Bondcare Willington Limited

Brancepeth Court

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?	Good
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 23 and 29 December 2014 and was unannounced. This meant the staff and provider did not know we would be visiting.

At our last inspection in September 2014 we found the provider had breached Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to the safety and suitability of premises. We saw during this inspection there had been some improvements to the premises and there was ongoing work.

Brancepeth Court is part of a complex of care facilities located on one site, called the Willington Care Village. Brancepeth Court is registered to accommodate up to 49 people. The home is split into two separate units; the main nursing and residential unit which is called Brancepeth Court and a smaller unit Rose Cottage. Rose Cottage is separated from the main unit and provides accommodation for eight people with learning disabilities.

At the time of our inspection Brancepeth Court had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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.'

We found the provider had in place recruitment arrangements to ensure staff employed by the service were of good character and were able to work with vulnerable people.

We saw there were four gaps in people's medication records which were attributed to agency staff not signing. Notes had been left for the agency staff to sign. However we could not be assured that although the agency staff had given people their medicines.

We looked at staff training records and found there were staff who had not received updated training in 2014 to meet people's needs. We also found staff had not received the required level of support through supervision meetings with their line manager. This meant there was a breach of the relevant legal regulation and you can see what action we told the provider to take at the back of the full version of the report.

We also found the management team required training in the Mental Capacity Act and the Deprivation of Liberty Safeguards to ensure proper procedures were carried out with people who had been assessed to be deprived of their liberty for their own safety.

Staff were able to tell us about how they met people's needs and described to us actions they took to engage people and achieve the best outcomes for them.

We found activities had been put into place by staff and had been adapted so that people were able to join in.

We found people's dignity and well-being was at risk of being compromised through the lack of continence care supplied to them.

We found the registered manager had appropriately responded to people's complaints. They had conducted investigations and responded to the complainant. People could be assured their complaints had been addressed.

There were processes to monitor the quality of the service but we found mattress audits had not been carried out since April 2014. These audits had been set up by the provider to be carried out on a monthly basis This meant people were at risk of cross infection through the provider not auditing the quality of the service they provided. We found there was a breach of the relevant legal regulation.

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.

We found improvements needed to the premises at our last inspection had started to be made.

We found there were four gaps in the medication administration records which staff attributed to agency staff not signing. However we could not be assured people had received their medicines.

We found the provider had in place arrangements to ensure staff employed by the service were of good character and were able to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not always effective.

We found staff needed further training on the Mental Capacity Act and the Deprivation of Liberty Safeguards so that people could be better cared for.

We found staff did not receive the appropriate support in line with the provider's training policies and not all staff had completed the required training in 2014.

We found the home had changed the tea time and lunch time menus to ensure people got a better balance of food intake throughout the day.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were able to tell us about how they meet people's needs and described to us actions they took to engage people and achieve the best outcomes for them.

In Rose Cottage we observed people were engaged in the running of the unit by helping to serve others their meals or clearing their plates away.

We found people's dignity and well-being was at risk of being compromised through poor management of continence products.

We found further work was required to address equality and diversity issues in the home.

Is the service responsive?

Good

The service was responsive.

We found activities had been put into place by staff and had been adapted to that people were able to join in.

Summary of findings

We reviewed people's care planning and noted there were care plans and risk assessments in place which were person centred. We found people's wishes had been included in their care planning.

We found the registered manager had appropriately responded to people's complaints. They had conducted investigation and responded to the complainant. People could be assured their complaints had been addressed.

Is the service well-led?

Requires Improvement

The service was not always well led.

We found the registered manager was open and accountable to us for her actions and whilst having had her actions questioned gave us satisfactory responses.

We found not all audits had been completed and there were lapses in the quality monitoring of the service.

We found the service worked in partnership with other agencies and family members to support people.

Brancepeth Court

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 23 and 29 December 2014 and was unannounced. It was carried out by one Adult Social Care inspector.

Before the inspection we reviewed notifications sent to us by the provider and any whistle blowing concerns sent to us.

During our last inspection the provider was not compliant with regulation standards in relation to the premises. We checked to see if the improvements had been carried out. We spoke to five people who used the service and three relatives. We spoke to fifteen staff these included the registered manager, the quality manager, the deputy manager, two senior carers, four carers, two domestic staff and three kitchen staff. We reviewed seven peoples' care records

Before this inspection we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We asked the management and staff in the service about what the service did well and what improvements were planned.

Requires Improvement

Is the service safe?

Our findings

One person told us they liked living in the home and, "It was good." Another relative expressed concern about the care given and said they were unhappy about the standard of care.

