Savace Limited

Bramcote Hills Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 5 and 6 March 2015 and was unannounced.

Accommodation for up to 58 people is provided in the home over five floors. The service is designed to meet the needs of older people and provides nursing care.

At the previous inspection on 16 May 2014, we asked the provider to take action to make improvements to the areas of consent to care and treatment, care and welfare of people who use services and management of medicines. We received an action plan in which the provider told us the actions they had taken to meet the relevant legal requirements. At this inspection we found that concerns remained in all of these areas.

There was not a registered manager in place. The previous registered manager's registration had been cancelled in August 2014. The current manager had been

Summary of findings

in place for 14 months but was not available during the inspection. An application to register the current manager had been received at the time of the inspection and the current manager is now registered.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People felt safe in the home; however, processes were not always followed to protect people from the risk of abuse. Systems were in place for staff to identify and manage risks; however these were not always followed. Staffing levels met the needs of people who used the service and staff were recruited safely. Staff did not follow safe medicines management.

People were supported at mealtimes; however, systems to protect people from the risk of insufficient food and drink were not always followed. The home involved external professionals in people's care as appropriate, however, actions were not always taken to ensure people were fully supported to maintain good health.

The requirements of the Mental Capacity Act 2005 were not always fully adhered to. Staff received induction, training, supervision and appraisal but not all staff had attended all relevant training. Limited adaptations had been made to the premises to support people living with dementia.

Most people felt that staff were kind and caring. However, staff did not always respect people's privacy as records were not kept securely. Relatives were involved in making decisions about their family member's care and the support they received; however, people's involvement in their own care planning was limited.

People's needs were not always promptly responded to. There were not enough activities available and people were not supported to follow their own interests or hobbies. Care records did not always contain sufficient information to provide personalised care. Complaints were handled appropriately by the home.

People and their relatives could raise issues at meetings or by completing questionnaires but actions to address concerns were not clearly documented. A manager was in post but an application to register with the CQC had not been promptly made. There were systems in place to monitor and improve the quality of the service provided; however, these were not always effective. The provider had not identified the concerns that we found during this inspection.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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 consistently safe.

Safe medicines management procedures were not always followed. Appropriate action was not always taken to make sure people were protected from the risk of abuse.

Risk assessments were not always in place where necessary and checks to keep people safe were not fully documented. The premises was not always managed to keep people safe.

Staffing levels met the needs of people who used the service and staff were recruited by safe recruitment procedures.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported to eat and drink at mealtimes; however systems to protect people from the risk of insufficient food and drink were not always followed.

Staff explained to people what they were going to do before they provided care. However, people's rights under the Mental Capacity Act 2005 were not fully protected.

Staff involved other healthcare professionals if they had concerns about a person's health, however, systems to ensure that people maintained good health were not always followed.

Staff received induction, training, supervision and appraisal, however not all staff had attended all relevant training. Limited adaptations had been made to the premises to support people living with dementia.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's privacy was not fully respected as records were not stored securely.

Relatives were involved in making decisions about their family member's care and the support they received. However, there was limited involvement of people who used the service in their care planning.

Staff were compassionate and kind and treated people with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Summary of findings

People's needs were not always promptly responded to and people were not supported to maintain hobbies and interests. Care plans were generally in place outlining people's care and support needs however, they did not always contain sufficient information to provide a personalised service.

People were listened to if they had complaints and appropriate responses were given.

Is the service well-led?

The service was not consistently well-led.

Audits carried out by the provider had not identified all the issues found during this inspection.

Systems to ensure people and relatives were involved in the development of the service were not robust and a registered manager was not in place.

Requires Improvement

Bramcote Hills 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 5 and 6 March 2015 and was unannounced.

The inspection team consisted of three inspectors and a specialist nursing advisor with experience of dementia care.

Before our inspection we reviewed all the information we held about the home. This information included notifications. A notification is information about important events which the provider is required to send us by law. We contacted commissioners of the service to obtain their views on the service and how it was currently being run.

