Mr Boota Singh Khangure

Brambles Rest Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Brambles Rest Home provides personal care and accommodation for up to 35 people. At the time of our inspection there were 31 people using the service. People who used the service had a range of support needs related to old age and dementia.

People's experience of using this service:
People did not always receive safe care and support. Medicine management was not consistently safe and required improvement. In addition, some incidents which should have been reported to safeguarding authorities had not been. Staff were knowledgeable about safeguarding and people told us they felt safe. Risk assessments were in place however they did not give clear information of people's needs and lacked guidance for staff to follow.

Staff had the skills and knowledge to support people and meet their needs. The appropriate requests to the Local Authority had been made where people lacked capacity and staff were aware of which people had a Deprivation of Liberty Safeguard in place. However, some improvements were required in record keeping to ensure best interest decisions were recorded appropriately. People told us they enjoyed their meals and had enough to eat and drink. Staff supported people to access health care when needed.

People told us that the staff were kind and caring. However, there was a lack of systems in place to ensure the service was consistently caring. People told us they could not recall being involved in reviews of their care.

We received mixed feedback in response to complaints. People had the opportunity to be involved in stimulating and meaningful activities. The service was good at discussing and recording end of life plans and had devised a leaflet to support people and their relatives.

The registered manager had carried out regular audits however they were not effective in highlighting issues for improvement. There was a lack of robust oversight of accidents, incidents and safeguarding's. People knew who the manager was and said they were approachable. Staff told us the management team were supportive.

Rating at last inspection:
The last rating for this service was good (published 06 October 2016).

Why we inspected:
This was a planned inspection based on the previous rating.

Enforcement:
We found the provider was not meeting all of the requirements of the law. We found multiple breaches in

regulations. You can see what action we told the provider to take at the back of the full version of the report. 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 continue to monitor the service through the information we receive until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

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

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 effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Brambles Rest 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection 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. In this case as a family carer for an older person.

Service and service type
Brambles Rest Home is a 'care home'. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection. The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection:
The inspection was unannounced.

What we did:
Prior to the inspection we reviewed information we held about the service since their last inspection. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also contacted the local authority who commissioned services from this provider.

We used information that the provider sent us in the Provider Information Return. 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. We used all this information to plan our inspection.

During the inspection we spoke with 10 people, 6 relatives and 3 health care professionals. We spoke with 9 care staff, the activities co-ordinator, chef, deputy manager and the registered manager. We looked at records relating to people's medicines, 9 people's care records and 3 staff files. We looked at records for how people were administered medicines as well as a range of records relating to the running of the service. This included incident and accident monitoring, auditing systems and complaints. We also spent time observing day to day life and the support people were offered.

Requires Improvement

Is the service safe?

Our findings

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

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. Some regulations were not met.

Using medicines safely

- Medicines management was not consistently safe. We saw a person being administered medicines but when we checked later they were not signed for in the medicines record.
- We found gaps in the medicine's administration records for 3 people, so we could not be satisfied that medicines had been given as prescribed.
- When people required medicines to be administered as and when required (PRN), medicines were not always administered in line with best practice. For example, we observed one person had been given their PRN medication every day over a significant period. No medical advice had been sought to assess the effects of long-term use of this medicine or to determine whether this person needed a medication review.
- On the day of the inspection we observed and a member of staff told us that the fridge was above the recommended temperature for safe storage of medicines. Action to address this wasn't instigated until we informed the registered manager the next day. This increased the risk to the safety of the medicines which could have been compromised.

Failure to provide medicines in a safe way is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Observations of staff showed that they took time with people and were respectful in how they supported people to take their medicines.

Systems and processes to safeguard people from the risk of abuse

- People were not consistently protected from the risk of abuse. For example, we observed two incidents where actions had been taken by the manager but they had failed to notify the local authority safeguarding team. For example, one person alleged physical harm from another person, actions were taken by the manager, but the local authority were not notified.
- The provider's safeguarding policy was out of date and did not reference current legislation. However, when we brought this to their attention they updated this immediately.

Failure to safeguarding people from the risk of abuse is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had received training on safeguarding and had an awareness of how to report abuse.
- People and relatives told us they felt safe. One person told us," Night staff check on me in the night, makes me feel safe." A relative told us, "No concerns about safety."

● People had Personal Emergency Evacuations Plans (PEEPs) in place and they were stored in an accessible place for staff to access. A recent fire risk assessment had been completed by an external company.

Assessing risk, safety monitoring and management

● Whilst risks had been assessed, care plans lacked guidance for staff to follow to reduce these risks. For example, one person was supported to transfer using 2 different hoists. Although there was a care plan in place it lacked enough guidance for staff to follow on which hoist should be used and when. This increased the risk of unsafe care being delivered. However, we did observe that staff were using safe practice to support people to move.

● Where action had been identified to address risks, care records were not clear. For example, one person's food and fluid chart did not have their individual target identified and their daily consumption was not calculated. This meant that insufficient intake would not be easily identified.

