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Braemar Lodge Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Braemar Lodge Residential Care Home is a residential care home registered to provide personal care to up to 14 people. The service provides support to older people and people living with dementia over two floors. At the time of our inspection there were 17 people using the service.

People's experience of using this service and what we found
People's care plans and risk assessments were not always detailed and documentation relating to both fluid charts and medication was not always completed. People did not always receive care from enough competent staff who had received appropriate training.

There were not robust processes for oversight of the service. Training compliance was not well managed, and audits did not identify all issues. Cultural issues had been addressed but there remained concerns among some staff.

People were cared for by staff who were caring and knew them well. People and their relatives were positive about the care and support provided.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 12 July 2019).

Previous recommendations
At our last inspection we recommended that the provider seek guidance in relation to health and safety within a care home and consult guidance in infection control and prevention and apply it. We found these recommendations had been met.

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We received concerns in relation to staffing levels, training, unsafe practices and potential neglect. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key

questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.
We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Braemar Lodge Residential Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safeguarding, risk assessments, staff training and competency, medication documentation and quality monitoring systems at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Braemar Lodge Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors carried out the inspection.

Service and service type
Braemar Lodge Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Braemar Lodge Residential Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with one person who used the service and two relatives and used observation to help us understand their experience of the care provided. We spoke with nine staff, the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included two people's care records and medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- Not all staff had received training on how to recognise and report abuse. None of the administrative or domestic staff were provided with safeguarding training.
- The registered manager was aware of their responsibility to raise safeguarding concerns to the local authority. However, they only submitted notifications to CQC when the concerns were substantiated by the local authority.

Safeguarding training was not provided to all staff and notifications were not always made to CQC. This was a breach of regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Care staff understood how to protect people from abuse. They were able to give examples of concerns and told us what they would do. One staff told us, "I would report anything to my manager".

Assessing risk, safety monitoring and management

- People's care plans contained conflicting and or limited information. For example, one person's file stated they had no falls, but then highlighted that a fall had occurred resulting in a fractured hip. Their mobility risk assessment was not created until a month after they were discharged from hospital.
- Detailed care plans and risk assessments were not completed for people on respite. This meant staff may not have all the information they needed to provide safe care.

Not all risks to the health and safety of people receiving care had been assessed. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us fluid and nutritional charts were completed retrospectively. The registered manager told us staff were to total fluids and escalate daily if targets were not met. Audits of fluid charts were completed weekly which did not identify whether records were completed correctly at the time. However, we found no impact on people.
- Staff managed the safety of the living environment and equipment well to minimise risk. There were risk assessments for pets entering the home. Equipment and temperature checks were completed, and hot water valves were being fitted where the water was too hot. However, a window in the conservatory did not have a restrictor. Following the inspection, we were told this had been fixed, but no evidence was provided.

Staffing and recruitment

● The service provided training in key skills but did not ensure all staff had completed it. Some new staff had not completed any training, while some existing staff had not received training in safeguarding.

● The majority of training was via e-learning. Practical moving and handling training was provided annually by an external trainer. We found examples where staff had completed numerous courses in quick session, one told us, "I did 22 in one day". We were not assured that this was comprehensive enough.

● Moving and handling training for new staff did not include a practical session. They completed e-learning and were observed using equipment to be assessed as competent. Some staff expressed concerns that moving and handling practices were not always safe. We were told staff had been seen lifting a person who should have been moved using a hoist. Following the inspection, the provider informed us that face to face training had been arranged for all staff to attend in June 2022.

● Staff did not always feel their induction was enough to prepare them. We were told that they would have preferred more opportunities to shadow other staff, to get to know people. One staff told us, "[it was] a bit difficult because I didn't know anyone, and you can't always go and read the plan".

● We received mixed feedback from staff regarding supervision. Whilst some staff said they had regular supervision, we were also told it was only every three or six months. There were staff who had little opportunity to speak with the manager and had not had supervision since they joined the service.

Care was not always provided by staff who were trained and competent to do so safely. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service did not always have enough staff with the right qualifications, skills, training and experience. We reviewed rotas and found planned numbers were not always met or included new staff meant to be shadowing. It was unclear how the staffing numbers were calculated, and some staff told us there was not enough staff at night. One told us, "It would be better if there were three because of the amount of medication, cleaning and checks". However, other staff did not have concerns. Staff told us, "There are enough staff" and "There has always been someone to help".

● We were told new staff were supervised while working until their Disclosure and Barring Service (DBS) was received, a recent recruit confirmed this. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. We reviewed two staff files and found both had in date DBS. One person had a gap in their employment history which had no explanation documented but the provider was able to tell us what it related to.

Using medicines safely

● Staff did not always sign Medication Administration Records (MAR) when they had given people their medication. We found numerous gaps in MAR charts for May 2022. We told the provider who said they had identified this via audit, and it was being addressed through training and competency checks. We saw no evidence of this; training records showed the most recent medication training was in March 2022.

