Mr and Mrs R Odedra

Bournbrook Manor Home Ltd

Inspection report

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Birmingham
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Tel: 01214723581

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05 March 2019

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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**

Summary of findings

Overall summary

About the service:
Bournbrook Manor Home is a residential care home that provides accommodation and personal care and support to a maximum of 23 older people and for some older people living with dementia. At the time of our inspection 15 people were living at the service.

People's experience of using this service:
● People told us they felt safe. Safeguarding systems and practices protected people from abuse.
● However, people were not always kept safe because risks were not always assessed, monitored or mitigated.
● People shared mixed feedback in relation to staffing levels. However, staff told us there were enough staff available to meet people's needs.
● Systems and practices required improving in relation to the safe management of medicines.
● Accidents and incidents were not always followed through with the appropriate action to minimise the risk of re-occurrence. Where lessons could be learned to improve the service, and make the care people received safer; these were not always identified and addressed.
● People received care from staff who had not always completed mandatory training the provider had required.
● Staff involved and consulted a range of health and social care professionals to ensure people's healthcare needs were met.
● People told us they enjoyed their meals but were not enabled or involved in the planning of their meals.
● Although staff knowledge of Mental Capacity Act (2005) had improved people did not always have their legal rights protected as the staff did not know which people had Deprivation of Liberty Safeguards authorisations in place or how to support people in the least restrictive way.
● People said staff were kind and caring but interactions between staff and people were generally task orientated with limited sustained interaction.
● People's dignity, privacy and confidentiality were compromised on occasions
● There were limited opportunities for engagement and stimulation for people living with dementia.
● People did not always receive care and treatment that was responsive to their needs or provided in a person-centred way. People's care plans were not consistently being followed and some were not current or reflective of people's needs.
● People were not consistently supported to be involved in the planning or reviewing of the care they received.
● Relevant care documents were not accessible to meet people's individual communication needs.
● People told us they felt confident to raise a complaint. However, Information about how to raise concerns had not been produced in an accessible format for people who had a visual or cognitive impairment.
●The provider had developed systems for identifying, assessing and mitigating risks, however, these had not always been operated effectively. The registered manager carried out audits of the service but these had

failed to ensure that people were always safe and that their needs were being met.
● The providers systems had not been effective at improving the quality of the service and the service had failed to achieve and sustain a minimum overall rating of 'Good' at three consecutive inspections.
● A new management team had been introduced and they were very committed to driving improvement to enhance the quality of the care and support delivered to people.

Rating at last inspection:
The service was rated Requires Improvement overall. Our last report was published on 02 May 2017.

Why we inspected:
This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received. At this inspection on 05 March 2019, we found the provider had failed to sustain and build on improvements and the service had deteriorated.

Enforcement:
We found that the provider was not meeting all of the requirements of the law. We found multiple breaches in regulations. You can see what action we told the provider to take at the back of the full version of the report. 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 continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

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

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 effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Bournbrook Manor Home Ltd

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by one inspector, one assistant inspector 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:
Bournbrook Manor Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was unannounced.

What we did:
When planning our inspection, we looked at the information we held about the service. This included the Provider Information Return (PIR), notifications received from the provider about deaths, safeguarding alerts and serious injuries, which they are required to send us by law. Providers are required to send us key

information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We also asked stakeholders, such as the local authority safeguarding team and commissioners, for their views of the service.

During the inspection we spoke with nine people and three relatives or visitors to ask their experience of the care provided. We spoke with the area manager, the registered manager, one senior care assistant, the cook and five members of care staff. In addition, we spoke with two health professionals. We used this information to form part of our judgement.

We sampled seven people's care records to see how their care and treatment was planned and delivered. Other records looked at included four recruitment files to check suitable staff members were recruited and received appropriate training. We also sampled records relating to the management of the service along with a selection of the provider's policies and procedures, to ensure people received a good quality service.

Details are in the 'Key Questions' below

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

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. Regulations may or may not have been met.

