Krinvest Limited

Branch Court Care Home

Inspection report

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Date of inspection visit: 10 and 12 June 2015
Date of publication: 12/08/2015

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

This was an unannounced inspection which took place on 10 and 12 June 2015. We had previously inspected this service in July 2014 when we found it was in breach of one of the regulations we reviewed; this was because the home was not suitably adapted for the needs of people living with a dementia. During this inspection we found improvements had been made and the service was now meeting this regulation. However we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to the unsafe management of medicines in the service and the assessment and management of the risks people might experience. You can see what action we told the provider to take at the back of the full version of the report.

Branch Court is a purpose built home which provides accommodation for up to 30 older people who require support with personal care needs. At the time of our inspection there were 29 people using the service.

There was a registered manager in place at Branch Court. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

The systems for managing medicines in the service needed to be improved to ensure that people always received their medicines as prescribed.

Care plans included information about the risks people might experience such as those related to falls, skin integrity and nutrition. However we found risk assessments had not always been regularly reviewed and updated to take into account people's changing needs. This meant there was a risk people might receive unsafe care.

People who used the service told us they felt safe in Branch Court and that staff were kind and caring. This was confirmed by our observations during the inspection.

Staff had received training in safeguarding adults and were able to tell us of the correct action to take should they have any concerns about people who used the service. Staff were aware of the procedures to follow to should they observe poor practice in the service.

Staff were safely recruited and received the induction, training and supervision they required for their roles. People told us there were enough staff on duty to meet their needs in a timely manner but we on the second day of the inspection we found improvements could be made to the deployment of staff in the dining room during the busy morning period.

We saw there were risk assessments in place for the safety of the premises. All areas of the home were clean and well maintained, although we noted there was limited space available for the storage of equipment people needed. Procedures were in place to prevent and control the spread of infection. Systems were in place to deal with any emergency that could affect the provision of care, such as a failure of the electricity and gas supply to the premises.

Staff we spoke with had an understanding of the principles of the Mental Capacity Act (MCA) 20015; this legislation provides legal safeguards for people who may be unable to make their own decisions. The registered manager had assessed the capacity of people who used the service to consent to the care and treatment they required. Where necessary, applications had been made to the local authority to ensure any restrictions in place were legally authorised under the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with were aware of their duties when these restrictions were in place.

Although care records were personalised and provided good information about the care people required, we found care plans had not always been reviewed and updated. Our observations showed that staff did not always provide support in accordance with the care plans for people who used the service

People gave positive feedback regarding the quality of the food provided in Branch Court. Systems were in place to ensure people's nutritional and health needs were met. We saw that staff would contact relevant professionals, if they had any concerns regarding the health of a person who used the service.

Systems were in place to help ensure people received the care they wanted at the end of their life. One of the professional visitors we spoke with spoke highly about the quality of end of life care provided by staff in Branch Court.

A timetable of activities was in place to help promote the health and well-being of people who used the service. We saw that people were supported to access local facilities and resources but not all people who used the service felt the activities on offer in Branch Court met their individual needs.

The registered manager had introduced a system to involve the relatives of people who used the service in reviewing the care provided in Branch Court. However, we noted it was not always evident that people who used the service had regular opportunities to provide feedback on the care they received.

People we spoke with told us they would be confident to raise any concerns with the managers or staff in the service. Relatives/friends we spoke with told us they found the managers to be approachable.

All the staff we spoke with told us they enjoyed working in Branch Court and considered they received the training and support they required for their role. Records we

Summary of findings

looked at showed regular staff meetings took place and were used as a forum to discuss required standards of care and improvements which could be made to the service.

There were a number of quality assurance measures in place in the service, including audits relating to care plans and medication records. The absence of the registered manager due to sick leave had led shortfalls in these audits. However a plan was in place to ensure all records were brought up to date following the registered manager's return to work.

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?
The service was not always safe.

The systems for managing medicines required improvement to ensure people always received their medicines as prescribed.

The system for reviewing and updating risk assessments needed to be improved to help ensure people were protected from the risk of unsafe or inappropriate care.

