B.L.I.S.S. Residential Care Ltd

The Brambles

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
The Brambles is a residential care home providing personal care to up to six people with a learning disability and/or autism spectrum disorder. At the time of the inspection there were four people living in the home.

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

People using the service were not always safe as the service had not fully assessed and put in place measures to reduce risks to their health, safety and wellbeing. This included management of their risks from Covid-19.

There had been improvements in the management of medicines. The service had responded to medicines errors and had sought an alternative administration method to reduce the risk of errors.

There had been some improvements in the reporting of incidents, however further improvements were required to ensure any learning could be identified. Staff had a good understanding of what needed to be reported internally as an incident and about types of abuse that needed reporting.

We identified records were not always up to date, complete or accurate and systems to review the quality of the service did not always identify issues for improvement.

The management team were aware of the culture in the home and were working to promote a more proactive approach within the staff team which promoted people's independence. Staff told us they felt supported by the team and worked well together. Most staff felt confident to raise concerns, however one staff member told us they did not feel information was kept confidentially.

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 guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Right support:
• Model of care and setting maximises people's choice, control and independence

Right care:
• Care is person-centred and promotes people's dignity, privacy and human rights

Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. The environment was suitable for people to live a life like any other citizen. The service is small and located in a residential area with access to local facilities.

Staff understood how to promote independence. Records could be improved to ensure this was consistent. We could not be assured that risks were considered in line with best interest and least restrictive practices. Some aspects of care planning were not person-centred and it was not clear how people's skills were being built upon to further improve their choice, control and independence.

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 19 November 2019).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found that some improvements had been made, however the provider had not made sufficient improvement and so was still in breach of regulations.

Why we inspected
This inspection was carried out to follow up on actions we told the provider to take at the last inspection.

We previously carried out an unannounced comprehensive inspection of this service on 29 August and 04 September 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions of Safe and Well-led which reflect those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained requires improvement. 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 The Brambles on our website at www.cqc.org.uk.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified continued breaches in relation to safe care and treatment and good governance 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 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

The Brambles

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
This inspection was carried out by an inspection manager, two inspectors and an assistant inspector.

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

The service did not have a manager registered with the Care Quality Commission at the time of the inspection. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. There was a manager supporting the service who had applied for registration. They will be referred to as "the manager" in this report.

Notice of inspection
This inspection was unannounced. We contacted the service prior to entry to ensure there was no-one isolating with confirmed of suspected Covid-19 and to ensure the inspectors complied with the service's policy on the use of personal protective equipment.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, commissioners and other professionals who work with the service. The provider sent us information as part of quality monitoring by the local authority and commissioning group to evidence progress on actions from the previous inspection. We used all of this information to plan our inspection.

During the inspection
We spoke with two people's relatives, seven staff including one team leader, the manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We received feedback from the local authority and clinical commissioning group involved with the service. We also observed interaction between staff and people.

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

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

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 the last inspection this key question was rated as requires improvement. At this inspection 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.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people and manage infection control risks. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Preventing and controlling infection

- At the last inspection it was identified that there were not sufficient procedures and practices in place related to infection control to keep people safe. There was no Legionella risk assessment or policy, and no checks of the water system were carried out to manage and reduce the risk of Legionella. At this inspection an appropriate Legionella risk assessment was now in place, however, required checks and flushes were not always carried out in line with the procedure.
- The provider had appropriate policies and procedures in place to manage the risks of infection in the home and from Covid-19, however, these were not followed in practice and there was no risk assessment or procedure for the measures that were in place in the home.
- We observed and staff told us, they were not wearing masks within the home, except for personal care with one person. This was not in line with the policy or national guidance.
- The service had not assessed specific risks to people from Covid-19, or their understanding of the risks and ability to follow precautions, such as not touching their face or putting objects in their mouth. There was no evidence of how measures in place balanced risks to people and were in their best interests.
- There was no evidence the provider had explored alternatives, such as visors or clear masks, where they felt wearing regular face masks would impact staff's communication with people or increase their anxiety. There was no evidence the provider had attempted to desensitise people to staff wearing masks in line with national guidance for services supporting people with a learning disability.
- As part of the provider's Covid-19 risk management arrangements, visitors, staff and people's temperatures were tested using an infrared thermometer. The thermometer used was not working correctly when inspectors arrived on site. Temperatures indicated were too low to be considered 'normal range'. There was no procedure in place to calibrate the thermometer and so people, staff and visitors could have a high temperature without this being recognised and acted upon. This was highlighted to the manager who agreed to take action.
- There were not always hand washing products available where they were needed during the inspection. This was highlighted to the manager and nominated individual who took immediate action.
- Following the inspection, the provider sent completed individual risk assessments for managing the risks