● At our last inspection in May 2017 we rated this key question as, 'Good'. However, we found the registered provider had not maintained this standard. We have now judged this key question as 'Requires Improvement' and the provider is in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Assessing risk, safety monitoring and management
● Risks associated with people's care and support were not consistently identified, assessed or mitigated.
● Some care plans did not always describe measures for staff to reduce risks as much as possible. For example, on one person's food and fluid chart we found their individual nutritional intake was not quantified and their fluid intake was not calculated daily to ensure their nutrition and fluid intake was adequate to maintain their health.
● We observed that staff were using unsafe practices to support people to move that increased their risks of falls. We observed staff support one person to stand. The staff supporting advised the person to pull themselves up using their walking frame.
● One person was transferred to a wheelchair that did not have any footplates. There was a risk assessment in place to address this but staff were not following this in order to keep the person safe.
● Appropriate action had not always been taken to assess, monitor and reduce risks associated with dysphagia for one person. Following a visit to the hospital on 01 March 2019 it was recommended by health professionals that toast is a risk for the person. However, their nutrition risk assessment and care plan stated, 'no concerns'. This information had not been updated in the records. In addition, a member of staff we spoke with was not aware that toast was a risk to the person. This placed the person at risk of harm.
● We found fire risk assessments were completed and staff we spoke with were familiar with the emergency procedure at the home. People had Personal Emergency Evacuation Plans (PEEPs) in place. However, they were stored in a place that staff were not aware of.
● Risks that had been identified were responded to promptly on the day of the inspection and the area manager advised us of the new plans to address some of the safety issues.

Failure to provide care and treatment in a safe way and do all that is reasonably practicable to mitigate risks to people is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not always managed safely. On one occasion medicines had been signed for before the person had taken them and on another occasion a person's medicines records indicated they had been administered but we found them in the medicine trolley. On one occasion four people's medicines were

administered at the same time. Medicines were in different medicine pots with no people's names on them. This was a potential risk to people.
● Medicines were stored safely and at the correct temperature. Guidance for 'as needed' medicines was in place.

Failure to provide medicines a safe way is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Although accidents and incidents were recorded there was limited evidence of lessons learned. For example, on 22 February 2019 one person was found on the floor. Whilst the immediate action taken had been recorded there was no outcome or lessons learnt from this incident.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe and happy living at Bournbrook Manor Home. One person said, "I feel safe knowing there's someone there night and day."
● Staff we spoke with understood their responsibilities to safeguard people from the risk of harm. They understood the different types of abuse and knew how to report concerns. A member of staff said, "I could whistle blow to CQC if I was worried about people's safety."

Staffing and recruitment
● People's views on staffing levels varied. One person told us, "There is enough staff, at night time and weekends too." However, two people told us, "There's enough but I don't like to bother them. Sometimes I have to wait and sometimes they forget."
● All the staff we spoke with told us there were enough staff to meet people's needs. Our observations confirmed that staff were available to support people when required.
● The registered manager advised that people's dependency levels were reviewed and calculated regularly.
● Records we sampled included all the necessary documents to demonstrate safe recruitment, including disclosure and barring checks (DBS) which ensured people did not have criminal convictions which may prevent them from working with vulnerable adults.

Preventing and controlling infection
● People were protected from the risks of infection by staff's practice. We saw staff followed infection control practices and used personal protective equipment, such as gloves and aprons, to help prevent the spread of infection.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

● At our last inspection in May 2017 we rated the service under this key question as, 'Requires Improvement' due to the concerns we found. At this inspection sufficient improvements had not been made. As a result, the rating for this key question remains as 'Requires Improvement.'

Ensuring consent to care and treatment in line with law and guidance

● The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● At our last inspection in May 2017 staff were found to lack knowledge about MCA and DoLS. At this inspection although staff had received additional training, they were still unable to demonstrate the understanding and knowledge of what this meant for people who lived at the service.

● Some of the staff we spoke with did not always know which people were subject to authorised DoLS, some had no knowledge of what DoLS meant. The registered provider had not worked with the staff team to make sure they understood who was legally authorised under DoLS and how best to support them with their restriction, ensuring least restrictive practices were followed.

Staff support: induction, training, skills and experience

● People were not supported by staff who had ongoing training.

● At the time of inspection, we identified significant gaps in refresher training such as moving and handling and fire safety. The provider recognised this was an area that required strengthening and plans were being made to ensure staff training was up to date.

● New staff received induction training to the service which included the Care Certificate. The Care Certificate is the nationally recognised benchmark set as the induction standard for staff working in care settings.

● Staff we spoke with told us they received regular supervision and felt supported by the registered manager. A member of staff told us, "I feel very supported and listened to."