During our last inspection we found the provider had not met the required standards in relation to premises. The registered manager had provided us with an action plan and said they would meet the required standards by March 2015. We worked through the action plan with the registered manager and found progress had been made, although at the time of inspection visits the registered manager had halted the redecoration due to it being the Christmas period. The registered manager discussed with us the adaptations which were planned as a part of the redecorating to support people with dementia type conditions. They also showed us the provider had made progress in seeking estimates to complete the work.

We looked at people's medicines to see if they were given safely. We checked the clinical area and discussed people's medicine needs with the nurse on duty including those people on Warfarin and who were diabetic and required medicines to manage their diabetes. We found people's medicines to be accurately recorded and checks were in place to show people were safe. The nurse showed us how medicines were stored including those which required refrigeration. We saw fridge checks were in place to monitor the temperature and ensure people's medicines were stored at the correct temperature. We also saw people's medicines were in a locked cabinet.

One person told us they self-medicated and we found an assessment had been carried out to assess if they were capable of managing their own medicines. The assessment was supported by evidence from the district nurse. The assessment included their understanding of what each medicine was for.

When we looked at people's medication administration records (MAR) for people living in the Brancepeth side of the home and we saw there were four post-it notes in the MAR charts asking staff members to sign the MAR to state they had given people their medicine. During our inspection the deputy manager of Brancepeth Court carried out their December medicines audit and we asked about the four post-it notes they had put on the MAR charts. They told us it was to remind the agency staff to sign the MAR. We queried how they knew the medicine had been given and they told us they had carried out an audit of medicines and there were some missing. Whilst agency staff were being told to retrospectively sign the MAR chart we could not be sure people had received their medicines,

We also looked at the MAR records in Rose Cottage and found there were no gaps in the record of administration of people's medicines. Each person's medicines were stored in a locked cabinet in their room. We checked to see if the medicine's stocks were accurate and found they matched the MAR. Staff showed us how records were maintained and checked. Each record had a person's photograph to ensure the medicines were given to the right person.

We looked at the provider's policy on Disclosure and Barring and found before staff were employed at Brancepeth Court they were required to have a Disclosure and Barring Services (DBS) check. According to the policy this check was 'To ensure that the appropriate individual is appointed to work with resident at our Care Homes'. We checked the files of three staff who had been newly appointed to the service and found no one had started work before the provider had carried out a DBS check. We found each new member of staff had completed an application form giving details on their background and previous experience. The provider had requested two references on prospective staff members and these references had been checked with the author of the reference to ensure it had been written by them.

We looked at staffing arrangements to see if there was enough staff on duty to keep people safe. The registered manager told us during the day time there was one nurse, one senior carer and five carers on duty on the Brancepeth side of the unit and one senior carer and one carer in Rose Cottage. On a nightshift the registered manager told us there was a nurse and two carers on the Brancepeth side and one carer on Rose Cottage. We queried the numbers of staff on a nightshift in Rose Cottage and were advised by both the registered manager and the senior carer there was only one person who required support from two carers and staff requested support from the Brancepeth side of the home when the person for example wanted to go to bed. We looked at the rotas and found they matched what we

Requires Improvement

Is the service safe?

had been told about the level of support provided. We also found the numbers of staff on duty during our inspection matched what we had been told by the registered manager.

Whilst we were conducting our inspection the home lights went out. We observed staff respond to the situation in different ways for example A staff member pointed out to the registered manager there was a torch in the emergency kit whilst the registered manager sought her own torch. Within a short space of time we found people were not delegated tasks in a coordinated way to ensure people were safe.

We found there were night time cleaning records in place. It was explained to us by the day time cleaning staff on duty that the staff on night duty were required to clean the communal areas of the home. We found the communal areas including the corridors and the lounges were clean and tidy. We looked at the kitchen area of Rose Cottage and found this to be clean.

The cleaning staff showed us their cleaning schedules and explained to us what they were required to do each day. They showed us records to demonstrate they had carried out deep cleaning of people's rooms and they told us they could only do this when people were not in their rooms. We looked around the home to see if it was clean and the potential for cross infection was minimised. We looked in the shower room in Rose Cottage. We saw the shower chair was stained brown underneath the seats. We found brown stains on toilet seats in people's room in Rose Cottage. We also found in the shower room the toilet seat was brown and chipped and the toilet frame was rusted around the legs. During our inspection the toilet seat was renewed and we saw cleaning arrangements had been put in place to address the issues we raised. We saw the shower chair was stained brown underneath the seats. In one person's room we found a smell of urine. This was coming from a bin where a wet continence pad had been placed. The registered manager told us she had recently purchased the bins for waste paper towels and this was not the proper use of the bins. The registered manager told us they would talk to staff about this issue.