● People's medication records did not always include protocols for PRN medication, which is medication to be administered as and when required. This meant there was not always guidance for staff on when to administer medication for pain relief or anxiety, for example, so people may not receive their medication at the right time.

● There was not a medication care plan for a person who was taking medication covertly to explain how the medication was to be administered.

Systems did not ensure medication was managed and administered safely. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed staff administering medication. They were very patient: allowed the person to take their time and take the tablet out of the pot themself. They asked if the person needed any pain relief and confirmed this twice before leaving to get it. Staff were able to describe what they would do if a person refused their medication.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were somewhat assured that the provider was accessing testing for people using the service and staff. The registered manager did not ask to see our LFT result and it was unclear how they monitored staff were testing as required. However, staff told us they tested twice a week and gave the result to the registered manager.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks could be effectively prevented or managed.
● We were not fully assured that the provider's infection prevention and control policy was up to date. It was unclear if or when it was updated throughout the pandemic as it did not have a creation or review dates.

Visiting in care homes
There was a booking system for visitors, and they did not allow visits to be booked during mealtimes.

Learning lessons when things go wrong
● Concerns were raised relating to completion of fluid charts and whilst this had been noted for discussion at handover, it had not been reported as an incident.
● The registered manager investigated all incidents. There was a book for staff to fill in, which the registered manager reviewed daily and identified any immediate actions required. Staff confirmed that any incidents were shared at handovers and any changes made would be in the person's care plan.
● There was a falls process to follow which included prompts for times and areas falls occurred. They had identified more falls were occurring at night and implemented more frequent checks.
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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA. In the files we reviewed, we saw DOLS had been applied for appropriately.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The process for monitoring if staff training was up to date was not robust. Some staff were not included on the staff training record, not all staff had completed all the required training and there were no alerts to advise when training refreshers were due.
- It was not clear how the registered manager identified, through audit, risks to the quality of the service. For example, staff told us of occasions when fluid charts were completed retrospectively. The audit was done weekly, which would not identify whether charts had been filled in at the time or later, meaning we were not assured the audit was effective.
- The medication audit we reviewed covered the time we inspected. It stated that gaps in medication records were being addressed via training and competencies, but this was following our findings on inspection. It did not identify the missing documentation and or detail all areas where temperature checks should be completed.
- Documentation was not always dated, making it unclear whether information was current. This included policies as well as people's care plans, risk assessments and reviews. There were cleaning schedules, but these had not all been completed. These issues had not been identified by the registered manager.
- It was not clear how staffing levels were calculated. There was not a dependency tool to show how needs of people had been assessed to determine the number of staff required.

Systems to monitor and improve the quality and safety of the service were not reliable and effective. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Minutes from the team meeting showed some concerns had been identified and addressed. For example, the importance of thorough handovers was raised to improve communication.
- Staff understood their roles and responsibilities. There was a clear structure with a manager, deputy, senior care workers and care workers. There were some lead roles including for compliance and activities.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- We received mixed feedback from staff regarding support from managers. Most staff we spoke to were happy and did not raise any concerns, one staff told us, "[I] always feel well supported…can go to them if something is wrong". However, we found others did not feel valued and supported or that their concerns

would be addressed because there were close relationships among some staff and managers.
● The registered manager told us issues among staff had been addressed via robust supervisions.
● The registered manager tried to identify who an anonymous whistle blower was. We requested the whistle blowing policy, but this was not provided. We were not assured that the culture was fully open so that staff felt able to challenge unsafe or unacceptable practice without fear of recriminations.
● Equality and diversity were evident in the home with a mixture of backgrounds among both staff and people. During our visit, the staff and people seemed happy and the atmosphere felt positive. We received positive feedback from relatives we spoke to, one relative told us, "Very happy with this place, very happy with staff".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Team meetings were held quarterly. We reviewed minutes which showed information was being shared with staff. Whilst acknowledging areas that had improved, further guidance was also offered by the registered manager for what could be better.
● The provider requested feedback from families. They also had a messaging app with families to keep them informed. However, there was little evidence of involving people and their families in people's care plan development and reviews.

Continuous learning and improving care; Working in partnership with others
● The service was in the process of moving their care planning system online. This was to improve care plans and reduce paperwork.
● Managers and leaders responded to our initial feedback and took action in response. For example, they told us face to face moving and handling training had been booked and were committed to addressing other concerns raised.
● People's records showed the service worked with other professionals, including district nurses and physiotherapists. During our visit, other professionals visited, including a specialist nurse practitioner and a community psychiatric nurse.
● The service worked with the local authority to arrange one to one care for a person who required additional support.

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 12 HSCA RA Regulations 2014 Safe care and treatment Not all risks to the health and safety of people receiving care had been assessed. Not all documentation relating to medication was completed.

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 Safeguarding training was not provided to all staff and notifications were not always made to CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor and improve the quality and safety of the service were not reliable and effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Care was not always provided by staff who were supervised or had the competence and skills to do so safely.