

Care UK Community Partnerships Ltd

Britten Court

Inspection report

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Date of inspection visit:
24 July 2023

Date of publication:
10 August 2023

Ratings

Overall rating for this service	Good ●
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Is the service safe?	Good ●
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Is the service well-led?	Good ●
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Summary of findings

Overall summary

About the service

Britten Court is a residential care home providing accommodation and personal care to up to 80 people. The service provides support to adults who may be living with dementia, mental health and/or a physical disability. At the time of our inspection there were 80 people using the service. The service was an adapted building with 4 suites accommodating 20 people in each, 2 providing nursing care and the other 2 providing residential and dementia care.

People's experience of using this service and what we found

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability.

There were systems in place to reduce the risks of abuse and avoidable harm. Where incidents happened, the management learned lessons and implemented actions to reduce them happening again. Staff were available when people needed support and staff were recruited safely. The service was clean and hygienic. People were supported to have visits from their family and friends.

People received their medicines when they needed them. Staff had been trained and their competency assessed to ensure medicines administration was undertaken safely.

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.

We received positive feedback from people using the service and relatives about the care provided, the management and staff. The registered manager understood their roles and responsibilities in managing the service and staff told us they felt the service was well-led. The registered manager had a good oversight of the service and the people who used it. Where we had identified improvements needed in the records, this was immediately addressed by the registered manager and their team.

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

Rating at last inspection

The last rating for this service was good (published 10 November 2017).

Why we inspected

The inspection was prompted in part due to concerns received about the care provided and a notification received from the service regarding moving and handling. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe and well-led only. We found no evidence during this inspection that people were at risk of harm from this concern. Please see the safe and well-led sections of this full report.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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.

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

Follow up

We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

<p>Is the service safe?</p> <p>The service was safe.</p> <p>Details are in our safe findings below.</p>	<p>Good ●</p>
<p>Is the service well-led?</p> <p>The service was well-led.</p> <p>Details are in our well-led findings below.</p>	<p>Good ●</p>

Britten Court

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 undertaken by 2 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.

Service and service type

Britten Court 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. Britten Court is a care home which provides nursing care in 2 of the suites. 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 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 8 people who used the service and 3 relatives. We reviewed the care plans and risk assessments for 7 people who used the service and multiple medicines records and records relating to food and fluid and support with repositioning. We observed the interactions between staff and people in the shared areas of the service.

We spoke with 8 staff members including the registered manager, deputy manager, team leaders, domestic, care and nursing staff.

We reviewed a range of records relating to the management and oversight of the service, including complaints, 3 staff recruitment files, training, and audits.

Following our inspection visit, we received electronic feedback from 8 staff members and 1 relative, we also spoke with a person's relative on the telephone.

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 good. The rating for this key question has remained good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Staff told us they received training in safeguarding and understood how to recognise and report abuse. There was information posted in the service for staff to refer to for guidance about reporting safeguarding.
- Where concerns of abuse had been identified, the service raised them with the local authority team, who were responsible to investigating abuse.
- People told us they felt safe in the service, which was confirmed by relatives.

Assessing risk, safety monitoring and management

- Care records included risk assessments which guided staff in how the risks related to people's daily living were reduced. These included risks associated with falls, choking and pressure ulcers.
- Records demonstrated people's weights were monitored and where there were risks identified, food charts were being maintained. A relative told us they were concerned about their family member's weight loss; however, we observed a staff member make a telephone call to the dietician to raise their concerns, which had already been identified by the staff.
- Environmental risk assessments guided staff in how risks were mitigated. Regular checks on equipment and the environment reduced risks. This included checks on the fire safety, legionella in the water system and mobility equipment.
- Meetings relating to care and health and safety, and daily head of department meetings, supported the management team to identify risks, such as pressure ulcers developing or weight loss, and address them to keep people safe.
- Staff told us they felt people were safe and they received training to support this. A staff member said, "The equipment is checked regularly to ensure safety of its use for residents and staff and training given beforehand on how to use the equipment safely." During our inspection visit we saw staff were attending fire safety training.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal

authorisations were in place to deprive a person of their liberty.