We looked at the cleanliness of the main kitchen and found the kitchen area to be clean and tidy. We saw the cleaning routines were monitored by the head of the kitchen and the kitchen received a deep clean on Sundays. Staff confirmed to us the cleaning was carried out.

We saw the Infection Prevention and Control Team had visited Brancepeth Court incorporating Rose Cottage and had made recommendations to improve the cleanliness of the home. During our inspection we did not find a sufficient lack of cleanliness to indicate a regulatory breach, nonetheless we found improvements were needed.

We spoke with staff about safeguarding. Staff felt they had sufficient training to understand safeguarding procedures. We asked staff who they would speak to if they had any concerns about a person. They told us they would speak to the nurse on duty or the deputy manager before speaking to the registered manager. We spoke with a person and their relative in their room and noticed a large bruise on the back of a person's hand. We queried the bruise with the relative who did not know how it had occurred. We also asked the registered manager if she had been made aware of the bruising and how it had occurred and she had not. The registered manager had delegated a staff member to make a safeguarding alert. This meant that although staff were confident about safeguarding we found an injury to a person which needed to be addressed.

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. We discussed the implementation of DoLS with the registered manager who told us they had prioritised another unit for which they were also the registered manager. This, they explained was due to the dementia care needs required by people on the other unit. We asked the registered manager who on Brancepeth Court required a DoLS application and she said, "Everyone." We further discussed the needs of people in relation to DoLS with the registered manager and found they required further knowledge about DoLS. We spoke to the deputy manager and the senior carer on duty and they told us they felt they needed further training in this area.

We checked to see if people had capacity assessments in place and found people's capacity had been assessed in relation to their healthcare. We found best interests decision had been made about people receiving a flu inoculation. However we found one person at risk of choking whose family wished their relative to continue eating their preferred foods. The person did not have capacity and there was no best interest's decision meeting in place. We discussed this with the deputy manager who recognised the role of a best interest's decision in this scenario.

We asked the registered manager how many supervision meetings staff were required to have in one year. She told us staff were expected to have four supervisions, one every other month. We pointed out this left staff for four months of the year without support using supervision meetings and asked to see the supervision policy. The registered manager checked the policy and told us staff were meant to have six supervision meetings with their line manager per year. We looked at the policy which said, 'All Care Staff require formal supervision/development meetings a minimum of six times per year' and 'It is recommended that all other Staff Members receive supervision and development meetings at least four times per year'.

We looked at the staff supervision planner records for January to December 2014 for Rose Cottage and saw that out of eight senior care and care staff listed one person had received four supervision meetings, four staff had received three supervision meetings, two staff had one supervision meeting and one member of staff had been on long term sick leave. On Brancepeth Court with the exception of staff on maternity cover and long term sick leave no member of staff had received the required amount of supervision during the course of the year. One member of staff told us they have supervision quarterly. Another staff member told us staff are not keen on supervision meetings and are reluctant to attend.

The registered manager explained to us staff received letters inviting them to complete their annual mandatory training requirements. Staff were required to return a slip of paper stating if they could or could not attend. We looked at the records and found some staff had returned their slips of paper more than once for a specific course stating they were unable to attend. We saw one member of staff had been invited for the same training three times and had not attended. We asked the registered manager what happened when staff could not attend for example if the training was arranged on their days off. The registered manager told us she was not aware of these people not having training as she had delegated the task to another member of staff.

We looked at the training matrix for Brancepeth Court. Excluding the people who were on maternity leave, long term sick leave or had left the service we found there were 46 staff who required training. We found some staff had not received the required updated internal training in 2014. For example 13 staff had not received training in food hygiene, 28 staff had not received training in moving and handling and 22 staff required updated safeguarding adults training. We asked the registered manager about the gaps in the training records and they told us it was because the staff had been engaged in more bespoke training. We asked about the bespoke training and were told by the registered manager this was cleanliness and infection control which had been mainly delivered to another part of the campus.

We spoke to staff about the training arrangements. They confirmed to us they received letters to say which training they needed to do. One member of staff told us that if the training was on their day off and they only had one short training session to do it was not worth them coming in for that session. We found the arrangements which the provider had in place were not conducive to staff involvement in training.

We asked the registered manager about staff meetings. She told us staff on Brancepeth Court did not usually turn up for

meetings. This was confirmed by staff members. We asked the manager how staff were for example given information about a new policy, she told us she talked to staff at handover periods and showed us the handover notes. We looked at the handover notes and found these did not contain directions from the manager.