People told us they felt safe in Branch Court and that there were enough staff to meet their needs. Staff had been safely recruited.

Requires improvement

Is the service effective?
The service was effective.

Systems were in place to ensure staff received the training and support they required to deliver effective care. Staff were able to demonstrate their understanding of the Mental Capacity Act (MCA) and DoLS and their responsibility to support people to make their own decisions wherever possible.

People were able to access professionals and specialists to ensure their health needs were met.

People who used the service told us food was good and they were given sufficient food and drink to meet their nutritional needs.

Good

Is the service caring?
The service was caring.

People who used the service spoke positively about the attitude and approach of staff. We observed staff to be kind, caring and thoughtful in their interactions with people.

People were supported to receive the care they wanted at the end of their life.

Good

Is the service responsive?
The service was not always responsive to people's needs.

Although people told us they always received the care they needed, we observed staff did not always follow the information contained within care plans.

Systems to involve people who used the service in commenting on the care they received needed to be improved.

A programme of activities was in place but people we spoke with did not feel the activities on offer always interested them.

Requires improvement

Summary of findings

Is the service well-led?

Good

The service was well-led. The service had a manager who was registered with the Care Quality Commission and was qualified to undertake the role.

People we spoke with gave positive feedback about the leadership of the service.

Staff told us they enjoyed working at Branch Court and received good support from the managers in the service.

Branch Court 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 10 and 12 June 2015 and was unannounced.

On the first day of the inspection the inspection team consisted of two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of services for older people. On the second day of the inspection the service was inspected by two adult social care inspectors.

We had not requested the service complete a provider information return (PIR); this is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. However, before our inspection we reviewed the information we held about the service including the previous inspection report and notifications the provider had sent to us. We contacted the local authority safeguarding team, the local Healthwatch organisation and the local authority commissioning team to obtain their views about the service. None of the organisations we contacted raised any concerns about Branch Court.

On the first day of the inspection we spoke with four people who used the service and four visiting relatives/friends. We also spoke with the registered manager, the deputy manager, a senior carer, three members of care staff and the activity coordinator. In addition we spoke with two health care professionals who visited the service on the first day of the inspection. On the second day of the inspection we spoke with the deputy manager, a senior carer and the chef. We also spoke with a further three people who used the service.

We carried out observations in the public areas of the service. We looked at the care records for four people who used the service and the records relating to the administration of medicines for all the people who used the service.

In addition we looked at a range of records relating to how the service was managed; these included four staff personnel files, training records, quality assurance systems and policies and procedures.

Requires improvement

Is the service safe?

Our findings

All the people we spoke with who used the service told us they felt safe in Branch Court. Comments people made to us included, “It's safe in here”, “I've always felt safe with the staff” and “I've been here about 5 months. I like having people around. It makes me feel safe. I was unsafe at night at home. I know there's staff around when I need them.” All the visitors we spoke with told us they had no concerns about the safety of their relative/friends in Branch Court.

We looked at the systems for managing medicines in the service. We looked at the medication administration record (MAR) charts for all the people who used the service. We noted missing signatures for the night before the inspection on 11 of the MAR charts we reviewed. We discussed this with the deputy manager who advised us the member of staff on duty was new to the role of senior carer. The deputy manager advised us the member of staff concerned had received training in the safe handling and administration of medication and was also supervised by a more experienced carer who should have checked all records were accurately completed. We also noted the MAR chart for two people who used the service had already been signed to indicate they had received their medicines as prescribed at night time on 10th June, although we had reviewed the MAR charts prior to this time. The lack of accurate recording meant we could not be certain that people had received their medicines as prescribed.

We checked the stock of medicines held for four people who used the service against the MAR charts and noted minor not sure I would put slight maybe minor discrepancies in three cases. This meant there was a risk people had not received their medicines as prescribed. When we checked the stock of the controlled drugs held in the service we found these corresponded accurately with the records.

Most people we spoke with told us they received their medicines as prescribed. However one person told us they did not always feel they received their night time medication at the correct time.