● Care plans we sampled did not contain sufficient information in relation to some health conditions, for example diabetes. There was no guidance for staff on what they needed to monitor and what to what to do if the person's condition deteriorated. We saw staff had referred to a health professional when they had concerns however, the lack of guidance increased the risk of people receiving unsafe or inappropriate care.

Learning lessons when things go wrong

● Accidents and incidents were recorded however, there was limited evidence of lessons learned. For example, in March 2019 there were 5 incidents recorded of people being found on the floor. Although the immediate action taken was recorded there were no analysis of the information or lessons learned highlighted.

Staffing and recruitment

● People told us there were enough staff. One person told us, "I never have to wait for help to get washed and dressed."

● The staff we spoke to told us there were enough staff to support people's individual's needs. Our observations were that were enough staff to support people.

● Recruitment processes were in place. We saw evidence of Disclosure and Barring Service (DBS) checks and two references being sought before staff were appointed.

Preventing and controlling infection

● We found all areas of the home clean and tidy. We observed staff wearing personal protection equipment like gloves and aprons and they confirmed that these were readily available.

● People told us, "My home is very clean," and "They clean my bedroom every day."

● The provider carried out regular environmental audits and followed up promptly when action was required.

Requires Improvement

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations were met.

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 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 with appropriate legal authority. 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
- Staff had undertaken training and demonstrated a good understanding of the principles of the MCA, however this had not always been embedded in practice.
- One person told us "Staff always ask my permission before helping me" and we observed this in practice, however on one occasion a staff member put a protective apron on a person from behind without gaining consent.
- We saw that there was a general consent to care form on people's care records, however we did not see decision specific capacity assessments. For example, we saw that a relative had been involved in a best interest discussion about the use of bed rails but there was no capacity assessment to evidence that the person lacked capacity to make this decision themselves.
- In one person's care plan we saw that a consent form had been signed by a relative but we could not see that they had the authority to do so. The manager agreed to record this as a best interest decision.
- Where it had been identified that people were being deprived of their liberty DoLS applications had been made to the Local Authority.
- Staff knew which people were subject to a DoLS and the reason why.

Supporting people to eat and drink enough to maintain a balanced diet

- People told us that they enjoyed the food provided. One person told us, " The food is lovely, they do curries here, very nice."
- The chef had detailed information about people's different dietary requirements. For example, who needed a soft and diabetic diet.
- Staff supported people to eat at mealtimes in a caring way. We observed staff supporting a person to eat explaining all the food on their plate and asking what they would like to try first.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People told us that they had access to health care professionals when needed. One person told us, "They have doctors on tap, they get them in straight away."

● A health care professional told us that the service was good at making referrals and, "React quickly when people need help."

Staff support: induction, training, skills and experience

● Staff were trained, skilled and knowledgeable. There was a system in place to monitor training and identify when updates were required.

● New staff received an induction programme which involved shadowing experienced staff and undertaking the Care Certificate. The Care Certificate is the nationally recognised benchmark set as the induction standard for staff working in care settings.

● Staff told us they were supported by the management team and had regular supervision.

Adapting service, design, decoration to meet people's needs

● The home was welcoming, warm and comfortable. We saw that people's bedrooms were personalised, one person had a double bed in their room.

● There was some signage on doors to help people with dementia orientate themselves.

● There was a secure garden that people could access and there were plans to update this with new benches.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● The provider carried out a pre-admission assessment to ensure care was planned and the service could meet their needs and preferences.

● People's religious beliefs were identified and respected. Someone attended the home to give Holy Communion.

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

Systems may not always ensure people are well-supported, cared for or treated with dignity and respect. Regulations were met.

We received positive feedback from people about the caring attitude and behaviours of individual staff. However, we also found that the providers systems did not always support the service to be fully caring. This can be demonstrated by the concerns found in other areas of this report.

Supporting people to express their views and be involved in making decisions about their care
● People told us they could not recall being involved in reviews of their care. Whilst we could see evidence of communication with relatives, when care plans had been reviewed there were no records of who was involved and what was discussed."
● People told us they were involved in day to day decisions about their care such as what time they got up in the morning. One person told us, " If I want to stay in bed until 10am I can. It's up to me what I do and when I do it."

Ensuring people are well treated and supported; respecting equality and diversity
● In one of the care records we sampled, we saw a staff member had referred to an adult in a disrespectful way. We brought this to the attention of the manager and they agreed to address this.
● People told us how kind and caring staff were. One person told us, " They are very caring, they have got me through a lot," another person said, "Staff are angels, all of them, thoughtful and respectful."
● Relatives we spoke to spoke highly of the caring nature of staff. One relative told us, "[Name of person] has dementia and can't talk much but they come and sit by [relative] and hold their hand, it comforts them."
● We observed staff treating people with kindness and taking time to talk to people and share stories together.
● Staff members we spoke to demonstrated an understanding of equality and diversity and religious needs were noted in care plans.

