Brampton View Limited

Brampton View 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 effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This was an unannounced inspection which was conducted on the 3 November 2014.

Brampton View Care Home provides nursing and personal care for up to 88 people for people with physical disability, dementia and care for adults over 65 yrs. At the time of our inspection there were 86 people living at the home.

There was a registered manager in post at the time of our inspection, however they resigned shortly afterwards and an interim manager was appointed. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were not always enough staff on duty to ensure people received the individual support that they required in maintaining their safety, independence, mobility and appropriate assistance with eating their meals.

Summary of findings

The provider had a robust recruitment system in place which included appropriate checks on their suitability to work in the home and new staff received a thorough induction training to ensure they had the skills to fulfil their roles and responsibilities.

The provider had appropriate systems in place to ensure people received their medicines as and when they required them.

There was a lack of formal systems in place to assess people's capacity for decision making under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

People did not always experience care and support to maintain personal routines because staffing levels were unstable. The support they received was chaotic and did not always maintain their dignity. The people who used the service lacked confidence in the management of the home because they viewed the staffing arrangements as chaotic.

Because staff did not have time people spent significant periods of time with little interaction or stimulation from the staff. No organised activities were taking place on either of the dementia units because the activities staff were working as carers because of staff shortages.

There were systems in place to assess the quality of service provided; however it was not always clear what action the management had taken to address people's concerns, particularly in relation to the staffing levels and the management had not formally assessed the number of staff required to meet peoples' needs.

Records were not always fully completed therefore management could not assure themselves that people received the care and support that had been specified.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

People were not always protected from avoidable harm.

Although people were assessed for the risks of injury staff were not always able to provide the support that was required to ensure their safety.

There were insufficient staffing levels to ensure that people were safe and that their needs were met.

There were systems in place to administer people's medicines in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not always receive care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities.

When people lacked capacity to consent to care staff did not always

follow the required legislation and guidance.

People were supported to eat and drink enough and to maintain a balanced diet, although records did not always demonstrate people's nutritional intake.

People were supported to maintain good health and had access to health care services and received on-going healthcare support.

Is the service caring?

Requires Improvement

The service was not always caring.

Although staff did not always have enough time to meet peoples' physical and emotional needs, they demonstrated good interpersonal skills when interacting with people.

People were supported to make decisions about their lives however staff were not always able to accommodate their wishes.

Although staff tried hard to meet peoples' needs peoples' dignity was not always maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staffing levels impacted on the staffs' ability to respond to peoples' individual and collective needs.

Staff were aware of their roles and responsibilities in responding to concerns and complaints.

Summary of findings

Is the service well-led?

The service was not always well-led.

The instability of the staffing levels at the home impacted on the ability of the management to deliver care of an acceptable quality.

People's comments and views had not been taken into account regarding the staffing levels in the home.

Although quality assurance processes were in place it was not always clear what action had been taken to respond to the findings and continually improve the service.

Records about peoples' care, treatment and support were not always updated and accurate records were not always maintained.

Arrangements were in place to ensure that staff were adequately supported in relation to their responsibilities, to enable them to deliver care and support to people to an appropriate standard.

Requires Improvement

Brampton View care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 3 November 2014 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience (ExE). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we looked at information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law. We contacted the health and social care commissioners who help place and monitor the care of people living in the home and other authorities who may have information about the quality of the service. This included Healthwatch Northampton which works to help local people get the best out of their local health and social care services and Total Voice Northamptonshire, an advocacy service which supports people who use adult mental health services.

During our inspection we used the 'Short Observational Framework Inspection' (SOFI); SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with seven people who used the service, three relatives and 11 staff, including registered nurses and care staff. We also looked at four peoples' records, three staff recruitment records and we observed the way that care was provided; one member of the inspection team ate lunch with people who used the service in order to share the meal time experience.