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

● At our previous inspection we found that the home environment was not 'dementia friendly' with a lack of pictures and objects to occupy and stimulate. At this inspection we found this was still the case.

● There was little for people to find to enable them to engage in independent activity and a lack of signage to help people orientate to time and place. There were some pictorial signs on doors to denote bathrooms and toilets.

●There were no individualised pictures or words on bedroom doors to help people recognise their own room.

● The provider advised us that new signage and objects had been ordered to improve the quality of life for those people living with dementia.

We recommend that the provider refers to current guidance or seeks advice from a reputable source on best practice to improve the environment for people living with dementia.

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

● Care plans we sampled did not contain guidance for staff to follow in relation to some health conditions, for example, diabetes. There was no care plan or risk assessment in place to guide staff how to support this health condition.

● People had access to their GP and other healthcare professionals such as tissue viability and social workers as necessary. A relative told us, "The GP are called in when necessary."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People were assessed before moving to live at Bournbrook Manor Home. However, this process was not always robust.

● People's protected characteristics under the Equalities Act 2010 were not identified as part of their needs assessments. This included people's needs in relation to their gender, age, culture, religion, ethnicity, disability and sexual orientation.

Supporting people to eat and drink enough to maintain a balanced diet

● People told us that they enjoyed the food provided. One person said, "Food is lovely."

● People told us they were not involved in the planning of meals and records we sampled corroborated this.

Staff working with other agencies to provide consistent, effective, timely care

● Staff told us they worked with other services to meet people's needs. This was corroborated by a visiting health professional who told us, "Staff follow our advice and work with us."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

● At our last inspection in May 2017 we rated this key question as, 'Good'. However, we found the registered provider had not maintained this standard. We have now judged this key question as 'Requires Improvement'.

Ensuring people are well treated and supported; respecting equality and diversity
● People spoke positively about the caring attitude of staff. One person told us, "The care and everything I have is wonderful."
● However, we also found that the providers systems did not always support the service to be fully caring. This can be demonstrated by the concerns found in other areas of this report.
● People did not consistently receive personalised care from staff as they were not always aware of or responsive to people's individual care, emotional and support needs. This did not demonstrate a caring and compassionate approach to people's care.
● We observed staff treating people with kindness, however interactions between staff and people were brief and not sustained and were generally related to completing tasks.

Supporting people to express their views and be involved in making decisions about their care
● People told us they were involved in some decisions about their daily care, such as what time they got up in the morning. However, one person told us, "I'd like to be able to choose when I have a bath."
● We saw several examples of good practice where staff were kind and caring in their approach. However, staff did not consistently support and encourage people to make their own decisions. For example, we observed some staff placing aprons on people at lunchtime from behind without any explanation.

Respecting and promoting people's privacy, dignity and independence
● We saw that the privacy and dignity of people using the service was not consistently promoted and protected.
● We saw occasions where staff failed to approach people discreetly when necessary to discuss aspects of personal care such as the need to go to the toilet.
● During the inspection we saw that the staff handover of information between shifts was conducted in a communal area where people could overhear what was being said. The registered manager had not ensured that arrangements were in place to protect the confidentiality, privacy and dignity of people living in the home.
● People told us that family and friends could visit any time. For example, one person explained how their relative visits after work.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

● At our last inspection in May 2017 we rated this key question as, 'Good'. However, we found the registered provider had not maintained this standard. We have now judged this key question as 'Requires Improvement' and the provider is in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
● People were not always involved in the decisions and reviewing of their care and support needs. Four people and two relatives told us they had not been involved in the planning of their care. One person said, "I'm not involved in care plans." The service had not ensured people's opinions were taken into consideration for the development and reviewing of their plans.
● Some care plans did not sufficiently guide staff on people's current care and support needs.
● Staff were not consistently provided with detailed information about people to enable them to deliver personalised care.
● There was very little life history in some care documents. Life history is important as it provides staff with a picture of how the person used to be and provides useful lines of conversation and activity.
●There were some social activities provided for people. One person said, "Someone came in to throw balls and do movements." During the morning of our inspection people enjoyed homemade pancakes and some people participated in a bingo session. In contrast, in the afternoon we observed very little activity or stimulation for people. Most of the time people were sitting in the lounge or their bedrooms doing very little.
●People were not consistently encouraged to access and integrate with the local community with support from staff to reduce social isolation, and maintain skills and independence where appropriate.
●The registered manager was not aware of the accessible information standard and information was not available in different formats that met people's individual communication needs.

