Brampton View Limited

Brampton View Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Brampton View Care Home is a residential care home providing personal and nursing care to up to 88 people. The service provides support to older and younger people with dementia or physical disabilities in four units within one adapted building. At the time of our inspection there were 75 people using the service.

People's experience of using this service and what we found
Risks to people had not been consistently managed to protect people from harm. Records did not always evidence support tasks had been completed. Risk assessments did not always contain relevant strategies to ensure staff understood how to mitigate the risk.

Observations during the inspection raised concerns regarding how people were safely supported to eat. Records of how much people drank in a 24 hour period were inconsistently completed and did not evidence that people were adequately hydrated.

Medicine administration records did not evidence people were supported to have their medicines as prescribed. Records were inconsistent and we observed medicines being given to people later than expected.

Systems and processes to ensure good oversight of the service were either not in place or ineffective. The provider had not identified the issues we found on inspection previously. Therefore, no mitigating strategies had been implemented to keep people safe.

The provider has failed to achieve to 'good rating' at the past five inspections. Concerns raised on previous inspections had not been mitigated and systems had not been embedded into practice.

During the inspection we found concerns with equipment in place to keep people safe. There were not always effective systems in place to identify these concerns.

Not all staff had the training required to meet people's healthcare needs. Information on health needs such as diabetes or epilepsy required improvement to ensure the information contained signs and symptoms that may require additional health support.

The provider used a dependency tool to identify the staffing levels required. However, we received mixed views from people, relatives and staff regarding whether staffing levels were adequate to meet people's individual needs. The provider used high levels of agency staff. People and relatives did not feel agency staff had the knowledge or skills to support them effectively and in a responsive way.

Staff felt supported within their roles and told us they received regular supervisions and meetings. Staff were recruited safely, and the provider followed safer recruitment decisions based on references and police

checks for all staff.

When people sustained an injury from an incident or accident, records included how the injury occurred, the size, shape and colour of injury and details of when the injury had healed. Investigations to establish the cause of an injury were in place.

The home appeared clean. Cleaning schedules evidenced regular cleaning took place.

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.

The manager worked with external professionals to meet people's healthcare needs. Relatives were kept updated with any changes in their loved one needs. The provider requested annual feedback from people, relatives and staff.

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 1 November 2022) and there was a breach of regulation. This service has been rated requires improvement for the last four consecutive inspections.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced inspection of this service on 6 September 2022. A breach of legal requirements was found. We undertook this focused inspection to check they had now met legal requirements. This report only covers our findings in relation to the Key Questions safe, effective, caring and Well-led.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

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

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.

Enforcement and Recommendation
We have identified breaches in relation to risk management, medicine administration, staff knowledge and skills and management oversight at this inspection.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
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?

Inadequate

The service was not 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Brampton View 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
The inspection was completed by 3 inspectors and 2 Experts 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.

Service and service type
Brampton View 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. Brampton View Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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 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 7 people who used the service and 13 relatives about their experience of the care provided. We spoke with 10 members of staff including, the manager, deputy manager, clinical development nurse, regional director, maintenance staff, nurses and care workers.

We reviewed a range of records. This included 9 people's care records and multiple medication records. We looked at 3 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.

Inadequate

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 changed to inadequate: This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

- People were at risk from skin pressure damage. Records did not evidence that staff had checked or changed dressings in a timely manner when people had pressure wounds. This put people at risk of deteriorating wounds and undetected infections. Support with repositioning was not always recorded. For example, records for one person who required support to reposition themselves every 2 hours to reduce the risk of pressure damage evidenced gaps of 8 hours or more.
- People were at risk from known health conditions. When people had specific health needs such as, epilepsy or diabetes, risk assessments were not always in place with details of the signs and symptoms to be aware of. Not all staff had received training on these specific health needs. This meant people were at risk as staff did not have the information or knowledge to understand the potential risks.
- People were at risk of harm. Staff did not always have the information or strategies recorded to support people when they experienced anxiety or distress. Incidents forms evidenced that people had been harmed by others during periods of distress. For example, one person who had regular periods of distress had no risk assessment or detailed strategies recorded to support staff in understanding how to mitigate the known risks to the person or others.
- People were at risk of choking or aspirating. During the inspection we observed people were not always supported appropriately to ensure they could eat their food safely. This put people at risk of harm.
- People were at risk of dehydration. When people needed staff to monitor their fluid intake, records did not evidence that staff had offered people regular fluids or taken action when people did not reach their fluid targets. For example, records for 3 people on multiple days evidenced insufficient fluids were offered and there were no recorded actions to mitigate the risk of dehydration or lack of fluids.
- Information recorded on accidents and incidents did not always include the information required to ensure analysis of the information was effective to learn lessons and monitor trends or patterns. For example, incidents of falls did not always include the time and location the person fell or if the fall was witnessed by staff or unwitnessed.
- Medicine management required improvement. People who required support with transdermal patches did not consistently have the placement of the patch recorded or the time the patch was administered or removed. A transdermal patch should not be applied to the same area to reduce the risk of skin damage. (A transdermal patch is placed on the skin to deliver regular doses of medication into the bloodstream through the skin.) This put people at risk of overdose.
- People were at risk of not receiving their medicines as prescribed. For example, we found not all medicines had been signed as administered by staff and when a person required a specific task, such as their blood pressure taken before a medicine could be safely given, records evidenced that this task was not always completed, and staff had not always followed the prescription guidelines.

