Pearlcare (Lincoln) Limited

Brantley Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Brantley Manor is a residential care home providing accommodation for persons who require nursing or personal care to up to up to 33 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 26 people using the service. Brantley Manor provides accommodation in a single house across two floors.

People's experience of using this service and what we found
The provider had quality assurance processes in place. However, there were shortfalls in medicines management, meaning systems and processes were not robust enough to identify issues in timely way.

We have made a recommendation about leadership and management oversight and accessible ways to feedback on quality and care delivery.

There was not always enough staff to meet the needs of people during the night. Staff had sufficient training to meet people's needs. Safe recruitment systems were in place to ensure staff were suitable to work with people.

Infection control measures were in place and a housekeeping team completed daily cleaning tasks. However, due to poor environmental safety some areas of the home required repairs and refurbishment. This meant whilst cleaning was completed, the effectiveness of cleaning could not be maintained.

Care plans detailed how to support the person to ensure their assessed needs could be met. We found some care plans required further work to ensure they contained person centred information in regards of people's medical conditions.

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.

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 20 April 2020)

Why we inspected
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 received concerns in relation to leadership and management of the service and staffing. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe 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.

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

Enforcement and Recommendations
We have identified a breach in relation to medicines management and risks associated with environmental safety at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from 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 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.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Brantley Manor 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 carried out 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
Brantley Manor 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. Brantley Manor is a care home without 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 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 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
During the inspection we spoke with 4 people who lived at the service, 8 care staff, the cook, the registered manager and the deputy manager. We looked at 3 people's care records in detail and records that related to how the service was managed including staffing, training, medicines and quality assurance. We spoke with 9 relatives of people living at the home. We also spoke with 1 visiting health professional.

Requires Improvement

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. The rating for this key question has remained the same. This meant 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.

Assessing risk, safety monitoring and management; Staffing and recruitment; Preventing and controlling infection; Using medicines safely

- Medicines were not always safely managed. We found instances where people had not received their prescribed medicines, on 3 occasions in April 2023, people's medicine records showed gaps in administrations, prescribed medicine treated as 'as and when', also some medicines were signed for but not given. This posed a risk to people's health and wellbeing.
- On the day of the inspection no documents were found with a record of the temperature for the medicines room. We queried this with the registered manager who stated they would produce this record. We were informed by the registered manager this record could not be found and they were not sure who was responsible for monitoring the temperatures. This meant the provider could not be assured temperatures were being checked daily and medicines stored in accordance with manufacturers guidance.
- Risks to people were managed effectively. However, more work was required to ensure people's records reflected their individual needs. For example, whilst we found risk assessments for people's medical conditions i.e. diabetes and epilepsy, these were generic and not personalised to the person. This meant if the person became unwell this may not always be identified by staff and acted upon appropriately.
- We identified staffing levels at night were not always adequate. For example, on 11 occasions in March 2023, staffing was below the services assessed numbers to safely meet people's needs. Records showed a risk assessment was in place for when the providers staffing levels were not maintained during the night, however, this did not give staff adequate information of contact numbers and what to do in an emergency. The document also had details of a senior person to contact who no longer worked for the provider. This meant people were at risk due to there not being enough staff to meet their needs and staff not having the information required in an emergency.
- Several areas of the environment were damaged which posed a risk of infection and compromised the effectiveness of cleaning. The upstairs bathroom and toilet were in need of refurbishment. We found damaged floors and walls with open cracks and damaged wooden areas. This bathroom was frequently used by service users. This posed a risk of harm due to poor environmental safety and impacted on effectiveness of cleaning.

The provider failed to ensure medicines management and environmental risks to people were identified, assessed and managed appropriately. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we discussed the concerns with the provider who took action to ensure environmental repairs were carried out. Additional staff had been employed and commencing work during

the night. Medicines temperature documents were located, however, gaps in recordings remained for the period of time the documents were missing.

● Records showed there were safe recruitment processes in place that ensured people were supported by suitable staff. A number of background checks had been completed. These included checks with the Disclosure and Barring Service to show that the staff concerned did not have criminal convictions. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● The provider had systems in place to ensure staff had the appropriate skills and knowledge to fulfil their role.
● Staff had received training, and competency checks to administer medicines. There were effective systems in place to manage risks associated with administration of medicines. People who required 'as needed' medicines, had detailed protocols in place with guidance for staff to administer safely when required.
● 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's infection prevention and control policy was up to date.