Respecting and promoting people's privacy, dignity and independence
● We saw staff approach people in a respectful and dignified way, however we saw one occasion where a staff member was not discreet when asking people if they required assistance to go to the toilet. When we raised this with the manager, they addressed this and we did not see a further incident.
● People told us that staff respected their independence, one person said, "I can totally keep my independence here which suits me."
● Some people chose to spend time in their bedroom's which was supported by staff. One person told us, "Staff always knock on the door before they come in."
● Staff knew the importance of keeping information confidential and people's information was stored securely.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations were met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- Providers of NHS care and publicly funded adult social care must follow the Accessible Information Standard (AIS). The standard aims to make sure that people are given information in a way they can understand to enable them to communicate effectively. Whilst picture cards were used for meal choice, we could not see evidence of any other formats for people to receive accessible information. The registered manager told us they would look into this.
- There were a range of activities on offer. We observed seventeen people taking part in an afternoon entertainment session. People were engaged, taking part in exercises and laughing.
- People told us they enjoyed taking part in the activities. One person told us, "We play skittles, we encourage each other, I absolutely love it."
- The care plans we sampled contained person centred information about the person's life history and interests. Staff demonstrated that they knew people well and one relative told us that staff had come in on their own time, to take their relative out in the community.

Improving care quality in response to complaints or concerns

- People's views on how complaints were handled varied. One person told us about a concern they had raised. They said, "The problem wasn't always sorted straight away but if you kept on it would be." However, another person told us their complaint about a staff member had been dealt with quickly by the manager. The person told us, "They are brilliant now."
- The provider had a complaints procedure on display however this was out of date and did not have up to date contact details. We raised this with the manager and they updated it during the inspection.

End of life care and support

- An end of life care plan was completed which recorded information about the person's wishes in the event of their death.
- A relative told us the home had supported them with information about wills.
- We saw compliments the home had received about how they had supported people at the end of their life. One said, "Thank you for everything that you did for [name of person]. We couldn't ask for better care."
- The home had produced an information leaflet for people and relatives about end of life care, which included how they could support people and useful contact details.
- Two staff had received extended training with the local hospice and were identified as palliative care champions.

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations were not met.

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

- The registered manager and provider had not appropriately submitted notifications to the Care Quality Commission. Whilst they had notified us of deaths, Deprivation of Liberty Safeguards (DoLS) and serious injuries they had failed to notify us of allegations of abuse.

This is a breach of Regulation 18 (Registration) Notification of other incidents.

- It is a legal requirement that the overall rating from our last inspection is displayed. We saw the rating displayed within the home and on the provider's website.

- There were ineffective systems in place to monitor accidents and incidents. There were no oversight systems in place to analyse information, identify patterns and use lessons learnt to reduce the likelihood of re-occurrence.
- There were inadequate safeguarding systems in place. Two safeguarding incidents had not been reported to the relevant body and there were no auditing systems in place to identify trends and reduce risk. The provider's safeguarding policy was out of date and did not reference current legislation. This was quickly updated when we brought it to their attention.
- Peoples medicines were not always safely managed. We found failings in the provider's quality assurance systems around medicine management, medicine errors were not being picked up and addressed.
- Governance systems had failed to ensure risk assessments and care plans provided sufficient guidance to staff to ensure safe care.
- The provider's care plan audits focused on records being up to date rather than quality of records and whether they were sufficient to minimise risk. Care records were not easy to follow and information was duplicated with gaps in records. The manager told us that they were introducing an electronic recording system which they felt would address this.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- There was no effective system in place to ensure that people were involved in reviews of care plans, which meant the service was not consistently promoting person centred care.
- Regular surveys were carried out to gain people's views and the manager did a monthly walk around to speak to everyone. However, it wasn't always clear on how this feedback had been actioned.
- There were limited systems in place to ensure people were given information in a way they could

understand to enable them to communicate effectively.

There were insufficient and inadequate systems in place to monitor and improve the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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

- People had been involved in interviewing new staff.
- The provider had organised a residents and relatives meeting to discuss changes in the home and gain their views.
- The service had links with the community. A school performed a carol concert once a year and had come in to do a film show. Someone came in monthly to give Holy Communion.
- People and relatives told us they knew who the registered manager was and they were approachable. One person told us, "Wonderful manager, will do anything for you."
- Staff told us the manager was approachable and a good leader. They received regular supervisions and team meetings.

Continuous learning and improving care

- Whilst there was evidence that some issues had been identified for improvement and actions taken, the oversight of the service was not effective enough to ensure this was consistently applied.
- Although the provider had introduced a new quality assurance system to improve standards in areas such as medicine errors, falls and records, this had not been effective.

Working in partnership with others

- We saw that the provider worked in partnership with several different professionals to ensure that people's needs were met. For example, district nurses, advance nurse practitioners and speech and language therapists.

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 People were not protected from harm due to a failure to ensure the proper and safe management of medicines

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 People were not consistently protected from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in place to monitor the quality of the service. The provider did not have effective systems in place to assess and monitor risks relating to the health, safety and welfare of people using the service.