The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● We received mixed views on staffing levels. People and relatives did not always feel there were enough staff to meet people's individual needs. However, staff told us they had sufficient staff on shift. One person told us, "No, there are not enough staff." A relative said, "There are not enough staff, that is a continual complaint for me." A staff member told us, "We have enough staff and if needed the managers get agency staff in to cover as soon as is possible."

● Not all people living at Brampton View Care Home felt well supported. People told us the issues they had were due to agency staff not always knowing their needs or responding quickly enough. One person told us, "I can hear in the middle of the night people shouting for help." Another person told us, "I had a lot of issues how agency staff were using my equipment." A relative told us, "The care is not brilliant. There is always a delay when people ask for help."

● The provider used a dependency tool to identify how many staff were required on each shift. The tool used identified sufficient staffing was in place. However, after the inspection the manager agreed to increase the nursing staff on one unit.

● Staff were recruited safely. The provider completed pre-employment checks such as references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● People were protected from potential abuse. Staff completed safeguarding training and understood how to recognise the signs of abuse and where to report them.

● Unexplained injuries were recorded and reviewed. The manager investigated unexplained injuries to identify any possible causes and to reduce the risk of reoccurrence in the future.

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 supporting people living at the service to minimise the spread of infection.

● 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 assured that the provider was responding effectively to risks and signs of infection.

● 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 can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● The provider followed government COVID-19 guidance on care home visiting. Visitors were given appropriate PPE.

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.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care

- Records of support offered to people were not always consistent. For example, records to evidence if a person had a bath, shower or cleaned their teeth were not always in place. Records for one person whose care plan stated staff should observe them every 30 minutes, evidenced this need was not being met as staff only recorded observations every hour.
- Staff did not always have the correct information to understand what support people required. For example, one person who was blind had no information recorded regarding how staff should engage them in activities or how written information should be explained. Another person had no information recorded regarding how staff should distract the person when they displayed anxiety or distress.
- People and relatives told us due to the level of agency staff used, staff did not always know people's individual needs. One person told us, "My biggest problem is dependency on agency staff, who are not trained by this company and do not have close knowledge of us residents." A relative told us, "They (Brampton View Care Home) get agency (staff) in, and they don't know the residents."
- Assessments were carried out in conjunction with the person themselves, their family where appropriate, and any professionals involved in the person's care and support.

Staff support: induction, training, skills and experience

- Not all staff received the training necessary to meet and understand people's individual needs. This is reported under the safe domain.
- Staff told us they felt supported within their roles. Staff completed an induction which included their training and shadow shifts before lone working.
- Staff received regular supervisions and annual appraisals. One staff member told us, "I have regular supervisions, and when needed various departments support each other wherever possible."

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

- People's rooms were personalised to their needs and wishes.
- The service provided equipment to support people's needs. Equipment included shower chairs, hoists and bespoke chairs to meet individual's needs.
- There were different areas within the service for people to use for their preferred activities, and private space to spend time with their families or visitors, or to have time alone.

Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat

and drink enough to maintain a balanced diet
● People received support from health care professionals as and when needed, such as GPs, speech and language therapists and occupational therapists. A relative told us, "People get support from health care professionals. [Person] choked, so a referral is being made to the SALT team. If I ever spotted anything they would get the doctor in." A person told us, "A district nurse comes in and I see the GP who comes in every week."
● Staff knew what action to take in an event of an incident or emergency.
● People were offered a choice for meals. People told us the food offered was nice. One person said, "Food is good, actually its very good, I have many choices and staff ask what I would like to eat."