During our inspection, we spoke with four people who used the service and three relatives. We spoke with the administrator, six care staff, two nurses and the regional manager. We looked at the relevant parts of nine care records, three recruitment files, observed care and other records relating to the management of the home.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

When we inspected the home in May 2014 we found that medicines were not always managed safely. We found concerns regarding the administration and storage of medicines. At this inspection we found that concerns remained in this area.

Medicines were not always managed safely. People's medicine administration record (MAR) charts were not accurately completed to show that people received their medicines as prescribed. Changes to MAR charts were not signed by two staff as required to reduce the risk of mistakes. We also saw that 11 people's MAR charts did not have an accompanying photograph to allow staff to check they were giving medicines to the correct person. Information was not in place for all people on how the person liked to take their medicines and guidance was not in place for staff for 'as required' medicines. We saw that prescribed creams were not always stored appropriately and there was no documentation in place to evidence that prescribed creams were being applied to people.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding referrals had not been made to the local authority when required. We saw that one person who used the service had told staff that they had been slapped by another person who used the service but this had not been referred to the safeguarding team. We saw that another incident form recorded that staff had found an unexplained injury on a person when assisting them to get ready for bed and this had also not been referred to the safeguarding team.

We also observed that a person who used the service was not safely supported by staff when transferring from a chair to a wheelchair as they did not follow that person's plan of care correctly.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments were not always in place where appropriate. One person had a number of risk assessments which had not been completed including for the use of bedrails. Another person's choking risk assessment was not signed or dated. This meant that risks to people may not have been identified putting them at risk of avoidable harm.

We looked at the care records of a person who was at high risk of falls. Health and social care professionals had been involved and their recommendations were being followed by staff. However, we also saw that documentation was not fully completed to show that staff had regularly monitored people's safety when in bed. Their care records stated that they should be checked every three hours at night, however this was not documented as taking place at all times. This placed people at a greater risk of avoidable harm.

We saw there were plans in place for emergency situations such as an outbreak of fire. A business continuity plan was in place in the event of emergency; however, the home had not received an updated fire risk assessment since the opening of the new extension. We saw that a personal evacuation plan (PEEP) was in place for people using the service. However, the evacuation list was not up to date with the names of all the people using the service. Additionally, people's names were not on all bedrooms which could delay the effectiveness of the evacuation procedure in the event of fire.

Premises and equipment were not always managed to keep people safe. One person said, "Yes it's safe, but I don't feel safe with the lift that keeps breaking down – that frightens me." A relative told us that the home needed another lift. We saw that the lift had broken down and in one case was out of order overnight. However, a lift contingency plan was in place in case of further problems.

We saw that bedrail protectors were not in place for one bed with bedrails. We saw that the person in the bed had their face resting on the bedrails. This was a concern because they may have suffered skin damage as a result of resting directly on the bedrails. We saw that two people in bed did not have their call bells within reach and that nail varnish remover was left unattended by a person who used the service. This placed people at risk of avoidable harm.

Requires Improvement

Is the service safe?

Appropriate checks and maintenance of the equipment and premises were generally taking place. However, there was no legionella risk assessment in place which meant that there was a greater risk of people being put at risk of avoidable harm.

A relative told us that there were not always enough staff which led to a delayed response. However, they told us that people were not put at risk as a result. Another relative told us that staffing was good during the week but, "A bit stretched at weekends." Staff had mixed views on staffing levels. Four staff told us that staffing levels were fine, two felt that they were "Short at times." However, they did not feel that people were put at risk as a result.

Staff were accessible throughout the day which suggested that there were sufficient staff on duty to meet people's needs. However, we observed that one person did not receive prompt care from staff.

Staff were recruited using safe recruitment practices. We looked at three recruitment files for staff recently employed by the service. The files contained all relevant information and appropriate checks had been carried out before a staff member started work.

People told us they felt safe in the home. A person said, "It is safe, there are no dangers here." Relatives told us that people were safe. Staff told us that they had attended safeguarding adults training. We saw that the provider's safeguarding policy and procedure contained appropriate detail.