People did not always receive person centred care that was appropriate to their needs and reflect their personal preferences. This constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

Improving care quality in response to complaints or concerns
● People told us they knew how they would complain about the care if they needed to. One person said, "I'd go straight to the top."
●We saw there was a formal complaints procedure. However, this was not accessible to meet people's communication needs and this was not displayed for people and their visitors to read.

End of life care and support
● There was no-one at the end of their life at the time of this inspection. However, there was little evidence

from records we sampled that people had been asked for their wishes regarding their end of life care.

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

● At our last inspection in May 2017 we rated the service under this key question as, 'Requires Improvement'. At this inspection sufficient improvements had not been made. As a result, the rating for this key question remains as 'Requires Improvement' and the provider is in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● People and relatives told us they knew who the registered manager was and felt they were approachable. One person told us, "[name of registered manager] is lovely and I can talk to her at any time."

● However, the provider failed to have effective systems in place to ensure that people received person centred care that was appropriate to their needs and were given choice and control over how they preferred to spend their days.

● People told us and records supported that they were not involved with the planning and reviewing of care plans.

● There were no systems in place to ensure people were given information in a way they could understand to enable them to communicate effectively.

● Throughout the inspection we found the management team honest, open and transparent regarding the failings of the service. The area manager demonstrated enthusiasm and commitment to making the required improvements to ensure people received safe and good quality care.

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

●The systems in place to demonstrate how the service monitored accidents, incidents or safeguarding concerns were not effective. There were no effective oversight systems in place to evaluate and use lessons learnt to reduce the likelihood of re-occurrence.

● Peoples medicines were not always managed safely. We found failings in the providers quality assurance systems around medicines management.

● Systems in place had failed to consistently ensure people's risks were mitigated and care plans and risk assessments reflected people's current needs.

● Staff training had not been effectively monitored to ensure all mandatory training identified by the provider were provided in a timely manner.

●There were no effective systems in place to check the competency of care staff to ensure they were equipped with the skills needed and were applying their learning into practice.

● There were no governance systems in place to monitor the effectiveness of the Mental Capacity Act (MCA) training to ensure staff were aware of how to ensure people's legal rights were promoted. This had been identified at the previous inspection in May 2017.
● The providers quality audit system for the environment was not effective. We checked records for servicing of fire alarms, emergency lights and the call bell system. We found systems had failed to identify they had not been serviced in a timely manner and were overdue by five months.

The provider did not have robust systems and processes in place in order to continually assess, monitor, evaluate and improve the service provided. This is a breach of Regulation 17 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014. Good governance

● The provider was reporting other notifications to us as required by law, with the exception of one. For example, deaths, abuse concerns and events that stop the service.
● The latest CQC inspection report rating was on display in the reception area of the service and on their website.
● The area manager and registered manager assured us they would be taking immediate action to rectify issues identified at this inspection. They advised us of their commitment to making the required improvements to ensure people received safe and good quality care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were given the opportunity to express their views at resident's meetings. However, one person told us there was no point attending meetings and said, "You don't get to say anything because staff do all the talking."
● There was no evidence to show what action had been taken with the feedback received.
● Plans were in place to re-design the providers satisfaction survey to get a clearer picture of people's views.
● Staff told us they felt supported in their role and found the registered manager and registered provider helpful and approachable.

Continuous learning and improving care
● The action the provider had undertaken following our last inspection had not been effective at identifying issues and had failed to drive the improvements required. The audits undertaken had not identified or effectively prioritised where improvements need to be made.
● Four people were found at the inspection to not have easy access to a call bell. This was addressed during the inspection and weekly audits have now been implemented.

Working in partnership with others
● The service liaised with other professionals when providing care for people using the service.

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 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person centred care that was appropriate to their needs and reflect their personal preferences. Regulation 9 (1) (3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment A failure to ensure risks for people had been effectively assessed and plans developed to mitigate these risks, including the management of medicines. Regulation 12 (2) (a) (h)

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 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems and processes in place in order to continually assess, monitor, evaluate and improve the service provided.

The enforcement action we took:

We served a Warning Notice requiring the provider to become compliant with this regulation by a set date.