to people from Covid-19. However, these did not follow national guidance or evidence that deviation from national guidance was proportionate and in people's best interest.
● At the time of the inspection, staff and people were not being routinely tested for covid-19. This was highlighted to the manager and nominated individual who agreed to discuss testing with the local commissioning group to seek guidance and advice. The provider has advised that staff are now being routinely tested.

We found no evidence people had been harmed, however, systems were either not in place or robust enough to demonstrate infection control was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Assessing risk, safety monitoring and management

Assessing risk, safety monitoring and management
● We could not be assured risks to people's health, safety and wellbeing had been fully assessed and that there were clear management plans in place to reduce and manage these risks.
● Records were being updated at the time of the inspection. We reviewed documentation held in people's care plan folders, as well as documents sent electronically which were to replace people's existing care plans and risk assessments by bringing them together in one format.
● People's support plans did not reflect all identified risks for the person. For example, there was a lack of written instruction for staff about how to manage the risks to one person in the community. Another person's record did not highlight their risks of previous possible seizures or mini-strokes. Their risk assessments and care plans had not been updated following weight loss. Care plans identified a restricted diet which did not reflect the person's increased risk of malnutrition and continued to refer to goals of weight loss, though they were now within a healthy weight range.
● One person's folders containing their support plan documentation, which was in the office, had out of date information around management of their seizures. This increased the risk of delay should emergency medical assistance be needed. Reference to professional guidance was not always clear or available to staff, such as guidance from a speech and language therapist on someone's dietary needs to reduce their risk of choking.
● Permanent staff we spoke with knew of risks to people's safety. The service utilised agency staff who worked one-to-one with people. When using agency staff it is important they have access to clear, accurate information on people's needs and risks in order to support them safely.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate health, safety and welfare of people was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At our last inspection we identified people were not always supported in the least restrictive way. This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection there was evidence of some improvement and actions the provider told us they would take had been completed. The service was no longer in breach of this regulation, however there were further improvements required to reflect the characteristics of good.

● There was an appropriate policy and procedure in place which identified how the provider reduced the risk of abuse or neglect to people, and how any issues would be reported. Most staff we spoke with had a good understanding of safeguarding.
● There had previously been concerns about reporting of issues to the relevant organisations which had been highlighted by the commissioners of people's care. This was improving with continued training and support of staff.
● Stakeholders continued to raise concerns that investigations were not always approached in an open and objective way. In one example; a concern had been raised by a stakeholder, the provider responded by email refuting the concern. In another example, we saw an investigation where the staff member subject of the allegations had not been included in the investigation.
● There was evidence that disciplinary action had been initiated when evidence concluded there had been staff misconduct.

Staffing and recruitment
● Staff told us there were enough staff to keep people safe. One member of staff told us that there wasn't always enough staff to take people out, if they need two-to-one support, but that staffing had been better since one person had moved out.
● It was difficult to ascertain if the staff mix was appropriate to meet people's needs based on their knowledge and training as the training matrix did not include all staff names and the staffing rota was not clear. This was highlighted to the provider who agreed to ensure records were accurate and complete.
● Staff we spoke with knew people well and understood what the main risks to their safety were, such as their risk of choking or running from staff, their interests and how to communicate with them.
● We identified a required staff pre-employment check, the Disclosure and Barring Service (DBS) check, was not completed prior to all staff beginning work. DBS checks help employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We were assured this was a historic practice and the nominated individual told us this had been rectified going forward. Other aspects of recruitment reflected required pre-employment checks.

