Alliance Care (Dales Homes) Limited

The Branksome Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Branksome Care Home is a residential care home providing personal and nursing care to 33 people at the time of the inspection. The service can support up to 34 people.

The home can accommodate 34 people in single rooms across two floors in one building. The home has shared communal bathrooms. There are communal lounges, a dining area and an outside space.

People's experience of using this service and what we found
The judgement of this service takes into account the previous breaches and rating in each domain.

Accident and incidents had not been properly recorded, reported, investigated or monitored. We found people had sustained multiple unexplained injuries which had not been reported to the manager so necessary actions had not been taken to reduce the risk of reoccurrence.

Risks to people had not been identified, monitored or reduced. At this inspection we found people were at risk of pressure sores, choking, dehydration and infection.

Medicines were not safely managed. We identified multiple instances where prescribed creams had not been recorded as administered in line with the prescribing instructions.

Staff were not always safely recruited. We reviewed recruitment records for staff and found the provider had not fully completed background checks for one staff member.

Care records did not always contain the correct information. One person's care records contained conflicting information about their choking risk. One section stated the person required monitoring whilst eating and drinking however another section stated they ate independently.

The majority of relatives we spoke with told us of concerns they had about the care being delivered. We raised safeguarding referrals to the local authority for investigation following the information relatives shared with us.

The provider had failed to ensure there was adequate oversight of the service. Quality assurance systems and processes did not identify or address issues in the service during this inspection and the previous inspection.

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; however, the systems in the service did not support this practice.

People were supported to access healthcare and appropriate referrals had been made when people had lost weight or were experiencing swallowing difficulties.

All of the people we spoke with during our inspection were happy and told us they enjoyed living in the home.

People's care plans contained information about their life history, preferences, likes and dislikes. We saw evidence that people's preferences had been respected and followed.

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

Rating at last inspection and update
The last rating for this service was requires improvement published 12 November 2020 and there were 2 breaches of regulation. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about risks to people not being managed safely. A decision was made for us to inspect and examine those risks.

We found the provider had not taken effective actions to mitigate the risks.

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 have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive 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.

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/We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care, meeting people's nutrition and hydration needs, recruitment practices and oversight of the service.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? This service was not safe Details are in our safe findings below	**Inadequate**
Is the service effective? This service was not effective Details are in our effective findings below	**Inadequate**
Is the service caring? This service was not always caring Details are in our caring findings below	**Requires Improvement**
Is the service responsive? This service was not always responsive Details are in our responsive findings below	**Requires Improvement**
Is the service well-led? This service was not well-led Details are in our well-led findings below	**Inadequate**

The Branksome 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 Care Act 2014.

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
The inspection was carried out by one inspector.

Service and service type
The Branksome Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager who had applied to be registered with the Care Quality Commission. Registered managers and providers are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed information we had received about the service since

the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and thirteen relatives about their experience of the care provided. We spoke with nine members of staff including the regional manager, home manager, nurses and care assistants.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance records and recruitment files.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management; Using medicines safely

At our last inspection the provider had failed to ensure people received safe care and treatment. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Unexplained injuries had not always been properly recorded, reported, investigated or monitored. We found people had sustained multiple injuries which staff had recorded, but these had not been reported to the manager, so the necessary actions had not been taken to reduce the risk of reoccurrence.
● Staff had received training in how to safeguard people from abuse. Staff understood how to report any concerns they had to relevant professionals, however as unexplained injuries had not been reported we could not see this training was put in to practice.
● People were not protected from the risk of pressure sores. We found people had not been repositioned in line with their assessed need. Recording charts had not been fully completed or monitored.
● People were at risk of harm from defective mattresses. We found one person's pressure relieving mattress to be on the incorrect setting. There was not a regular system in place to check if pressure reliving mattresses were safe or on the correct setting. The provider had failed to identify or action this.
● People were not protected against the risks associated with poor oral hygiene. We identified continuous recording gaps in daily oral health assessments. This put people at risk of harm from poor oral hygiene as the assessments had not been completed within the timeframes specified in peoples care records.
● Medicines were not managed safely. We found multiple instances of when staff had not recorded if people's prescribed creams had been administered in accordance with the prescriber's instructions. This meant people were at risk of not receiving their medicines as prescribed.
● People were not protected from the risks associated with medicines. We identified one person who had been prescribed medicine which placed them at increased risk of bruising, the provider had failed to identify this or provide staff with information on how to support the person safely.
● People, staff and visitors were not protected from catching and spreading infection. Cleaning records had not been maintained or monitored. The provider had failed to identify or action this.