Following the inspection we asked the provider to send us a range of information including staff duty rotas, staff training records, the results of satisfactions surveys and audits, minutes of meetings with people who used the service and minutes of the staff meetings. The provider sent these to us and also sent us an action plan detailing the improvements that they intended to make as a result of our inspection findings.

Requires Improvement

Is the service safe?

Our findings

All the people we spoke with expressed concerns that there were not enough staff to meet people's needs. One person said "I worry that the staff will forget to get me up in the morning."

Staff told us that there were not enough staff and expressed concern that they were unable to meet people's needs. They said that they tried hard to assist everyone with their personal care before breakfast but staffing levels meant that this was not possible. One member of staff said "I love care work but most nights I could go home and cry. I feel a failure I am not able to do what is needed."

During our inspection we found that some people were waiting in bed for long periods without any personal care assistance. At 10.45am, there were two people still waiting for assistance with their personal care, this was because staff were not available to help them. At 11.30am staff found they had omitted to assist another person to get up and they had been left in bed without having any breakfast.

On both dementia units we saw that there were insufficient staff to assist people with personal care in their bedrooms whilst ensuring that people in communal areas were adequately supervised. Some people required at least two members of staff to assist them, this left only one member of staff that worked across both units to supervise and support people in the communal areas. For example there were no staff in the communal areas on two occasions when people became distressed and unsettled. We saw that three people had facial bruising; staff were unable to explain what had happened and felt that this may be due to unwitnessed falls or injury.

We spoke with three visitors who told us that they had concerns about the staffing levels; one person said "It takes a while for the staff to respond to the call bell in the afternoon and there is a lack of activities provided." Staff told us that there were occasions when they were moved from their normal roles and responsibilities to help cover other areas in the home. For example staff told us that the activity co-ordinators were regularly asked to cover for care staff and people did not get the activities that were planned. We were also told of two occasions where care staff had to help out in the kitchen because of staff shortages.

We observed lunch on the dementia unit and found that staffing levels impacted on the support people received to eat their meals. Staff had resorted to multi-tasking in an attempt to meet all of needs of the people that they were caring for. For example one staff sat between two people encouraging one person to eat on the left whilst supporting and encouraging another person on their right. Staff also moved between tasks such as clearing plates and pouring drinks whilst supporting people and prompting others. This created a chaotic atmosphere which was not conducive to a pleasant and supportive dining experience. One member of staff said "It can be very hectic. We try to assist everyone who needs help eating but it is difficult with the staff available."

The registered manager told us there was a formal system in place to assess the staffing levels required however there was no evidence to demonstrate that this had been used. We raised our concerns with the provider who took action to strengthen the management of the home and provide additional staffing.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All of the people we spoke with told us they felt safe. One person said "I feel safe and if I didn't I would talk to my relative." The visitors and staff we spoke with also told us they thought the home was a safe place to be.

There was a policy in place to guide staff in the action to take should they suspect abuse; this included information about when and how to involve the local authority safeguarding team. However during our inspection we found three occasions where people had sustained unexplained injuries and where these had not been reported to the relevant authorities. Staff told us that the registered manager normally notified the relevant authorities; however when the manager was not on duty staff were not sure who fulfilled this role. We raised our concerns with the provider and they took immediate action to ensure staff understood how to respond when the manager was not on duty.

Peoples' individual plans of care contained a range of robust risk assessments including movement and handling, risk of falls and the use of bedrails. The plans specified the support that people needed to help keep them safe. Staff had a good understanding of how to safely

Requires Improvement

Is the service safe?

care for individual people. For example we observed staff offer reassurance whilst assisting people to move from chairs to wheelchairs with the use of appropriate moving and handling aids and techniques. However we also saw that some people had unexplained injuries which staff felt were as a result of unwitnessed falls or other injuries. We saw one person with a known risk of falls walking independently with a mobility aid; their risk assessment stated 'Requires staff assistance when mobile to prevent falls'. However this person walked some distance before staff were available to provide adequate support. Accident records showed there had been at total of 24 incidents or accidents, including five unwitnessed falls that occurred during October 2014. The provider's policy on accidents requires staff to make two hourly checks for 24 hours after an accident or an incident however the registered manager was unable to provide us with evidence that the checks had been carried out for six of the 24 accidents and incidents. We discussed our concerns with the provider who took immediate action to improve the internal processes.