During our tour of the building on the first day of the inspection we noted medicines for three people who used the service had not been stored as directed. This meant there was a risk these medicines would be unsafe or ineffective when administered.

We noted all staff responsible for administering medicines had received training for this task. The registered manager had also introduced a system for checking the competence of staff to safely administer medicines although this was not being completed on an annual basis.

The lack of robust systems to ensure the safe administration of medicines was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our observations in the communal lounge we noted one member of care staff appeared uncertain about the correct procedure for assisting one person who used the service to transfer from a wheel chair to a chair. They were observed to ask another member of care staff if the person required a walking frame to transfer. When this was confirmed they took a walking frame from those stored in the dining room and assisted the person to transfer. When we checked the walking frame used we noted it was labelled with another person’s name. We found that the walking frame belonging to the person who had been assisted to transfer was in their bedroom. The use of equipment not designed for the individual concerned meant there was a risk of unsafe care.

We looked at the care records for the person concerned and noted that their moving and handling assessment stated they were able to mobilise independently with the use of their walking frame. We raised this with the deputy manager and the fact that the person was being restricted from moving independently as they did not have the necessary equipment easily available to them. The deputy manager could not give any explanation as to why the walking frame was in the person’s bedroom other than the lack of storage space in the communal area.

The care records we looked at showed that risks to people’s health and well-being had been identified, such the risk falls or of developing pressure ulcers. We saw care plans had been put into place to help reduce or eliminate the identified risks. However, we noted that risk assessments had not been regularly updated on the care records we reviewed. This meant there was a risk people might receive unsafe or inappropriate care and was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us they had received training in safeguarding adults and records we looked at confirmed

Requires improvement

Is the service safe?

this. Staff were able to tell us of the appropriate action to take to protect people who used the service from the risk of abuse. Staff also told us they would feel confident to raise any concerns regarding poor practice in the service and considered they would be listened to by senior staff.

We looked at four staff personnel files and saw a safe system of recruitment was in place. The recruitment system was robust enough to help protect people from being cared for by unsuitable staff. The staff files contained proof of identity, application forms that documented a full employment history, a medical questionnaire, a job description and two references. Checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

Our observations and discussions with people who used the service and their visitors showed there were generally enough staff on duty to meet people's needs. Comments people made to us included, "There's a red light next to my bed. If I press that the staff come pretty quickly. Staff move pretty quickly to help" and "There's a lot of changing staff to look after you. It's never a long wait for attention." However, we noted on the second day of the inspection that there were no care staff available in the lounge area for a short period of time in the morning; this meant staff were unable to respond promptly to requests from people who used the service for assistance with personal care. The activity coordinator was available to support people to have their breakfast but was not qualified to deliver personal care. We were told they had come on shift early to cover for a care staff member who had rung in sick.

The registered manager told us the numbers of staff on duty had been increased due to the dependency needs of people who used the service. However, we discussed the deployment of staff with the deputy manager and the need to ensure a suitably qualified staff member was available at all times in the communal lounge area to ensure people's needs were met in a timely manner. They agreed to review this as a matter of urgency.

On the first day of the inspection we looked around all areas of the home and saw the bedrooms, lounge/dining room, bathrooms and toilets were clean and there were no unpleasant odours. However, we noted one occupied bedroom on the ground floor was being used to store five wheelchairs during the day. We were told the person who occupied the bedroom did not return there during the day but that this arrangement had not been discussed with them or a family member to secure their agreement. We were told there was a general lack of storage facilities throughout the home. On the second day of the inspection we noted all the wheelchairs had been removed and were now stored in either a corner of the dining room or in the bedrooms of their individual owners.

Records showed risk assessments were in place for all areas of the general environment and policies and procedures were in place in relation to ensuring compliance with health and safety regulations. The records also showed that the equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions.