This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

We highlighted our concerns with the provider who following the inspection provided some evidence of action taken to mitigate risk.

Staffing and recruitment
● Safe recruitment practices were not consistently in place. Appropriate actions had not been taken where information of concern had been raised in pre- employment checks for one staff member. This placed people at risk of harm by being cared for by unsuitable staff.

This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not made every effort possible to gather background information about the person.

● Staffing rota's evidenced that during August and September 2021, there were multiple occasions where insufficient numbers of housekeeping staff had been deployed to carry out the cleaning and laundry duties in the service. The provider told us they were aware of this and were in the process of recruiting additional staff.
● During the inspection, we observed call bells to be responded to in a timely manner and staff spending time speaking and listening to people, however relatives told us they felt staffing levels were poor in particular at weekends. One relative told us "I have witnessed low staffing levels, alarm bells constantly going off and bedroom doors slamming shut on more occasions than not."

Preventing and controlling infection
● 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 accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach

Learning lessons when things go wrong
● The provider did not improve their practices in relation to the management of risks as identified in our previous inspection. We found continued issues which placed people at risk of unsafe care and treatment.
● The provider had a system in place to monitor and analyse accidents and incidents, this system however had failed to identify the unexplained injuries we found during the inspection, preventative measures had not been put in place which led to repeated issues.
● Accidents and incident forms had been completed by staff, however they did not provide sufficient follow up information to reduce any further risk.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet
- People were at risk of dehydration. People's fluid intake had not been fully completed or monitored.
- Care records for people who were at risk of dehydration did not contain the information required for staff to support them safely. The records did not detail fluid targets, or the actions staff should take in the event the person had a low fluid intake.
- People were at risk of malnutrition. Records were not consistently maintained, there were unexplained gaps on food records which meant it was not clear if people had eaten anything.
- Care records did not always contain the correct information. One person's care records contained conflicting information about their choking risk. One section stated the person required monitoring whilst eating and drinking however another section stated they ate independently. This meant staff did not have the correct information to support people safely and they were at risk of harm.
- During the inspection we observed the person to be eating unsupervised alone in their bedroom, we raised this with the provider, who immediately arranged for a staff member to support the person. The provider told us they would arrange for the persons care records and staff to be updated to prevent a reoccurrence.
- Staff told us that they often bought people the drinks and snacks they preferred and requested as the provider did not make these available. Staff told us they had raised this with the provider, but this had not been resolved.

This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to ensure peoples nutrition and hydration needs were met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- Assessments made in relation to choking risks, by other professionals such as speech and language therapists (SALT) were included in people's care records, however these were not used appropriately to create or develop existing care plans and risk assessments. We identified that a person's risk assessment conflicted with the information in the persons SALT assessment.
- Care records in place for people with pressure sores lacked detail, staff told us they supported a person with a pressure sore to reposition every two hours at night, however this detail was not recorded in the persons care plan.
- Care records were evaluated monthly, however they continued to lack the required detail to ensure

people received care and support safely.
This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not done all that was reasonably practicable to reduce the risks to people's safety. This placed people at risk of harm.

Staff support: induction, training, skills and experience
● Staff had completed appropriate training, however people's experiences of care demonstrated that staffs understanding, and competency was not effectively managed as people continued to experience unsafe care and treatment in relation to repositioning, medication, eating and drinking.
● The service had systems in place to ensure staff received regular supervision which included feedback on their performance and checking staff's understanding of training they had received.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The service worked in partnership with a GP surgery, who conducted weekly reviews of people's ongoing health needs. Relatives told us they were not kept updated following these appointments.
● People were supported to access healthcare. Records showed us that appropriate referrals had been made when people had lost weight or were experiencing swallowing difficulties.

Adapting service, design, decoration to meet people's needs
● The premises did not have any signage or decoration to support people living with dementia to orientate themselves within the environment. We raised this with the provider who told us they would action this.
● People's bedrooms were personalised with their belongings, chosen pictures and ornaments.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● We saw evidence that the applications for DOLS had been completed and submitted correctly.
● We saw people had mental capacity assessments and best interest decisions completed in line with best practice, these had involved people with the legal authority to do so on behalf of the person where appropriate.
● Where relatives held Lasting Power of Attorney (LPA) for people which meant they were legally able to make decisions on people's behalf, the provider had checked the LPA was in place.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- Peoples care records were not stored securely. We found multiple people's records to be stored in corridors. We raised this on the first day of the inspection, when we returned on the second day of the inspection the records continued to be stored incorrectly.
- The majority of relatives we spoke with told us of concerns they had about the care being delivered. We raised safeguarding referrals to the local authority for investigation following the information relatives shared with us.
- All of the people we spoke to during our inspection were happy and told us they enjoyed living in the home. One person told us "Lovely staff, very good, they will do anything for you." And another told us "Everybody is nice, I have no complaints".
- We observed staff to be considerate throughout the inspection. We saw staff spending time listening and talking to people and encouraging their independence in a kind and caring manner.