Visiting in care homes
● The service facilitated visiting in line with national guidelines.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People were protected from abuse. Systems and processes were in place and effective. However, some staff told us they didn't always feel comfortable raising issues to the registered manager, as they felt they were not always approachable, this was discussed with the provider and additional avenues were put in place for staff to effectively raise concerns.
● Records showed the registered manager understood their responsibilities to record and report any incidents of a safeguarding nature. The registered manager had informed the appropriate professional bodies when an incident occurred and took appropriate action. Additionally records showed accidents and incidents were reviewed to identify any themes and trends. Systems were in place to ensure lessons could be learnt following an incident and we found evidence action was then taken by the provider to reduce the risk of reoccurrence.
● Staff demonstrated their knowledge of when they would report an incident of a safeguarding nature. For example, one staff member told us, "I would report any safeguarding issues to the team leader or next in charge. If necessary, would report to area manager and would go to the local authority safeguarding team if needed."

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. Any conditions related to DoLS authorisations were being met.

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- We found the culture in the home was not always positive. Staff told us they felt they could not raise concerns due to issues with the registered manager not maintaining confidentiality and felt the manager had not acknowledged concerns raised. This posed a risk to people if concerns were not being raised or managed appropriately.
- We spoke to more staff and received some negative feedback regarding the manager. They told us they felt unsupported. One staff member told us, "[Name of registered manager] is not approachable, they are unprofessional….I have raised complaints, but nothing gets done, it's not taken seriously." More positively another staff member told us, "The manager is nice, fair. I can talk to her if I had a concern."
- When we spoke to relatives, we received mixed feedback, one relative told us, "[registered manager] can be slightly curt." Another relative we spoke to told us, "[Registered manager] has been very helpful and supportive."
- The provider had quality assurance systems to monitor quality of the service. There were a range of audits in place to monitor the quality of the service people received. Whilst we saw actions had been completed to address any outstanding issues, they had not always identified all issues as detailed in safe. Further work was required to ensure the audits were robust.
- The maintenance and environment of the home required improvement. A plan of works was in place but did not have set time frames for completions of all works required. Furthermore, regular maintenance was not always completed due to awaiting employment of a suitable person. This meant environmental safety could not always be achieved.
- We discussed the areas of concerns within care delivery, governance and leadership with the provider. The provider responded to the concerns identified with an action plan, which gave us assurance the provider was committed to driving improvement in leadership and care delivery in the service.

We recommend the provider improves, embeds and sustains systems and processes for staff and people to raise concerns and feedback on quality and care delivery also maintaining oversight of management and leadership within the service.

Following the inspection, the provider supported staff and relatives to have open discussions. For example, senior management spent additional time in the home to speak with staff and relatives, giving opportunities to speak freely about any concerns. Staff were given information of who they can contact to raise concerns.

Additionally, the provider completed repairs to ensure environmental safety in toilets and bathrooms. A maintenance person had been employed by the provider to support regular maintenance of the service.

● Systems were in place to gain staff and people's feedback. However, as detailed above further work was required to improve systems. We did find evidence of positive impact from feedback and the provider used the information to drive improvement. For example, preferences for female carers were not being met for one person, this was then acted upon, and the persons care plan updated with their preferences.

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; Continuous learning and improving care

● Systems were in place to monitor the quality of the service. Effective analysis of incidents was in place. For example, falls analysis clearly detailed the incident, any themes or trends, action taken and what measures were put in place to effectively mitigate further risk.

● Additionally, staff understood their responsibility to identify incidents and report and record these correctly. The provider had developed robust systems to inform staff of the correct procedures to document incidents. This meant actions were in place to prevent reoccurrence which reduced the risk of harm to people.

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

● Records showed staff meetings had taken place regularly. This was an opportunity for staff to raise any concerns or discuss the service. However, we received mixed feedback from staff regarding the outcomes of staff meetings. One staff member told us, "It is an opportunity to make suggestions, but nothing gets done about it." More positively another staff member told us, "They [staff meetings] are every few months, these are good, and you can express your concerns and changes are made."

● We observed partnership working to support people's health and wellbeing with external support coming into the service daily. A healthcare professional visiting the service told us, "We have a good relationship with the home, issues get dealt with and they [staff] seek advice in a timely way."

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 The provider failed to ensure medicines management and environmental risks to people were identified, assessed and managed appropriately.