Staff recruitment systems were robust, staff told us that they attended interviews and had the right checks conducted before being allowed to start work in the home. The registered manager also described a thorough recruitment process and this was evident from the three staff files that we reviewed.

People could be assured that there were safe systems in place for the storage and administration of medicines. We found that medicines were stored appropriately; records were well maintained and regular audits were undertaken. Appropriate systems were in place for staff to administer medication to be taken 'as required'. Nursing and senior care staff only administered medication following specific training and completion of competency assessments. Staff demonstrated competence in the safe administration of medication.

Requires Improvement

Is the service effective?

Our findings

People did not always receive adequate support during the lunch time service because there were not enough staff available and they had resorted to multi-tasking which created a chaotic dining experience.

However when the food was served staff ensured that people were supported to make their own selections from the three course menu. For example people on the dementia units were able to select their food choices because staff showed them the plated meals. This meant that people with dementia could see the food that was available and were able to select their preference.

Staff had identified people who were at risk of not having enough to eat or drink and took action to ensure that they received the support or specialist input that they required. For example where required people received support from a dietician and we saw that systems were in place to support people who received their nutrition through a feeding tube. Staff monitored some people's food and fluid intake by recording how much they had consumed. However, we saw that fluid records were not always fully completed or totalled daily and this made it difficult for staff to identify whether people had taken enough fluid to maintain their health and well-being.

People told us they liked the food available on the seasonal menus; a member of the inspection team joined some of the people who lived at the home during the lunchtime service. They saw that the food provided was enjoyed by the people there; that there was a good choice, the food was appetizing, was well presented, was of an adequate portion and served at the appropriate temperature.

Although over half of the staff had received training in relation to the Mental Capacity Act 2005 (MCA) and in relation to the Deprivation of Liberty Safeguards (DoLS) they had limited knowledge of their responsibilities to ensure that peoples' human rights were protected. For example people living in home were unable to give informed consent in relation to the care that they received, yet mental capacity assessments and DoLS applications had not been made. This included the use of bed rails and an advanced decision relating to treatment in the event of a medical emergency. We discussed our concerns with the provider who took immediate action to ensure that people were referred for assessment in terms of their capacity and any potential restrictions on their liberty.

People told us that they were supported to maintain their well-being by access to health professionals such as general practitioners and hospital services. One person said "The staff are ace, I can't fault them." Staff told us they had good relationships with the district nursing services and that there were planned visits from a local GP on three days a week. People were also referred to a variety of health care professionals when required and referrals were made to NHS health care specialists when needed. Guidance had been sought from nurse specialists, such as the tissue viability nurse when people had been assessed as at risk of the development of pressure ulcers. Individual plans of care contained detailed instruction to staff about the care needs that each person required.

A thorough induction process was in place. Three recently recruited staff told us that they had had induction training which had provided them with the information and skills they needed before being allowed to work in the home. Staff also told us that they had regular supervision and found it helpful. We spoke with a team leader who told us that they supervised the care staff every two months to ensure staff were supported to fulfil their roles and responsibilities. One member of staff told us that the staff training was of good quality and enabled them to fulfil their roles and responsibilities. Training records showed that the majority of staff had received dementia awareness training and training in the management of challenging behaviour. One member of staff told us managers had supported them to complete a vocational qualification in care; however training records showed that very few staff had undertaken vocational qualifications to enhance their knowledge of providing care to people who used services.

Requires Improvement

Is the service caring?

Our findings

Staff demonstrated a caring approach and understood people's individual needs. However staffing levels meant that people's decisions and choices about how their care needs were met could not always be respected. For example staff were not always able to assist people at their preferred times of rising and retiring to bed. During our inspection there were not enough staff to assist three people to get up at their preferred time.