We looked to see what systems were in place in the event of an emergency. We saw procedures were in place for dealing with any emergencies that could arise, such as utility failures and other emergencies that could affect the provision of care. We also saw that personal emergency evacuation plans (PEEPs) had been developed for all the people who used the service. Inspection of records showed that a fire risk assessment was in place and regular in-house fire safety checks had been carried out to check that the fire alarm, emergency lighting and fire extinguishers were in good working order and the fire exits were kept clear.

Good

Is the service effective?

Our findings

We looked for evidence that people who used the service had given consent before any care or support was provided. We saw that there were signed consent forms in place to indicate, wherever possible, people had agreed with their care plan. Where people lacked the capacity to make their own decisions, we saw family members and independent professionals had been involved in ensuring any decisions made were in the best interests of the individual concerned.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We therefore asked the registered manager how they ensured people were not subject to unnecessary restrictions and, where such restrictions were necessary, what action they took to ensure people's rights were protected. The registered manager told us of the correct procedure to follow to ensure any restrictions to people were legally authorised. At the time of the inspection there were 26 people subject to a DoLS authorisation. This was because most of the people who used the service were unable to consent to their care and treatment at Branch Court.

Records showed that not all staff had completed training in the Mental Capacity Act (MCA) 2005 However when we spoke with staff they were able to demonstrate they were aware of their duties when any restrictions were in place and had an understanding of the legislation and the need for them to support people who used the service to make their own decisions, wherever possible. One staff member said, "We let [people who use the service] do as much as they can in their own time; we only assist if they need help. I ask the residents what clothes they would like to wear and respect their wishes."

The four staff members we spoke with confirmed they had received an induction at the start of their employment at Branch Court. One staff member told us, "I had a good Induction, I shadowed 12 medication rounds until I was confident." Another staff member commented, "I have been here since it opened, on day one. I had a good induction, I went through care plans, and shadowed [experienced staff]."

Three of the staff we spoke with told us that they had received training in subjects such as fire safety, moving and handling, and health and safety; this was confirmed by the information on the staff training and development plan we reviewed. The registered manager told us they had identified any gaps in training and staff had been enrolled to complete the required courses.

From the four staff records we looked at we saw that supervision session had been carried out although there was no regularity in the timing of these supervisions. However staff told us they felt supported by senior staff in Branch Court. One staff member told us, "I can't speak highly enough about [the registered manager] or [the deputy manager]. They are always here if you need them." Another staff member said "I feel well supported. If I'm stressed I am able to go to [the deputy manager] or [the registered manager] or the seniors."

We saw that people had access to specialist health care professionals. During the inspection we spoke with a visiting district nurse about the skills and knowledge of the staff team. They told us, "Staff are really good here. There is a lot of respect for us district nurses. They call us instantly about skin issues and staff know the residents really well. I have no concerns and would be happy to have a relative cared for here." We also spoke to a community physiotherapist who commented "Excellent home, staff are very friendly and engage with people, residents seemed cared for."

On our last inspection in July 2014 we had concerns that the premises were not suitably adapted for the needs of people living with a dementia. On this inspection we noted significant improvements had been made. The communal areas had been decorated and the lighting improved. We saw that bedroom doors had been personalised and memory boxes installed outside each door to help people to recognise their own personal space. There was an area where people could sit out in good weather. During the inspection we saw one person being supported by staff to maintain the garden and take enjoyment in doing this.

People spoken with during the inspection made positive comments about the meals served in Branch Court including, "The quality of food is good", "Definitely plenty to eat" and "We always have cakes." We looked at the kitchen and saw people's dietary requirements, likes and dislikes had been noted. The kitchen was clean and had received a

Good

Is the service effective?

5 star rating from the national food hygiene rating scheme. We looked at the supplies of food and saw there was a good selection of fresh, frozen, dried and tinned foods available.

We spoke with the cook on the day of the inspection and they told us, “If residents don’t like the food on the day, they can choose something else.” This was confirmed by our observations during the inspection. We found that the food served looked appetising, balanced and nutritious. Everyone was given a hot or cold drink with their meal. People who required assistance to eat were provided with support from individual staff. We observed that staff sat next to people and talked with them during their meal time. This helped to make mealtimes an enjoyable and social occasion.

