Rowans Care Homes Limited

Burton, Bridge and Trent Court Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We undertook a focused inspection visit on 19 July 2016. This visit was unannounced and was required to check that the provider had addressed the areas identified as requiring improvement at our last comprehensive inspection visit on the 29 February 2016.

At our last visit we identified that improvements were needed to ensure safe medicine practices were always followed and that people's creams were available to them as prescribed. The quality monitoring systems in place required further development and improvements were needed to the recruitment checks and staffing levels.

The provider sent us a report on the 21 June 2018 to address the areas of concern we had identified. The provider and registered manager have continued to inform us on a regular basis of the improvements being made at Burton, Bridge and Trent Court Care Centre.

The areas that required improvement at our last visit were under the two key questions; is the service safe and is the service well led. This report covers the areas that required improvements and all key lines of enquiry (KLOEs) under these two questions. The KLOEs are a set of questions we use that directly relate to the five key questions we ask of all services.You can read the report from our last comprehensive inspection visit, by selecting the 'all reports' link for Burton, Bridge and Trent Court Care Centre on our website at www.cqc.org.uk

Burton, Bridge and Trent Care Centre is registered to provide accommodation for up to 99 people. They can offer support to people with dementia and mental health related conditions. Bridge Court, Burton Court and Trent Court are three separate buildings but are registered with us as one location. Bridge Court provides nursing, residential and dementia care to older people. Burton Court provides nursing care to women with mental health related conditions and Trent Court provides nursing care to men with mental health related conditions. All three units are allocated a unit manager.

At the time of our inspection visit 58 people were using the service. On Bridge Court there were 16 people, on Trent Court there were 27 people and on Burton Court there were 15 people.

There was a registered manager in post at the time of this inspection visit. This 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.

We saw that improvements had been made to medicines practice, discussions with nursing staff and records seen, demonstrated that improvements had been made to ensure medicines were available to people as prescribed. However nurses were not always given protected time to ensure they were not

disturbed or distracted when administering medicines, therefore we could not be sure people would receive their medicines safety.

Staffing levels had improved since our last visit. However the deployment of staff on Burton Court over the lunch time period did not ensure people were supported in a timely way.

The recruitment checks undertaken at the service had been improved. Staff spoken with and records seen demonstrated that all of the required checks were undertaken before staff commenced employment.

We saw that the provider had made improvements to the environment. New furniture and equipment had been purchased, some redecoration had been undertaken and further environmental improvements were planned.

The recording of the support people received had improved. We saw that these records were completed and this enabled the management team to monitor the care people received and to address any identified concerns.

The provider had made improvements in the auditing process relating to the management of medicines. The records confirmed medicine audits were in place and undertaken each month. Any areas for improvement were identified and actions taken as required.

The staff understood how to protect people from abuse and had clear direction on how to support people who demonstrated behaviours that put themselves or others at risk; this ensured the support people received met their needs and kept them safe.

Assessments were in place that identified risks to people's health and safety and care plans directed staff on how to minimise identified risks. Plans were in place to respond to emergencies to ensure people were supported in accordance with their needs. Care staff told us they had all the equipment they needed to assist people safely and understood about people's individual risks. The provider checked that the equipment was regularly serviced to ensure it was safe to use.

There was clear leadership and direction for staff to ensure people's needs were met. Staff told us they were comfortable raising concerns which demonstrated that a transparent and open management approach was in place.

Quality monitoring checks were completed by the provider and registered manager and when needed action was taken to make improvements. The registered manager understood their responsibilities around registration with us.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were sufficient staff; however their deployment did not always ensure people were supported in a timely way. Staff were distracted during medicine administration so we could not be sure people received their medicine safely. Risks were identified and managed to ensure staff could minimise the risk for people. Staff understood how to keep people safe and protect them from harm. There were arrangements in place to support people's safety in relation to the premises and equipment. Recruitment procedures were thorough to ensure the staff were suitable to work with people.

Is the service well-led?

Good

The service was well-led.

People told us the manager was approachable and staff felt supported in their work. People and their representatives were encouraged to share their opinions about the quality of the service to enable the provider to make improvements. There were quality assurance checks in place to monitor and improve the service.