Staffing and recruitment

- There were systems in place to calculate the staffing numbers required to meet people's needs. We observed staff were available when people needed them and requests for assistance were responded to promptly.
- We received mixed views from people and relatives about the staffing numbers. However, all people told us their call bells were answered quickly, which was confirmed in our observations. We saw people in their bedrooms had their call bells to hand. A person said, "[Staff] come straight away... my bell is usually on my bed in case I need them in the night." Another person said, "They come quick. They bring me a cup of tea at 5:15am. My call bell is always close by my bed or chair."
- Staff told us there were enough staff to meet people's needs safely. A staff member said, "Across each department I feel that the staffing levels are regularly monitored to ensure that safe staff levels are achieved. In circumstances of last-minute sickness or changes that cannot be controlled, the management team makes best efforts to prevent any unsafe staffing levels."
- The registered manager told us staff recruitment was ongoing and new staff had recently been employed, for which they were awaiting satisfactory recruitment checks. Use of agency staff had recently reduced, however, where required, regular agency staff were used, who were familiar with the service and the needs of people supported. Records of agency staff profiles were maintained.
- Staff recruitment records showed the appropriate checks had been made before a staff member started working in the service, such as Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

- People received their medicines as prescribed, which was confirmed in records. Records demonstrated the safe administration of medicines to be given as required and medicines which were given covertly, for example hidden in food.
- People told us they received their medicines as required. A person said, "I get my tablets regularly." Another person listed their medicines and when they took them and commented, "No issues they've never run out or anything."
- We observed part of the medicines administration round, and a staff member showed us their electronic system as they were giving people their medicines. We noted this was done safely.
- Staff received training and their competency was checked. A staff member told us, "I'm confident that medications are administered as instructed and know if they are not the correct actions are taken."
- Audits and monitoring systems supported the management team to identify discrepancies and address them. A staff member told us medicine administration records were, "Checked daily for errors." Immediate action was taken by the registered manager when a person's records did not always identify where on the body medicines, in the form of patches, were placed to ensure they were effective.
- There were no risk assessments in place relating to the use of creams which were flammable. The registered manager took action to ensure these were in place. However, we were assured risks were reduced due to guidance being posted in the staff office and a staff member explained how risks were reduced when people used these creams.

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.
- People told us they were satisfied with the cleanliness of the service. A person said, "This place is spotless. They work very hard keeping it that way." Another person told us, "Very clean as you can see. The domestics come in here [bedroom] and do my bathroom every day."

Visiting in care homes

- People told us they had visits from friends and family, this was confirmed in our observations and feedback received from people's relatives.

Learning lessons when things go wrong

- There were systems in place to learn lessons when things went wrong. Lessons learned were shared with staff in, for example, meetings.
- Lessons learned included actions such as retraining staff and advising them of their roles and responsibilities.
- Records demonstrated accidents and incidents, including falls, were analysed, identified any trends and actions taken to reduce them happening again.

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. The rating for this key question has remained good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

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

- People's care records provided guidance for staff in how their individual needs were to be met to achieve good outcomes. Records of the care and support provided and any concerns to people's wellbeing were identified and acted on.
- Immediate action was taken by the registered manager relating to discrepancies in care records. For example, the registered manager consulted with a health professional and updated the person's care plan to ensure the effects of their mental health were fully documented.
- People told us they felt they received person centred care provided by caring staff. A person said, "I've loved it here from the beginning. The staff said to me, think of the home as your home and I have and do. When I arrived, the managers were in reception welcoming me. I loved it then and I love it now." A relative said, "There are a few care homes in this area, and I can say [family member] is in the best one. Everybody just goes overboard and treat everyone like they were their own relatives."
- People and relatives told us the service was well-led. A person told us, "[Registered manager] is the manager and there's a deputy manager. They are often around the home and stop to ask how I am." Another person commented, "[Registered manager] is very approachable. [They] will often stop to ask me if everything is okay." A relative listed the names of the management team and said, "They all keep in touch regularly, very well-led, not got a bad word to say about the place."
- Staff told us they felt the service was well-led. A staff member said, "[Registered manager] is amazing, approachable and [their] professionalism is to be commended. And now with [deputy manager], I believe we have the best management team we have ever seen, [deputy manager] is again approachable, professional, kind and understanding." Another said, "The management team we have now is the strongest the home has had, they work well as a team and in my opinion have the best interest of the residents and staff. The door is always open... The area manager is also regularly visiting the home and is very approachable."