This meant staff in Brancepeth Court staff did not receive suitable support. This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw people had a pre-admission assessment in place. This meant the provider was aware of people's needs before they started living at the home. We also saw the provider had information from other professionals for example from social workers or occupational therapists which gave staff information on how to care for people.

We spoke to the catering staff who told us they had recently swapped around the lunchtime and evening meals. They told us they had found people might have a late breakfast and then could not eat a two course dinner at lunchtime. By changing the meals around they felt they had achieved a better balanced food intake for people who lived in the home. The catering staff told us people seemed to prefer the new meal arrangement. We found the care staff had given the kitchen staff notifications of people's diets including their specific likes and dislikes and their allergies. This meant the catering staff were aware of people's needs.

Following information of concern given to us prior to the inspection visit about a people's weight loss we checked their files to ensure appropriate action had been taken if a person had lost weight. We found the provider had contacted GPs, and put arrangements in place to provide additional support to the person concerned. We spoke with staff regarding the person's needs and found the staff were aware of the actions to take. One member of staff spoke with us about people's diets and told us, "[A person] eats better when they are up so we try to encourage that." This meant staff were aware of ways to try and support people to eat.

We spoke with another visitor to the home who expressed concern about a persons' intake of food and possible weight loss. They told us a relative brings in cakes as the person is often hungry. The staff told us the person has a limited diet due to preferences and does not eat vegetables. They told us about what the person likes and will eat. We checked the person's weight records and found their weight had remained stable. The deputy manager agreed to review the person's nutritional needs with their family.

Requires Improvement

Is the service caring?

Our findings

One person told us the staff were very caring and they would, 'Do anything for you'. Another person told us they liked the staff and they were 'Good'. We observed one relative who was thanking the staff for their care and support during a difficult time.

We asked staff about what was good about the home. One member of staff told us they felt the level of care was good and staff were committed to working with the people living at the home. They gave us the example that people were prepared to take people to a pantomime on their days off.

We discussed with staff how they met the needs of people in their care. Staff have us examples of how they managed individual behaviours to engage people and prevent the escalation of the behaviours.

On one of our inspection days there was a concert being held in the home. We observed staff in Rose Cottage asking people if they wanted to attend and offering to support them to change into their party clothes. We heard staff asking people what they might like to wear and gave them some suggestions and choices. We later saw the staff and people from Rose Cottage attend the concert dressed in their party clothes and wearing Christmas hats and glasses. This meant people had the option to be included in the activities and were supported by staff in their choices.

We observed people being treated with dignity for example we saw a member of staff squeeze through a narrow gap in the toilet door to avoid people being able to see a person on the toilet. However we spoke to one person who told us they had recently needed to go to the toilet during the night and had asked for staff to support them. They told us the home had run out of continence pads and the member of staff told them to wet the bed. The person said they had to do that and their body warmth helped dry up the urine. We spoke to the registered manager who had yet to address the issue at the time of our inspection. Following our inspection the registered manager told us she had investigated the incident and was unable to find any evidence to support the person not being treated with dignity.

During our inspection we asked the registered manager and the deputy manager about the home running out of pads. They told us they made referrals to the continence service and if a person requires continence aids they are given a limited amount of pads for each person each day but they find people need more pads. We asked the registered manager about how they obtained additional pads. The registered manager told us they borrow from other units and pay the other units back when they get their new supply. We pointed out this would mean they would then run out at some point and people's wellbeing was then not met. We found the provider did not have in place suitable arrangements to manage people's continence needs and manage their dignity. This also meant that when the provider ran out of continence pads people were at risk of being neglected.

We observed people in the home at mealtimes. We saw staff giving people support at the pace they required to eat. One member of staff finished supporting one person with their meal before they began to support another. In Rose Cottage we observed people were engaged in supporting others by serving others their meals or clearing their plates away.

During our inspection we looked at equality and diversity issues in the home. We found staff tried to engage people irrespective of disability. One member of staff proudly told us the work they had done with one person had led to an increase in their use of speech. We spoke with the registered manager about how gay and lesbian issues might be approached in the home and found further work was required to explore equality and diversity.

Good

Is the service responsive?

Our findings

One person told us they had repeatedly asked for their relative to have a bath and not a shower but this had not always happened. Although not everyone was able to share with us their care experiences we observed staff responding to people's care needs and discussing with each other who would respond. We found for example staff responded quickly to call bells.

In Rose Cottage people showed us the Christmas decorations they had made with the activities coordinator. This included snowmen which were displayed around the room. One person told us the programmes they wanted to watch over the Christmas period. Staff told us about the Christmas arrangements in place for each person for example one person was visiting their previous carers. This meant staff had planned ahead and were supporting people over the festive season.