Relatives told us that their relatives received medicines when they needed them. We observed that people received their medicines safely. We saw that medicines were stored securely and the temperatures of the room and fridge where medicines were stored were checked daily. Staff received medicines training and had their competency assessed to give medicines.

Requires Improvement

Is the service effective?

Our findings

When we inspected the home in May 2014 we found that assessments of capacity and best interests' documentation were not in place for people who lacked capacity. At this inspection we found that some improvements had been made but more work was required.

Staff had a mixed understanding of the requirements of the Mental Capacity Act (MCA) 2005, an Act introduced to protect people who lack capacity to make certain decisions because of illness or disability. Two staff had a good understanding of the MCA, however four staff did not. Two staff told us that they had not received any MCA training. Training records showed that not all staff had received MCA training.

We saw assessments of capacity and best interests' documentation were not always in place for people who lacked capacity. One person had capacity documentation completed for a number of areas of care; however, two assessments were undated. Another person also had capacity documentation completed for a number of areas of care; however, they did not have the documentation completed for the use of bedrails. This meant that there was a greater risk that people's rights were not being protected.

Appropriate actions were not always taken to ensure that people were supported to eat and drink enough. One person's care records contained an entry stating that supplement drinks would be ordered for the person who was recorded as losing weight. We asked staff who confirmed that the drinks had not been ordered. Two people's care plans stated that they should be weighed weekly as they were losing weight but we did not see evidence that the weekly weights were taking place.

Documentation was not always fully completed to ensure that people's nutrition and hydration needs were met. We saw that food and fluids charts were not always fully completed. This meant that there was a greater risk that problems with people's nutrition and hydration intake would not be promptly identified and action taken. We looked at the care records for people at risk of skin damage. We saw that one person was identified as requiring a specific mattress for their bed and a specific cushion for sitting in an armchair. We saw that the mattress and cushion were in place. However, a health and social care professional had advised that the person should be assisted to stand every hour when sitting in an armchair and to have two hours bed rest in the afternoon. We observed the person sitting in their chair for four hours without being assisted to stand and there was no evidence in their records of bed rest.

We saw that another person's care records noted that their position should be changed every two hours at night. Repositioning charts were not fully completed to show that the person was receiving care in line with their care plan. Another person with a pressure ulcer did not have a wound care plan in place. Additionally, their repositioning charts were not fully completed to show that the person was receiving care in line with their care plan. We also saw that the urinary output for a person with a catheter had not been recorded for four days. This meant that there was a greater risk that problems with the catheter would not be promptly identified by staff.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. Staff told us there was no one currently living in the home that was being deprived of their liberty. One staff member had a good understanding of DoLS, six staff did not. Training records showed that not all staff had received DoLS training. This meant that there was a greater risk that people's rights were not being protected as staff were less likely to be able to identify when a DoLS application was required.

We looked at the care records for five people who had a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) form in place. Three forms were correctly completed, however, two forms were not completed to show whether the person had been involved in the decision. One of the forms also did not have a review date. This meant that there was a greater risk that the person's rights were not being protected.

Requires Improvement

Is the service effective?

A relative told us that their relative saw other professionals where necessary. Care records showed that other health and social care professionals were involved in people's care as appropriate. However, a health and social care professional told us that it was difficult to get good quality information from the home and they had to repeat recommendations made to staff to ensure they were followed. We saw that one of the communication books for staff had not been completed for two weeks and the regional manager told us that the provider's handover sheets were not being completed by staff. This meant that there was a greater risk that health concerns would not be acted upon and advice from professionals would not be communicated to, and followed by, all staff.

People did not raise any concerns regarding the competence of staff. One person said, "They do a lot of training here, because they tell me they do and they seem to know things." A relative told us that staff knew what they were doing.