Supporting people to express their views and be involved in making decisions about their care

- People had contributed to their care planning, however relatives told us they had not always been involved and regularly had to ask staff for updates on queries they had raised. One relative told us "I have asked numerous times about being involved in care planning" and another told us they felt "Excluded and I want to be involved".

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant people's needs were not always met.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
- The service was not providing menus and signage in appropriate formats to support people living with dementia to make choices and support their orientation. We raised this with the provider who told us they would action this.
- People's communication needs were identified and detailed within care plans. Care plans gave staff direction on the methods they should use to assist people with their communication such as speaking clearly and giving time to allow the person to express their choice.

Improving care quality in response to complaints or concerns
- The majority of the relatives we spoke to, told us they had raised concerns about peoples care and did not feel their concerns had been resolved appropriately. Relatives told us they had attended a relatives meeting in August 2021 with the manager. One relative told us," Nothing has happened since. The manager has not finished the minutes."
- There was a complaints policy in place and formal complaints were recorded, investigated and responded to appropriately, however relatives told us the informal concerns they had raised had not been responded to.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
- People's care plans contained information on their life history, preferences, likes and dislikes. We checked people's care records and could see that people's preferences had been respected and followed.
- People told us they were happy with the care they received, one person told us "I like to stay up late and it's not a problem, they [staff] help me when I am ready to go to bed."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
- People had access to a wide range of activities which included keep fit and music through the decade's sessions. People told us they enjoyed the activities, relatives told us they felt activities could be improved for people who stayed in their bedrooms.

● Staff supported people to maintain relationships with people who were important to them. The manager told us how they supported people to use video call in addition to face to face visits to enable people to stay in touch.

End of life care and support

● Care plans were in place which reflected peoples wishes and people they would like to be involved at the end of their life.

● Staff had completed training on how to support people at the end of their life, to ensure their needs and preferences were met.

Inadequate

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our inspection, the provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Risks to people's safety had been assessed, however the records lacked detail on how staff can support people safely with medication, eating, drinking and repositioning. People's records continued to be presented in a way that was not easy for staff to navigate. This had also been identified at our previous inspection in September and October 2020. The provider had failed to take actions to reduce this risk.
- The provider had failed to ensure there was adequate oversight of the service. Quality assurance systems and processes did not identify or address all of the issues found during this inspection.
- Systems and processes in place were ineffective. Known risks to people in relation to their food, fluid intake and repositioning needs were not monitored or met, which left people at risk.
- The provider had failed to put a system in place to ensure safety checks were completed for people using pressure relieving airflow mattresses. This lack of oversight placed people at risk of harm as mattresses were not checked to ensure they were safe or on the correct setting.
- The service had breached the Data protection act as people's confidential information was not stored securely.
- The provider had identified shortfalls of recordings in people's care records, however the actions taken had been ineffective as the issues continued.

This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

●The provider understood their responsibility to keep people informed when incidents happened in line with the duty of candour, however they had failed to identify and action areas of the service which required improvement.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

●The provider gathered feedback about the service from people using the service and their relatives. However, relatives told us they felt that nothing had changed following the feedback they had provided.

● Staff provided feedback to the provider through surveys, staff told us issues they had raised had not been listened to. For example, a staff member told us they raised concerns that people's preferred and requested food and drink was not made available, however the provider had not made any changes.

Continuous learning and improving care

● The provider had not addressed the all areas they were in breach of, as identified during our previous inspection.

● Staff meetings and supervisions with staff took place regularly, the manager raised findings from audits they had carried out and the improvements required however we could not see that this had been effective as the issues continued.

Working in partnership with others

● The service worked in partnership with other professionals such as GP's and podiatrists to support people to access healthcare when they needed it.

● The service had worked in partnership with wheelchair services to ensure a person had the specialist equipment they required.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure peoples nutrition and hydration needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not made every effort possible to gather background information about staff they employed

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not done all that was reasonably practicable to mitigate the risks to people's safety and welfare. This placed people at risk of harm.

The enforcement action we took:

Imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not operate an effective system to assess and monitor the service

The enforcement action we took:

Imposed conditions on the providers registration.