well-being director, who was a specialist in dementia care, was due to visit the home to complete an audit. This was to identify the training staff needed to enhance the interactions with people that used the service and promote their well-being.

Since the regional support manager had commenced in post people's care plans and daily records were up to date and improvements had been made to ensure the staff team monitored people's health and welfare, so that appropriate action could be taken when changes in their well-being were identified.

Visitors told us they were aware of the complaints procedure and knew how to raise any concerns with the registered manager. One visitor told us, "If I have any issues I would talk to the [regional support] manager. Although the care staff usually sort out any niggles I have." We saw there was a copy of the complaints policy on display in the home.

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection in February 2017 there had been an increase in the number of people that demonstrated behaviours that put them, other people that used the service and the staff at risk of harm. This had led to several incidents which had not been reported by the registered manager who had been in post at that time. Notifications regarding these incidents were not reported to the local authority safeguarding team or us as required in accordance with the requirements of registration. Since the provider had been made aware of these incidents, safeguarding referrals have been made and we had received notifications regarding these. Actions had been taken by the provider to address the concerns raised regarding people's safety.

The provider had quality monitoring systems in place; however these systems had not been effective in monitoring the previous management deficits and the subsequent concerns that were identified by the local authority. We saw that actions had been taken by the provider to address these concerns. A home improvement plan had been developed. We saw the regional support manager was involving external resources, staff and people's representatives in the process of change. Actions had been taken in a timely way to improve the safety and quality of the service. The home improvement plan had been updated on a regular basis and remained ongoing. The regional director advised us that a new manager had been appointed and was due to commence in post. They confirmed the new manager would be supported throughout their induction period and that regular monitoring of their performance would be undertaken, to ensure any support or improvements required were met.

The views of people's representatives were sought on a regular basis. This was done through an annual satisfaction questionnaire and regular relatives meetings. On the 3 July 2017 a meeting was held for people's representatives to discuss the 'Large Scale Enquiry' and the actions that were being taken to improve the safety of people that used the service. Relatives had stated at this meeting that communication required improvement between the staff to ensure relatives requests were passed to all staff. Relatives told us they had seen improvements. One relative told us, "It is definitely better than it was. The [regional support] manager keeps us informed." Staff told us, "Since the regional support manager has been here things have improved, the communication is much better. We have a communication book and the new handover forms which are good as things won't get missed. We have the new lounge duty as well." We observed that communication with people's families was warm and mutually respectful. The staff acted on relatives wishes and relayed any communication to the nurses on duty.

Staff told us that in recent months the morale had been low due to lack of management support and training to support people that demonstrated behaviours that put themselves and others at risk of harm. Staff now felt supported, listened to and training had commenced which they felt would improve the care and support people received. Staff told us the regional support manager was, "well liked and respected", "hands on" and "very effective". The staff were aware of the goals to be achieved and told us they were looking forward to the new culture and values that they were involved in maintaining, to improve the quality of care provided.

The provider had sought the advice of dementia specialists that worked for the organisation to improve staff knowledge and understanding and to improve the environment for people living with dementia. For example, the lighting was to be improved to support people's vision and blind spots leading to bedrooms. We discussed this with the Admiral nurse who confirmed this had been identified and plans were in place to improve the environment. Additional training had commenced for staff to promote dementia awareness and behaviour management training had been booked.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the home and on their website.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's prescribed medicines were not always available to them. Medication administration records did not always clearly demonstrate why people had not received their medicine at prescribed times. Clear assessments were not in place to demonstrate why people may require their medicine to be administered covertly. Where pain patches were administered, body maps were not always completed to ensure they were administered correctly. Records to demonstrate that medicines were stored at the correct temperature were not always completed