Using medicines safely
● Medicines were stored appropriately, there were protocols in place for people's 'as needed' medication which identified how people communicated any symptoms, such as pain.
● Support plans reflected how people took their medication, though some sections had not been updated when medications had been changed. Staff understood that no-one had their medicines covertly (without being told they were taking medication).
● Stocks were monitored appropriately. Staff competencies were being re-visited and the service was changing to a different administration method to reduce errors.

Learning lessons when things go wrong
● Staff understood when to report incidents internally using incident forms. Detail contained within these forms had been an area of focus for improvement. The local authority fed back there had been some improvement in reporting incidents and encouraged the service to continue to work to improve in this area.
● Recent incident reports we reviewed contained some information related to incidents of behaviour which may challenge. However, information was not detailed enough in all cases to identify triggers, approaches tried by staff and whether they were successful for incidents which occurred. This meant it was not always possible to learn and adapt behaviour support for people to reduce distress to them.
● Incident reports did not always reflect effective management following positive behaviour support plans. One note by a member of staff stated, "I just stood there and took the hits and blows" which did not reflect plans in place to protecting people and staff.

● There was evidence that there was communication of learning from events, such as one person being allowed to take bins out whenever they like, and this being reflected in the care plan.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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.

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

At our last inspection the provider had failed ensure systems were in place to appropriately manage risks to health, safety and wellbeing. The provider had failed to maintain accurate and complete records. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Records were not always consistent, accurate or up to date, for example people's care plans differed between different versions with no explanation. For example, one person's care plan folder contained out of date information related to the management of their epilepsy which had changed in July 2020. An up to date document was seen but was not placed in their folder.
● Changes in people's needs were not always reflected and risk assessments and care plans did not always contain detailed enough information to ensure people's needs were met. For example, one person had lost weight and was no longer "obese". Their care plan had not been updated to reflect their risk of malnutrition due to sudden weight loss, their new goal to maintain their healthy weight and to ensure restrictions on 'less healthy' options were least restrictive based on this new goal.

● Descriptions of risk management were not always clear for staff, which put people at risk if this was not followed appropriately. For example, one person was at risk of choking, their support plan contained three differing descriptions of foods they could have. In another example, a person's risk and signs of possible seizures or mini-stroke had not been reflected in the support plan for staff to monitor, as per the healthcare professional guidance.
● The provider ensured audits were carried out. The audits used were detailed and covered a range of areas for review. There were some useful points identified as areas for improvement, however not all areas identified in this inspection had been identified on the audit. Not all areas for improvement identified on the audit had been carried through to the action plan and the action plan had not been updated with progress.
● For example, one audit included a question related to whether the person's end of life wishes were reflected in their record, this was marked "yes" related to one person's record. When we reviewed

information related to this person there was no end of life wishes or advanced care plan included in their record. For the same record the audit stated the person's support plan represented their needs, however during this inspection we identified all of their needs were not reflected in their support plan.
● Not all parts of all audits were completed. Some relevant parts were labelled 'not applicable' or were blank. For example, questions related to whether the manager and deputy were 'visible and approachable', whether residents at risk of falling had appropriate measures in place reflected in their support plans and elements related to people with dementia were labelled 'not applicable'. Parts of the most recent infection control audit were labelled 'not applicable', such as the laundry and kitchen cleaning rotas being completed daily.

Failure to ensure systems and processes ensure risks to people are assessed, monitored and managed appropriately and failure to maintain accurate and complete records is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

At our last inspection the provider had failed ensure people were treated with respect and dignity. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 10.