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 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 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 , whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Mental capacity assessments had been completed appropriately and if a person lacked the capacity to make a certain decision a best interest meeting was held.
● Staff knew about people's individual capacity to make decisions and understood their responsibilities for supporting people to make their own decisions.
● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care; Ensuring people are well treated and supported; respecting equality and diversity

- Care plans did not always record if a person had a preferred gender of staff, or how staff should meet peoples identified religious or cultural needs
- We received mixed views on people being able to make choices and decisions that staff could meet. One person told us, "I do have a shower every night, this is my choice." However, a relative told us, "When I asked about [person] having a bath staff said they weren't able to as the bath was on the other side of the building."
- Most people and relatives were involved in the development and review of care plans. One person told us, "My daughter sorted out my care plan with staff." A relative told us, "They (staff) encouraged [person] to do it and be involved."

Respecting and promoting people's privacy, dignity and independence

- During the inspection we found people's personal information had been left out in a communal hallway. This information could have been accessed by anyone. The manager removed it during the inspection.
- Staff told us, and people confirmed, staff respected people's dignity and supported independence. One person told us, "Staff help me to undress, and I do my front and my face, but staff do rest (when washing). Staff also help me with dressing up." A relative told us, "Staff are respectful, they always knock on [person's] door." Staff confirmed they always ensured curtains and doors were closed when supporting a person, always knocked and requested permission before entering a person's room, and always made sure conversations about people were held in private.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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.

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; Continuous learning and improving care

At our last two inspection the provider had failed to ensure systems and processes were effective and robust enough to monitor the quality and safety of the service This was a breach of regulation 17(1) 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

- The provider has failed to achieve to 'good rating' at the past five inspections since 2019.
- Systems and processes were not in place to ensure people received safe, effective care. We found concerns with the management of skin pressure damage and fluid intake. These issues had not been identified or mitigating strategies implemented to reduce the risk to people. This put people at risk of dehydration and deteriorating wounds and undetected infections.
- At our last inspection we found systems and processes were not always effective in ensuring staff had completed the necessary training to meet people's individual needs. At this inspection we found staff still not all received the training required to support people safely. The provider had not implemented effective systems to review staff training.
- Systems and processes were ineffective in identifying and mitigating environmental or health and safety concerns. During the inspection we observed two mattresses that were not appropriate for the bedframes being used. This put people at risk of harm. The provider had not identified or put any actions into place to mitigate this risk prior to the inspection.
- Systems and processes were not in place to ensure records were accurate, complete and factual. We found concerns relating the recording of observation checks and food records. This put people at risk of neglect and harm.
- Medicine audits were ineffective. Audits were completed monthly on 20% of medicine administration record. Therefore, the concerns found on inspection with medicine administration had not been identified or risks mitigated. This put people at risk of not receiving medicines as prescribed.

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 continued breach of Regulation 17 (1) (good

Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager was engaged with the inspection process and remained open and transparent throughout. We received updated and reviewed records after the inspection.

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 manager was aware of their duty of candour responsibility and had systems in place to ensure compliance.

● Staff knew how to whistle-blow and knew how to raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns were not acted upon.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider had systems in place to take account of staff, relatives and people's opinions of the service. The provider requested feedback from people, relatives and staff annually through a survey.

● Staff and people were offered regular meetings to share information about the service and discuss any issues. However, due to the management turnover, not everyone felt their suggestions had been acted upon or that information was consistently shared. One person told us, "I have made a couple (of suggestions), but they haven't been acted on." One relative told us, "In 3 years I can't tell you how many managers they (Brampton View Care Home) have had. When you enquire why you don't get an answer."

● Relatives told us the staff kept them up to date on any changes, incidents or accidents relating to their loved one. One relative told us, "They (staff) are very good at telling us how [person] is, whether they have had a good or bad day." Another relative said, "They have always been spot on with letting me know anything."

Working in partnership with others

● The management team worked in partnership with other health and social care professionals.

● The manager was working with commissioners to implement improvements and to formulate an action plan.

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 The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks.

The enforcement action we took:

Notice of Proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 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.

The enforcement action we took:

Notice of Proposal