Burton, Bridge and Trent Court Care Centre

Detailed findings

Background to this inspection

We carried out this inspection visit 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 visit took place on 11 October and was unannounced. The inspection visit was carried out by two inspectors 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 checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service. Notifications are changes, events or incidents that providers must tell us about. We reviewed the provider's statement of purpose. A statement of purpose is a document which includes a standard required set of information about a service. We also spoke with the local authority who provided us with current monitoring information.

On this occasion we did not ask the provider to send us 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.

We used a variety of methods to inspect the service to gain people's views about the care and to check that standards of care were being met. We spoke with 12 people that used the service, three care staff, two unit managers, the administrator, two visiting professionals and the registered manager.

Some people were unable to share their views with us, due to their mental health conditions. So we spent

time with them and observed them being supported in the lounges and dining areas. We looked at the assessments and monitoring information in place for six people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service, including quality checks and staff files.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in February 2016 we saw that the nurse working on Bridge Court was distracted during medicine administration on four separate occasions by staff and a visiting professional. This meant that we could not be sure the medicines were being administered safety. At this visit we identified similar concerns during the lunch time medicines administration round on Burton Court. The nurse was regularly distracted by people that used the service and by care staff. We saw they had to stop administering medicines on several occasions to support people. Although no errors were made, the risk of a medicine error was increased due to these distractions. The registered manager needs to identify a way for nurses to have protected time, so they are not disturbed or distracted when administering medicines.

At our last inspection people were not always receiving their creams as prescribed and creams were not always or stored correctly. At this visit we saw that improvements had been made. Creams were stored correctly and medicine administration records (MAR) had been signed to demonstrate creams were applied as prescribed. We saw that medicines were stored safely and records were in place to demonstrate that people received their medicines as required.

At our last inspection improvements were needed to the staffing levels. This was because people were not always supported in a timely way on Bridge Court. At this visit we saw that there was enough staff to meet people's needs across the three units, however there were concerns relating to lunchtime on Burton Court. People living at Burton Court were not supported in a timely way to eat their lunch. For example one person, who had been supported into the dining room prior to lunch, being served, was not supported to eat their meal at the same time as other people in the dining room. We saw that everyone else in the dining room had finished their meal and this person was still waiting for their meal. This caused anxiety to the person who had to wait.

Another person taking lunch in the lounge required physical prompts to eat their meal. One member of staff told us, " Some days [name of person] eats well independently and on other days they need us to prompt them and place food on their fork for them and today they need that extra support." We saw that at the time this person's lunch was served to them, there was not enough staff available to support them on an ongoing basis; This meant this person only ate a small amount of their lunch whilst it was still warm. We asked the registered manager to look at the deployment of staff and the lunchtime routine to improve the lunch time experience for people.

At our last inspection we asked the provider to make improvements to the environment and some equipment. At this visit we saw that improvements had been made. New furniture and equipment had been purchased and some redecoration had been undertaken. For example we saw that a new food trolley had been purchased for each unit, new arm chairs had been purchased and some areas redecorated, such as the lounges in Burton Court. The registered manager told us that further environmental improvements were planned. For example, quotes were being obtained for a new carpet in the lounge on Bridge Court. The administrator told us, "A third company are coming today to give us a quote for new carpet for the large and

small lounge on Bridge Court and one of the bedrooms, so we will be able to order them soon. It is loads better now; things we need get done."

At our last inspection improvements were needed to the recruitment checks undertaken. At this visit we saw that the registered manager checked staff's suitability to deliver care before they started work. 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. Staff told us they were unable to start work until all of the required checks had been completed by the provider. One member of staff told us, "I had to have all my checks back before I could start; I had to bring my DBS in to work as well." We looked at the recruitment checks in place for three staff. These demonstrated that all the required checks had taken place before the staff commenced employment.

People who used the service told us they felt safe. One person said, "I feel safe. If you have a problem it is fixed." Another person said, "I like it here, they are a good crowd. It is very good and I have no worries. I feel safe." Another person told us they felt, "Safe as houses." The staff we spoke with knew and understood their responsibilities to keep people safe and protect them from harm. One member of staff told us, "The training we had was about keeping people safe and how to approach the issue and report any concerns. I would report to the manager but I could go higher to the local authority if needed." Staff told us they were aware of the whistleblowing policy. Whistleblowing is a way in which staff can report misconduct or concerns about poor practice in their workplace. Staff knew they could contact external agencies such as the local authority or us. One member of staff told us, "It's my right to express my concerns and go to the local authority if I need to." Another member of staff told us, "Safeguarding and whistleblowing is discussed in staff meetings, there is a poster in the staff toilet about how to whistleblow and the manager discusses reporting concerns with me at my one to one meetings."