We looked at the systems for ensuring people’s nutritional and health needs were met. Care records we looked at showed people were weighed regularly and, where necessary, a log of their dietary intake was maintained. We also saw evidence that staff had made the necessary referrals to health professionals including speech and language therapists and dieticians and that any recommendations made had been incorporated into the relevant care plans.

Good

Is the service caring?

Our findings

People who used the service and the visitors we spoke with were very complimentary about the staff in Branch Court. Comments people made to us included, “The staff are pleasant. I think they do the best they can for me”, “When staff see I'm down they have a joke with me and cheer me up. They treat me with respect”, “Staff talk nicely to people and explain what they are doing. They make my family welcome and if we want privacy we go to my room” and “I'm made welcome when I come and am offered a drink. I do think staff are kind and caring and take time to speak with residents.”

Our observations during the inspection showed that staff were kind and respectful in their interactions with people who used the service. We noted one member of staff had brought a bookmark in for one person who used the service to help them with their reading. This member of staff had also taken time out of their shift to support a person who used the service to do some gardening at the service. They told us this meant they were a little behind with their cleaning duties but that they would stay later until all their tasks had been completed. This caring attitude of staff was confirmed by a visitor we spoke with who told us, “One carer in particular has helped us in her own time for my relative to attend a wedding. All the staff made the day special for my relative. They made her feel special when they dressed her and made her feel important.”

Care records we looked at included a ‘This is me’ document which had been completed with people who used the service. This included information about people’s life histories, family and interests. This information should help staff form meaningful and caring relationships with people who used the service. We noted that care records were held securely in a locked office; this helped to ensure that the confidentiality of people who used the service was maintained.

Staff we spoke with told us they understood the importance of person-centred care. One staff member told us, “I let people do as much as they can in their own time and only assist if they need. I ask residents what clothes they want and what they want to eat and respect their personal space.” Another staff member commented, “I always treat people as individuals.”

We looked at the comments people had made regarding the service their family member had received in Branch Court and saw these were all very positive. One person had written, “We are very satisfied with the care that [my relative] receives at Branch Court. All the staff members are attentive and helpful and have a professional approach to the work.” Another person had commented, “I find the staff all very hard working and really good with the people in their care.”

We observed there were several visitors to the service during the inspection. We noted that staff made all visitors welcome and took the time to chat with them.

We noted there was a system in place for staff to discuss end of life wishes with people who used the service. When we spoke with the district nurse who visited the service during the inspection they told us they were impressed with the compassion of staff and the quality of end of life care delivered in Branch Court.

Requires improvement

Is the service responsive?

Our findings

All the people we spoke with told us they received the support they needed. Comments people made to us included, “They [staff] give me the freedom to be as independent as I want”, “I get the care I want at the right time” and “I please myself when I get up.”

We found care records included good information about people’s needs, wishes and preferences and the level of support they required from staff. However, three of the four care records we looked at had not been reviewed on a monthly basis as required by the service. This meant there was a risk staff would not have access to the most up to date information about people’s needs.

Care records we looked at showed the registered manager had invited relatives of people who used the service to attend review meetings to discuss the care their family member received in Branch Court. We saw that comments from relatives had been recorded. However, we saw limited evidence that people who used the service had been involved in the review process. We discussed this with the deputy manager who told us they would take action to ensure people who used the service were always offered the opportunity to comment on the care they received and that any comments made were included in the review documents.

During the inspection we noted one person asked repeatedly to be taken to the toilet. We noted some staff responded sensitively to the requests whilst other staff did not acknowledge their requests. We looked at the care records for this person and noted it contained good information for staff about how best to support this person should they become repetitive in their requests for support with personal care. However, our observations showed that not all staff were following this care plan. We discussed this with the deputy manager who confirmed that staff should acknowledge all requests from the person concerned and provide the necessary support and reassurance at all times. They told us they would remind staff of the need to follow individual care plans to ensure people who used the service always received the support they needed.