Almost all staff told us that they had received an induction and supervision. Records showed that staff had received an induction. We reviewed the supervision and appraisal records of four members of staff. Three of the staff had received appropriate supervision and appraisal; however, a nurse had not received clinical supervision from another clinically trained staff member. This meant that the nurse was less likely to receive effective supervision. We looked at the training matrix which showed that not all staff had attended all relevant training. This meant that there was a greater risk that staff would not have the knowledge to be able to effectively meet people's needs.

We saw that limited adaptations had been made to the design of the home to support people living with dementia. Toilets and communal rooms were identified by signs and symbols, however, there was little directional signage to aid people to orientate themselves or move around the home independently. Not all bedrooms had people's names on them.

A relative told us that staff explained what they were doing when helping people. We observed staff explained to people what they were going to do, before they provided care.

One person said, "The food is better some days than others. The pork casserole was very nice today." A relative said, "It's basic food but it's alright. [My relative] has enough to eat and drink." They told us that their relative was supported appropriately by staff at mealtimes. Another relative told us that the food was good. We observed that people had drinks within reach and were offered snacks between meals. People were appropriately supported at mealtimes by staff.

Requires Improvement

Is the service caring?

Our findings

We observed that people's care records and other correspondence were not always stored securely. We observed that the door to one of the rooms where care records were stored was unlocked and open and the room was unoccupied on a number of occasions. This room was entered through a communal area where people and their relatives had access. We also saw that confidential information had been left outside a person's bedroom. This was not moved despite being brought to staff members' attention. This meant that people's privacy was not always respected by staff. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A visitor told us that their relative was treated with dignity and respect. We observed staff treating people with dignity and respect. We saw staff knocking and waiting before entering people's bedrooms and staff could explain how they maintained people's privacy and dignity. However, we saw that one person was in need of attention to personal care. We noticed this even though one of the care staff had just moved the person to the dining table and had not noticed. We told staff that the person needed attention and staff supported the person appropriately.

A relative told us that staff encouraged their relative to be independent where possible and we saw that people were supported to be independent at mealtimes. A visitor told us they could visit when they wanted to and we saw friends and relatives could stay with people as long as they wanted to. The information guide for people who used the service contained details which confirmed this.

People told us that staff treated them with kindness. One person said, "They couldn't care more about us." One person told us that there were a mixture of caring staff and those that were not bothered. A health and social care professional told us that staff were caring. Two relatives said, "Staff are kind." They told us that staff knew their relative well.

We observed interaction between staff and people who used the service and saw people were relaxed with staff and confident to approach them throughout the day. Staff interacted positively with people, showing them kindness and compassion. We discussed the preferences of people who used the service with care staff. Staff had a good knowledge of people's likes and dislikes.

On admission to the home the provider took into account and explored people's individual needs and preferences such as their cultural and religious requirements. This meant that people's diverse needs were being assessed. A relative told us that their relative attended church services in the home.

We saw that one person was blind and was listening to a talking book which staff had put on for them. We also saw that staff clearly explained to the person where their food and drink had been placed on a table in front of them.

We saw that basic Polish words were displayed on a person's bedroom wall to support staff to assist a person's whose first language was not English. However, we also observed that this person had no interaction with any staff. A staff member told us that one of the care staff could communicate with the person, but that person was not on duty and it was not known when they would be.

We saw that one person had been involved in a review of their care and we saw involvement of relatives in people's care. However, most people were not involved in their care and we saw that no advocacy information was available for people if they required support or advice from an independent person.

Requires Improvement

Is the service responsive?

Our findings

When we inspected the home in May 2014 we found that care plans were not always in place for identified needs. At this inspection we found that concerns remained in this area.

We saw that three people's care records did not contain sufficient information to provide effective guidance for staff about how to meet the person's personalised needs. Information about these people's life history and important things in their lives had not been noted. This meant that their needs may not have been fully identified to allow staff to provide personalised care.

Care plans were reviewed regularly and care plans were generally in place for people's needs. However, we saw that one person's care records did not include information on how to identify whether their health was deteriorating as a result of their diabetes. Another person's care records did not include information on how to identify whether their health was deteriorating as a result of their epilepsy.