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 duty of candour policy and procedure was understood by the registered manager.
- Records demonstrated the registered manager used duty of candour policies and procedures, to ensure an explanation and apology was provided when things had gone wrong.

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

regulatory requirements

- The registered manager understood their role and responsibilities in managing the service, this included sending information to CQC regarding notifiable incidents, as required.
- The registered manager was supported by a deputy manager. Both were very knowledgeable about the people using the service and were committed to providing a high-quality service.
- Staff understood their roles and responsibilities in providing good quality care to the people who used the service. A staff member said, "Britten Court is a lovely home to work in. We go above and beyond for the residents." Another said, "It's extremely hard work but I believe this is because we achieve a high standard of care with due care and attention paid to our resident's needs and ensuring we give person centred care at all times."
- Relatives listed the names of staff in the service, with a relative commenting how they were all approachable and provided assistance where needed. This included care staff, management, domestic staff and reception staff. This demonstrated an open caring culture where all staff put people first.

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

- People and their representatives, where appropriate, were asked for their feedback about the care provided and the care plans in the monthly resident of the day monitoring system. We observed a staff member call a person's relative to ask if they had any feedback or comments they wished to raise about their family member's care.
- Relatives said they were kept updated about their family member's wellbeing and any concerns were addressed. A relative said, "I have been contacted by the home and asked if I am happy with the care my relative receives and they do listen and make adjustments."
- Relatives were also supported to share their views about the service in satisfaction surveys and meetings. The registered manager told us they had a low turnout for relative meetings; however, they sent a newsletter to relatives to keep them updated.
- Minutes of 'resident' meetings attended by the people using the service demonstrated their views about the service were valued and listened to. People were kept updated on the actions taken as a result of their comments, for example, amendments to the menu.
- Staff told us they attended 1 – 1 supervision meetings and team meetings, which was confirmed in records. A staff member said, "Management hold drop in for staff for their own mental health and well-being and hold monthly supervisions on a 1 to 1 where you can talk about any concerns including personal ones and I feel I am listened to when I raise concerns." Another staff member said, "If I am unable to attend the staff meeting, I am issued with minutes so I can be aware of all discussion points."

Continuous learning and improving care

- Staff told us they received the training they needed to meet people's needs; this was confirmed in records. Staff training was kept under review and refresher training was provided to ensure staff were kept updated with any changes in the requirements of their role.
- A programme of audits and monitoring activities were undertaken by the management team and the provider, which supported them to identify any shortfalls and address them to continuously improve the service.
- Staff understood their responsibilities in reporting poor practice, known as whistleblowing. A staff member said, "We are encouraged to report any wrongdoing and unsafe practice."
- A recent resident and relative committee had been set up to oversee social events, be involved in the running of the service and make suggestions. The residents' shop run by the people using the service, had recently re-opened after the pandemic.
- The registered manager told us they held a dementia care forum for relatives, and they were planning to

start an end-of-life forum to be able to signpost and give information to relatives what to expect.

Working in partnership with others

- The registered manager told us they had good relationships and worked in partnership with other professionals involved in people's care.
- People told us they had access to health professionals when needed and records included guidance and support received to ensure people received the care they required.
- The registered manager told us how they had links in the community where people lived. This included a recent open day and activities with a local nursery school. A person told us, "I really enjoy it when the children come in. We do craft things and play, it's so lovely." Another person said, "We had an open day fete recently and everyone was busy making hats and sorting everything out. The gardens looked wonderful. It was a super day. I think everyone enjoyed themselves."