Although staff tried hard to meet peoples' needs we saw examples where peoples' dignity was not always maintained. For example we observed one person access the toilet independently and when they came out their trousers were inside out however two and a half hours later this person had not received the attention they required. Staff acknowledged that they could not care for people in the way that they wanted to; one staff member said "We all work hard and want to provide the best care but we don't have the time to give the care people need."

Staff addressed people by their preferred name; they were kind, patient and respectful. Staff also demonstrated good inter-personal skills; they approached people calmly with open smiling faces and ensured good eye to eye contact and effective techniques to engage with people. One person said "The staff are kind and respectful."

Visiting times were flexible so people could receive their visitors at a time that was convenient to them. People were able to receive their visitors either within the communal areas or in the privacy of their own rooms. We saw that staff were respectful of people's privacy for example staff knocked on bedroom doors before entering, bedrooms and bathrooms were fitted with appropriate privacy locks. People also had access to appropriate aids and adaptations to promote their mobility and independence. One person said "It's a nice place; the staff are very good they treat me with respect, I have no problems there."

People were dressed according to their age, gender and weather conditions. People were able to be involved in planning their care if they wished to be, for example people had been involved in the provision of their life histories, decisions about their care and whether to participate in activities. One of the relatives also confirmed that they had been involved in planning the care of their relative.

Requires Improvement

Is the service responsive?

Our findings

Arrangements were in place to enable people to be involved in planning their care if they wished to do so. People had their needs assessed before being admitted to the home and these assessments formed the basis of individualised plans of care. Staff were knowledgeable about the needs of the people for whom they cared and the plans of care provided them with the information required to care for people in an individualised manner. However staffing levels meant that people did not always receive the personalised support that they needed.

Although staff tried hard to meet people's needs and we saw that they were very busy carrying out personal care tasks, people often had to wait to speak with staff and one person gave an example where they had queried their medication and had to wait for two hours to speak with the nurse.

People spent long periods of time sitting in the lounges with little interaction or stimulation from the staff. People told us that activities had often been cancelled because the activities co-ordinators were required to provide personal care to cover staff shortages. One person said "I like to go to the activities when they are on but can miss them if I am not ready or there is no one to take me to them." During our inspection no activities were taking place and we were told this was because the activities staff were covering for care staff.

A member of staff said "The staff care for the people who use the service and are committed to them. The carers interact well with people but there is not enough time to give them individual time and there is not always time for activities."

There were no specific activities for people living on the dementia units as most organised activities took place on the residential unit, so people from the dementia unit had to be assisted to attend these events. There were no activities or resources to stimulate people on the dementia units such as music relevant to the age of the people living there; or objects to stimulate reminiscence such as books, or other artefacts or rummage boxes containing tactile objects for people touch or stroke.

People told us they knew how to complain and staff knew how to respond if a complaint was made to them. The complaints policy contained appropriate information including contact details and time-scales for acknowledgement and response.

There had been six complaints during the last 12 months and records showed that the registered manager had investigated the complaints; records showed that the complainant had been informed of the outcome. Where the investigations were found to be substantiated action had been taken to prevent a reoccurrence. For example one complaint related to a member of staff who had not complied with the provider's uniform policy records showed that the concerns had been followed up with individual staff through additional supervision.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post at the time of our inspection however we were advised that they had resigned from their position soon after our inspection. Subsequently the provider notified us about the action they had taken to ensure effective management and clinical leadership of the service.

At the time of our inspection people who lived in the home lacked confidence in the management of the home and all of the people we spoke with expressed concerns about staffing levels and the impact this had on the care and support that they received.

The management of staffing levels at the home was inadequate. There were ineffective systems in place to monitor peoples' dependency levels or staffs ability to meet their needs

Although the registered manager told us a system was in place to assess the dependency of people who used the service, they were unable to provide us with any significant evidence that this had been used to calculate staffing levels. In addition we found that there was a lack of appropriate contingency arrangements in place to cover unplanned absences without impacting on the lives of the people who lived there.