A relative told us that staff were responsive to their relative's needs. A health and social care professional told us that staff were responsive to people's immediate needs. However, we saw that people's needs were not always responded to promptly. We observed a person became distressed and it was confirmed by their relative that they needed to go to the toilet. This person was not taken to the toilet for 40 minutes. This meant that this person's needs were not responded to promptly by staff.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people whether they were supported to follow their preferred hobbies or interests. One person said, "I like the quizzes, but they don't come to do them very often." Another said, "We have a quiz and some poems every second Tuesday – that's worth going to. I also like to go down to the lounge when the singer comes in." Another person said, "They [staff] sometimes take me outside." One person told us the activities people were very good and took people for a walk around sometimes as well as organising the entertainers and Autumn Fayre.

We observed limited activities taking place during our inspection and saw limited evidence of people being supported to follow their preferred hobbies or interests during our inspection. One relative told us there had been a big increase in activities over the last six months. However, five staff told us that there were not enough activities available for people who used the service. A staff member said, "I would like to take people out more." Another staff member said, "People don't go out enough."

A relative told us that they knew how to make a complaint. The complaints procedure was displayed in the reception and on some corridors but it was quite difficult to read; however it was also included in the guide provided for people who used the service. We looked at recent complaints and saw that they had been investigated and responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

We looked at the processes in place for responding to incidents, accidents and complaints. We saw that incident and accident forms were not always well completed. We saw that appropriate notifications were not always made to us where required by law.

Audits were completed by the manager and also representatives of the provider not directly working at the home. Audits had taken place, however, these were not always accurate and action plans were not always in place to address identified concerns. We identified a number of shortcomings during this inspection which had not been identified by the provider or had been identified but actions had not been taken to address the issues by the time of the inspection. These shortcomings constituted breaches of a number of regulations.

These were breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us they had completed a questionnaire recently. A relative told us that they attended relative meetings although there had not been one since November 2014. They also told us that they had completed questionnaires. We saw that the last meeting for people who used the service had taken place in July 2014. We saw that the last relatives' meeting in January 2015 had noted concerns about activities but it was not clear what action had been taken. We saw completed relative questionnaires which raised a number of issues but they were undated and it was not clear what actions had been taken in response. We saw completed questionnaires from people who used the service. It was not clear what actions had been taken in response to any issues identified.

We saw that the provider's set of values were in the information guide provided for people who used the service. A whistleblowing policy was in place and contained appropriate details. Staff told us they were happy to raise concerns. However, we saw that a staff member had raised issues but that documentation in response to these concerns was incomplete and it was unclear whether a thorough investigation had taken place.

A person told us that the manager never came to see people and was always preoccupied or not in the building. They told us that even if people requested to see her, she was not available. The person said, "The manager just doesn't know people's needs." A relative told us that the manager was a nice person but, "[They] don't have a high profile in the home." Another relative said the home, "Needs more visible leadership."

We saw that a staff meeting had taken place in June 2014 and the manager had clearly set out their expectations of staff. Most staff felt well supported by the manager, however, one staff member said, "Supportive when she's here, but she's only here a couple of days a week." The manager was working across two of the provider's homes providing management support; however, the provider had taken steps to recruit a manager for Bramcote Hills Care Home.

There was not a registered manager in place. However, an application to register the current manager had been received at the time of the inspection and the current manager is now registered. The previous registered manager's registration had been cancelled in August 2014. The current manager had been in place for 14 months. This meant that an application to register the manager had not been made promptly as required.

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 **The registered person must ensure the proper and safe management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Systems and processes must be established and operated effectively to investigate, immediately become aware of, any allegation or evidence of such abuse.**

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The care and treatment of service users must be appropriate, meet their needs and reflect their preferences.**

The enforcement action we took:
We served a warning notice on the provider with a timescale for compliance of 15 May 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.**

The enforcement action we took:
We served a warning notice on the provider with a timescale for compliance of 29 May 2015.