● There was an understanding within the management team of the culture within the service and how this had not been positive. We saw some positive interactions between staff people. The commissioners fed back, "During visits the staff team were welcoming and more recently the engagement with the individuals living there was positive."
● We observed staff encouraging people to do things for themselves and talking with them in a respectful way. Staff we spoke with used respectful language and were kind towards the people they spoke of.
● The focus on people's independence and freedoms had improved and was an area for continued improvement. Care plans needed more information on how staff could encourage and support people to be more independent. One person's family member had concerns that their loved one was losing skills as they felt not all staff were proactive in supporting and practicing communication, or able to recognise signs, such as needing the toilet to promote their independence.
● There was largely positive feedback from staff about the staff team and team working. Some staff were very positive about the support they received from other staff and how they supported people to be independent. One staff member told us that some staff, particularly agency staff, could be "lazy" and tend to do things for people, rather than encourage them to do things for themselves as it would take more time.
● Most staff told us they felt supported and able to raise concerns, however one staff said they did not feel information was kept confidential and so did not always feel comfortable raising concerns with the management team.
● We observed that one file contained the name of a whistle-blower and identified them as such. Although this file had limited access, this was not protecting the person's identity in line with the Public Interest Disclosure Act 1998. This was removed once highlighted to the nominated individual.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider understood their duty to be open and honest with families when things went wrong. We spoke with two people's families. Both fed back that they were informed when something went wrong, though one person's family said for one incident there was a delay in informing them.

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

● Staff told us they could make suggestions and felt listened to. The nominated individual told us they were encouraging staff to professionally challenge one another to promote high quality care.

● One person's family told us they felt the communication was good and they were involved in planning care for their loved one. They told us, "They always ask if I'm happy, or if there is anything we need. Staff know him better than I do."

● Another person's family was less positive and did not feel as involved in planning their loved one's care as they would like. They told us, "I don't know the new manager, the only way I find out [about loved one] is if I speak to [staff member], they will tell me what's going on, but only if I ask." The manager and nominated individual told us they were looking at doing regular updates for families about their loved one to improve this.

● There was limited evidence of connections with the local community in people's records. Most people's social network identified only family and others within the service. We identified areas this could be improved (acknowledging the challenges posed by Covid-19), such as identifying which local amenities people frequented in their care plans and working with those local amenities to ensure people had positive experiences.

● There was a good example related to the local pub where the service had developed a good relationship to support people to have a good experience when going there.

Continuous learning and improving care

● The service had an ongoing action plan for completion developed from the previous inspection and with feedback from other agencies. The service was subject to monitoring meetings with the Local Authority and Clinical Commissioning Group to review progress and support improvements. The service had engaged with this process.

● There had been considerable changes in the staff and management team which had impacted progress. Though some actions had been completed, not all had been completed in line with anticipated timeframes. Actions to reduce risks to people's safety had not been clearly prioritised based on feedback from the previous inspection and from other professionals involved in the service. Though some actions had been completed, these were not always the highest priority based on risk to people.

● There was evidence that some aspects of care and documentation had been improved. For example, negative language was being identified and addressed with staff. The nominated individual told us they were focussing on performance management and were using their disciplinary procedure where needed.

● There were some aspects of care and record keeping which required continued focus by the provider to ensure there was continued and sustained improvement. For example, ensuring care plans were up to date and reflected people's needs and supporting staff learn Makaton and more fluent communication skills with people to promote people to fully use and learn further communication skills.

Working in partnership with others

● We obtained feedback from other agencies who had worked with the service. The Local Authority, the Clinical Commissioning Group and a healthcare professional that fed back, all felt there was still support needed to implement improvements.

● Professionals told us they felt that the service needed feedback regularly on support plans and incidents in order to identify areas which required improvement, and feedback was not always followed the first time.

Feedback collated by two professionals to us stated, "It is evident when updated documents are received following feedback that the feedback given has not been taken on board and there remains concerns with documentation being inadequate to support individuals safely."

● There was concern investigations were not always completed in an objective way in line with timeframes and local procedures. Feedback was that the response to concerns raised could be defensive. One professional told us, "The evidence required to support the [investigation] can be difficult to obtain and information lost and not shared. There have been occasion where communication is conflicting, and questions left unanswered."

● Other stakeholders had identified professional guidance and information was not always reflected in support plans. For example, speech and language therapy guidance on communication was not fully reflected in support plans. Another person had an orthotic device which was not mentioned in their support plans.

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 Infection Control procedures were not robust to manage the risk of covid-19 to people. Risks to people's health, safety and wellbeing were not always assessed with appropriate risk management plans in place.

The enforcement action we took:

We issued a warning notice to the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not always up to date and accurate. Systems were not robust to manage the risks to people's health, safety and wellbeing. Systems did not always ensure quality issues were identified and addressed.

The enforcement action we took:

We issued a warning notice to the provider