Carebase (Histon) Limited

Bramley Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 5 and 6 April 2016. At this inspection we found two breaches of the legal requirements. This was because the provider had failed to notify the local authority safeguarding team and the Care Quality Commission about a safeguarding incident that had taken place. The provider also did not make sure that there were sufficient staff to meet people's needs.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Bramley Court' on our website at www.cqc.org.uk.

Bramley Court provides accommodation, personal care and nursing for up to 67 people including those living with dementia. Accommodation is located over three floors with one unit per floor, called Damson, Pear and Cherry. There are communal areas for people and their visitors to use. There were 59 people living at the home when we inspected.

At the time of this inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At our focused inspection on 12 December 2016, we found that the provider had followed their plan, which they had told us would be completed by 3 July 2016, and legal requirements had been met.

People who lived at the home were supported by staff in a kind and respectful way. Staff understood their role and responsibilities to report poor care and suspicions of harm. The local authority safeguarding team and the Care Quality Commission were notified about any safeguarding incidents that had occurred within the home.

We saw that there was a sufficient number of staff to meet the needs of people living at the home. A dependency tool (people's assessed dependency support needs) was used by the registered manager to determine safe staffing levels.

Whilst improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating at the next comprehensive inspection.

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

We found that action had been taken to improve the safety of the service.

People were protected from harm because staff had an understanding of what might constitute harm and the procedures they should follow. This included reporting incidents to the local authority and Care Quality Commission.

There were enough staff to provide the necessary support and care for people.

This meant that the provider was now meeting the legal requirements.

Whilst improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating at the next comprehensive inspection.

Bramley Court

Detailed findings

Background to this inspection

We undertook a focused inspection of Bramley Court on 12 December 2016. This inspection was undertaken to check that improvements, to meet legal requirements planned by the provider after our comprehensive inspection on 5 and 6 April 2016, had been made.

We inspected the service against one of the five questions we ask about services: is the service safe? This was because the service required improvement under the question 'is the service safe?'

The inspection was undertaken by one inspector. Before our inspection we reviewed the information we held about the service. This included the provider's action plan, which set out the action they would take to meet legal requirements.

During the inspection we spoke with two people who lived at the home and two relatives of people living at the home. We also spoke with the business manager, the registered manager, a registered nurse and two care workers. We used observations to help us understand the care provided to people who had limited communication skills.

We looked at accident and incident records, safeguarding records, staff rotas and the dependency assessment tools, which were used to assess people's dependency needs.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection of Bramley Court on 5 and 6 April 2016, we found that not all safeguarding incidents had been report to the local authority and the Care Quality Commission, as required by the regulations and by local protocols. We also saw that there were not enough staff to meet people's needs.

During this inspection on 12 December 2016 we found that the provider had made the necessary improvements.

Staff told us that they had been trained in safeguarding and demonstrated to us their knowledge on how to identify and report any suspicions of harm or poor care practice. They were able to give us examples of the different types of harm and what action they would take in protecting people. This included the reporting of such incidents to their registered manager and/or any external agencies such as the CQC and the local authority. Records we looked at demonstrated to us that safeguarding concerns were now reported to the local authority and the Care Quality Commission.

Staff said that it had been made clear by the registered manager that there was to be no delay in reporting any safeguarding concerns. One staff member said the expectation was that if you had any concerns about suspicions of harm or poor care practice you "brought it to the attention of the [registered] manager, there and then….you don't delay." This showed us that there were now processes in place to report safeguarding concerns to the local authority for investigation and to notify the Care Quality Commission. This reduced the risk of harm to people living at the home.

We saw that there were sufficient staff on duty to meet people's care and support needs throughout our visit. One person told us that, "Staff are quick to respond to my [care] call bell… They answer the bell quickly." Another person said, "I wait about five minutes for staff to give me assistance." However a relative told us that staff were sometimes "rushed."

The majority of staff said that there was enough staff on duty to meet people's needs. One staff member told us, "There seems to be a lot of staff…there is nothing that doesn't get done." A nurse told us, "The registered manager checks every floor each day and checks that all staff are in [working]. It is much better now. I have enough staff to do everything that needs to get done." However, one staff member said that, "Sometimes weekends seem pushed [for staff numbers]. But everything gets done." Our observations showed that people's care and support needs were met in a timely manner by staff and care call bells responded to promptly.

The registered manager told us that they had no vacancies for staff. They said that they were trying to increase the number of bank staff available to reduce the need to use agency staff. Bank and agency staff were used to cover short notice staff sickness and annual leave. The registered manager assessed the number of staff required to assist people with higher dependency support and care needs using a dependency assessment tool. We saw written evidence that the decision making process to determine safe staffing levels was in conjunction with people's assessed dependency levels. This meant that there was a

process in place to make sure that there was sufficient staff on duty to meet people's assessed needs.