We talked to one person and asked their permission to read their file whilst sitting alongside them. Their file contained their likes and dislikes and the person confirmed what was written in their file was true. A member of staff showed us on the front of the file where there were pictures of what the person liked to do including watching TV and reading magazines. This meant people's files had been personalised and staff were able to see from the front of a person's file what they liked to do.

Whilst we were inspecting Brancepeth Court we observed a quiz taking place. We heard staff inviting and encouraging people to attend the quiz. We observed a member of staff sat on a high chair and shouted out the questions so people could hear. Staff supported teams of people by repeating the questions to them and then engaged them in thinking about the answers. The same process occurred when it was time for the answers and the winning team was announced. This meant people were involved in social activities which prevented isolation.

We looked at the complaints file and found a number of complaints had been made since our last inspection. Each complaint had been documented and investigated by the registered manager with an outcome provided to the complainant. All of the complaints had been addressed within the required deadlines. We found people could be assured their complaints were appropriately investigated.

We reviewed people's care planning and noted there were care plans and risk assessments in place which were person centred. For example we saw one person was at high risk of falls due to their cluttered bedroom and two staff members were required to support the person at all times. Another person was at risk of choking, staff were required to observe the person eating and drinking. We spoke to staff who were aware of the need to be observant with this person. We found risk assessments were in place for one person who wished to have the footplates from their wheelchair removed to enable them to move around independently. We asked staff about when peoples' care plans and risk assessments were reviewed. They told us this was carried out on a monthly basis or as and when the person needed them to be reviewed. We saw care plans and risk assessments had been reviewed. This meant the home was responding to people's needs.

Staff spoke to us warmly about people and their needs. We observed staff respond to people's needs and asked people for permission to carry out care tasks, for example one staff member asked a person if they could wipe their mouth. The person gave their consent and we saw that their mouth was wiped in a gentle manner.

Requires Improvement

Is the service well-led?

Our findings

We saw the registered manager had in place a maintenance file from where she could track invoices and planned work to carry our repairs to the building. The registered manager demonstrated to us using the file that work identified in the action plan the provider had sent to us following our last inspection had been progressed.

We looked to see if the registered manager had checked on the quality of service delivery by sending out quality surveys. The registered manager pointed to a board where people's last responses in 2014 had been displayed. The registered manager told us she was preparing to carry out another survey and she preferred to survey people every six months. We found external professionals had last been surveyed in 2013. We saw a staff survey had been carried out in 2014. We asked the registered manager had the surveys been aggregated to enable her to look at trends, the manager told us the responses had not been aggregated.

We looked at the mattress audits carried out by the registered manager and found no mattress audits had been carried out since 22 April 2014. The registered manager explained she was allowed by the provider to replace a mattress every other month. We found in April 2014 four mattresses had failed the audit and we found these mattresses had been replaced between April and December 2014. However without current audits in place the provider was not able to determine if further mattresses had deteriorated and required replacing.

This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Information had been given to us by a person who wished remain anonymous regarding the use of bed rails and staffing levels. We spoke to the manager about bed rails who explained to us if people have been assessed as being at risk if bed rails were used she would not use them. Instead people's beds would be on the lowest setting and provided with a crash mat to prevent injury. The manager pointed out one person had been assessed as requiring one bed rail and the family were in agreement. We saw records to this effect. We discussed staffing levels with the registered manager and she felt the home had been unfairly criticised regard staffing levels. The manager showed us a board she was preparing to put up in the reception area so people could see on entering the building who was on duty. We found the manager was open and accountable to us for her actions and whilst having had her actions questioned gave us a satisfactory response where risks to people had been measured.

During our inspection visit the quality manager was also conducting their monthly quality audit. We observed the manager in discussion with staff about how they were currently managing medicines. This meant there was oversight by the provider from a quality perspective. We looked at previous quality audits and found the quality manager had made recommendations including actions for improvement for the management of medicines and care documents.

We looked at the 'partnership working' in the home and found there was a culture of working in partnership with other agencies. For example we found the home referred people to GP's, district nurses and occupational health. We saw records which indicated the home worked in partnership with relatives and carried out the wishes of relatives to support people in their care. This meant Brancepeth Court including Rose Cottage cared for people with the knowledge and support from other agencies.

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
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The provider had not taken appropriate steps to ensure staff were appropriately supported to enable them to safely deliver care and treatment to people.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The provider had not protected service users against the risks of unsafe care by regularly assessing and monitoring the quality of the service provided.**