We looked to see what activities were provided for people in Branch Court. We noted there was a weekly timetable in place which was organised by the activity coordinator employed by the service. On the day of the inspection we noted two people were supported to attend a local community centre to participate in a dementia friendly football group and a small group of people participated in an organised bingo session in the service. However, we received mixed views regarding the provision of activities in Branch Court. Comments people made to us included, “It's a bit boring in here. I don't like bingo. You can join in things if you want”, “We don't do anything really. We had bingo today. I'd like to play dominoes. I'd like to be taken out to a garden centre or even just shopping” and “I like reading. They put a little show on sometimes.”

We spoke with the activity coordinator about the activities they provided in Branch Court. They told us that, although there was a timetable in place, they were flexible to meet people’s wishes and preferences. They told us they would always speak with people who used the service and their relatives to find out their interests. They also told us they had been working relatives to put together memory boxes for people who used the service. Memory boxes are used to enable people living with a dementia talk about their family history and past events.

The registered manager told us staff supported people who used the service to participate in local events such as a regular tea dance held in the town centre. We were told there were plans in place for staff to support people on a trip to a local seaside resort. We saw that the local library also attended on a regular basis.

We noted there was a copy of the service user guide in each bedroom and that this contained information about how people could make a complaint if they were not happy with the service they received. A suggestions box and comments book were also available for people to provide feedback on the service provided in Branch Court. People we spoke with told us they would be happy to raise any concerns they had with staff and were confident they would be listened to.

We looked at the most recent satisfaction survey conducted by the service in May 2015. We noted the completed surveys contained positive feedback regarding people’s experience of the care provided in Branch Court.

The registered manager told us that although they had arranged meetings for people who used the service and their relatives to provide an opportunity to comment on the care provided in Branch Court, these had not been well attended. In an effort to improve communication with

Requires improvement

Is the service responsive?

relatives we saw that the registered manager was completing monthly newsletters which included information about activities which had taken place in Branch Court and planned future events.

Good

Is the service well-led?

Our findings

The service had a registered manager in place as required under the conditions of their registration with the Care Quality Commission (CQC). At the time of the inspection the registered manager had only recently returned to work following a period of ill health. They were supported in the day to day running of Branch Court by a deputy manager.

Five of the seven people we spoke with who used the service told us they were aware of the identity of the registered manager. One person told us, “I don't know the manager's name but I see her regularly on the shop floor.” Another person commented, “I think I know who the manager is. She's been ill for a few weeks. I could talk to her if I had a complaint.”

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be must be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

All the relatives/friends we spoke with were positive about the leadership of the service. Comments people made to us included, “I know who the manager is. I speak to her every day. She's absolutely approachable”, “I know the managers. They are both approachable and would want to know if anything was wrong and would put it right. The staff would be the same. They all work as a team” and “The manager is always helpful.” During the inspection we noted the registered manager maintained an ‘open door’ approach to all visitors and staff.

The registered manager told us they considered the key achievement since our last inspection had been the improvement in the environment. They told us the key challenge for the service was to maintain and build on the improvements already made.

We asked the registered manager to tell us how they monitored and reviewed the service to ensure that people received safe and effective care. We were told that regular checks were undertaken on all aspects of the running of the home. However, we found that some of these checks had not been sufficiently robust to identify some of the shortfalls in care records which we had identified during this inspection. We also noted that shortfalls in medication records had been identified on three consecutive audits. We were told the shortfalls in checks were due to the sick leave of the registered manager. We saw that arrangements had been put in place since the return to work of the registered manager to ensure all records were brought up to date.

Records we looked at showed regular staff meetings were held. We noted that these meetings were used as a forum to discuss the standards to which managers expected staff to adhere. The staff we had discussions with spoke positively about working at Branch Court. Comments staff made to us included, “We have a good team here. [The registered manager] is easy to approach” and “It’s brilliant working here. It’s the best job I’ve had; I get a lot of job satisfaction.”

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with the unsafe handling of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured that risk assessments relating to the health, safety and welfare of people who used the service were regularly reviewed and updated.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.