We saw that plans were in place to respond to emergencies, such as personal emergency evacuation plans. These plans provided staff with information on the level of support a person would need in the event of fire or any other incident that required the home to be evacuated.

Staff told us they had all the equipment they needed to assist people, and we saw that the equipment was maintained and serviced as required. We observed staff supporting people with moving and handling equipment and this was done in a way that showed us that people were supported safely. For example we saw that people were supported to put their feet on the foot plates when being supported in a wheelchair.

Where risks were identified the care plan described how care staff should minimise the identified risk and behaviour management plans provided staff with clear direction on how to support people who demonstrated behaviours that put themselves or others at risk. One member of staff told us, "I feel safe, because we know people's triggers and we share information on what to do. I read risk assessments to make sure I know about people and we have handovers at each shift." This meant that staff had the information they needed to support people according to their identified needs and to keep them safe.

Good

Is the service well-led?

Our findings

At our last inspection we saw that improvements were needed because staff were not always recording the care or checks they provided to people. At this visit we saw that improvements had been made. Staff had completed records after providing care to people. For example we saw that repositioning records for people cared for in bed were completed. For people assessed as at risk of not eating well, staff were recording their food intake. This enabled the management team to monitor the care people received and to address any identified concerns.

At our last inspection we saw that improvements were needed to monitor the management of medicines across the service. At this visit we saw that improvements had been made. We looked at the medicine audits which were undertaken, and saw these were done on a weekly and monthly basis. Any areas for improvement were identified and actions taken as required. For example one audit had identified the clinical fridge had been left unlocked. We saw this had been discussed with the nursing staff. The provider and nurses ensured the clinical fridge would be locked when not in use.

Records showed that accidents, incidents and falls were analysed to identify any patterns or trends. We saw that when a pattern was identified the manager had taken action to minimise the risks of a re-occurrence, such as referring people to other health care professionals. Other audits seen included care plans, infection control, mattresses and hoist audits. We saw that where actions had been identified these had been addressed. For example specialist mattresses, used for people at risk of skin damage, were checked daily. These daily checks resulted in a pass or fail score. Records showed that when a mattress failed the audit check, a new mattress was ordered. This ensured people's well-being regarding their skin was maintained.

People told us they liked the staff and the management team. One person said, "Everyone is friendly here, they are all very good really. I have never been to a meeting but they do listen to us. The staff are perfect." Another person said, I know who the manager is and she is helpful. I don't know of anything that needs improving." Another person said, "The staff do really listen to you. You can have a good laugh with them. We have got a really good crowd here. They check regularly how we feel about things and our opinion."

At our last inspection the registered manager was in the process of developing satisfaction surveys to gather the views of people's representatives. They confirmed that these had been sent out but had received a poor response, so people were asked to complete these when visiting. We saw that comments received were positive, for example one relative wrote, 'The staff are very good to [name of person].' Records showed that people and their families were involved in developing and reviewing their plan of care.

We spoke with two visiting professionals both confirmed they had no concerns regarding the care provided or the management of the home. One told us. "The staff are really good, the communication is good and the staff follow our instructions. I have no worries at all, it's well organised here."

Staff had a clear understanding of their responsibilities and accountability within their role. A registered

manager was in post and they were supported by unit managers and a team of nurses. Senior care staff were in post to support care staff on each shift. Monitoring from the registered provider was also in place to support the registered manager. The registered manager told us about the support they received and said, "I get a lot of support from the unit managers and my line manager is my greatest support and is very thorough." This meant that people were cared for by staff that were appropriately managed.

Staff confirmed that the registered manager and management team were available and easy to talk to. One member of staff said, "I feel very supported, if there's an issue I am not scared to go to anyone at any time. My manager is willing to listen and make changes." Another member of staff told us, "I love my job and the people I support, there's lots of support and good team work." This demonstrated that a transparent and open management approach was in place to support the staff and protect the well-being of people that used the service.

The registered manager was aware of their registration responsibilities. Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. The registered manager had informed us about incidents that had happened.

The last inspection report and ratings were displayed in a conspicuous position in the reception areas in line with our regulations.