All of the staff we spoke with expressed concerns about staffing levels and the impact on the people who used the service. One member of staff said "There was a staff meeting four or five months ago and the regional manager attended. Concerns about staffing levels were raised by staff and we were promised more people to help with lunch but this has not happened yet."

People told us there were opportunities to be involved in the running of the home. One person said "I like to be involved; we have arranged our own residents meetings and some of the activities. We sometimes have meetings with the manager about things that concern us, such as the staffing levels, the lack of activities and outings."

The minutes of residents' and staff meetings showed that concerns about staffing levels were raised with the management and that they were briefed about the efforts being made to recruit new staff.

The provider conducted a quarterly satisfaction survey to establish the views of the people who used the service and their representatives. Although no specific questions relating to the staffing levels in the home were included; people did provide their views about staffing levels these included; "There are no staff to cover sickness during the day or night. Staff just get moved from one floor to another, we could do with at least two extra staff during the morning." Another person said "All that this home needs is more staff, all the good hard working, reliable carers and staff on other floors are leaving."

These responses supported our inspection findings that staffing levels were inadequate to meet people's needs. We discussed our concerns with the provider who told us that they were reviewing the terms and conditions of employment to improve the retention of staff and that they continued to recruit more staff. However it was clear that insufficient action had been taken to stabilise staffing levels or to listen to people's comments or views about the impact of the staffing arrangement on people living in the home.

Quality assurance systems were in place and included a variety of audits which were conducted on a regular basis. These included monthly audits of the accident records to identify trends and risk factors; the audits identified the unexplained bruising however it was not always clear what action had been taken to reduce these and manage the risks. Medication audits demonstrated that medication was well managed and controlled medication was checked at the change of each shift. The registered manager also conducted weekly audits on referrals to the GP, the incidence of infections, pressure ulcers and nutritional risk factors.

The analysis conducted by the provider showed that the results for this home were less favourable than the results for the provider's other homes. The provider told us that they had met with people living there on two occasions to discuss their concerns. This gave people the opportunity to discuss the type of activities that they wanted such as more visiting entertainers. The activities programme was amended to accommodate this request and more external entertainers were being booked. However staffing levels meant that activities were not being provided on a regular basis.

Records were not always up to date or fully completed. Recent audits had identified that the individual plans of care had not been updated since August 2014; none of the four care plans reviewed had been updated since that date.

Requires Improvement

Is the service well-led?

We were concerned that staff may not have access to up to date information about people's individual needs and discussed our concerns with the provider; they sent us an action plan which included the review of all of the individual plans of care and a timescale for that work to be completed.

Minutes of staff meetings identified that fluid balance and repositioning charts used in the prevention of pressure ulcers were not always completed. This corresponded with our inspection findings; fluid balance charts were not always fully completed to demonstrate that people at risk were in receipt to adequate fluids; and fluid charts were not always totalled to ensure that people had had exceeded a minimum amount of fluids during a 24 hour period. Without accurate records managers could not assure themselves that people were protected from the risk of complications such as urinary tract infections, constipation and pressure ulcers. We discussed our concerns with the provider who took immediate action to ensure that managers reviewed charts relating to the delivery of people's care on the completion of each 24 hour period.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Systems had also been put in place to ensure that staff received regular supervision to ensure they were supported to fulfil their roles and responsibilities. Systems were in place to ensure staff training was undertaken and renewed when it was required.

Staff were empowered to act as 'whistle-blowers' by raising their concerns with senior management or external agencies. Evidence obtained through the inspection process confirmed that the processes were effective.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Quality assurance systems were not robust because they did not always identify, assess and manage risks relating to the health and welfare and safety of service users and others who may be at risk for the carrying on of the regulated activity. **Regulation 10 (1) (a) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There were insufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. **Regulation 22.**