Barron Kirk Quality Care Limited

Bryher Court Nursing Home

Inspection report

85 Filsham Road
St Leonards On Sea
East Sussex
TN38 0PE

Tel: 01424444400

Date of inspection visit:
21 March 2016
22 March 2016
23 March 2016

Date of publication:
02 June 2016

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Bryher Court Nursing Home is registered to provide nursing care for up to 45 older people. There were 38 people living at Bryher Court at the time of the inspection. People required a range of care and support in relation to living with memory loss, dementia, nursing and personal care needs.

Accommodation is arranged over three floors, and access to each floor can be gained via stairs or the two passenger lifts.

This was an unannounced inspection which took place on 21, 22 and 23 March 2016.

Bryher Court did not have 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 2008 and associated regulations about how the service is run.

An acting manager had been appointed and had worked at the service since December 2015. The acting manager told us they would be starting their application to register as manager in the near future.

This inspection took place to follow up on previous breaches identified at the inspection in March 2015. Two regulations which were in breach at the last inspection had been met at this inspection; however, we found four continued breaches and two new further breaches of regulation.

The provider sent us an action plan following the previous inspection telling us the actions they would take to ensure they met regulations. However, we found that these had not been completed to ensure the provider met all registration requirements.

The provider did not have a system in place to continually assess and monitor the quality of service provided. A number of areas identified in the last inspection had not been addressed by the provider to ensure the service met regulations. People's safety had not been maintained as a number of required checks and risk assessments had not been completed. This included water temperature checks to all areas of the home, legionella risk assessments completed by an appropriately trained professional to access and monitor the risk of water borne infection. Personal appliance testing (PAT) testing was not up to date and some electrical items had no evidence of ever being checked to ensure they did not present a safety or fire risk to people. Fire risk assessments and personal emergency evacuation plans (PEEPS) were not in place for everyone living at Bryher Court. This meant people's safety had not been maintained.

Although recruitment systems were in place. Induction information for trained staff had not been completed. There was no evidence to show how RNs competencies had been assessed and reviewed. Some staff had not received required 'in-house' training before working unsupervised. This included fire training, which had not taken place since 2013. Training records had not been maintained and it was not possible to

get a clear picture of when staff had attended or training needed to be updated.

People's care plans and other care related documentation, including charts and risk assessments had not been completed consistently to ensure information about people was current and accurate. When incidents had occurred these had not been documented in people's care files to ensure all staff were aware of wounds and treatment required. Care plans currently in place for people did not reflect recent changes to care and people's daily notes were task orientated, and did not evidence person centred care. Information about people's care and nutritional needs were displayed on bedroom walls and in public areas. We found that some wording used did not take into consideration people's privacy or refer to their care needs in a dignified manner.

Medicine procedures needed to be reviewed to ensure they were following best practice guidelines and ensure people received their medicine in a safe and consistent manner; documentation around the application of topical creams was not consistent.

A system of supervision had been introduced and staff told us they felt supported. The acting manager was also in the process of introducing a variety of staff meetings to ensure staff were kept informed of any changes. We saw that staff knew people well and displayed kindness and compassion when providing care. Relatives felt informed when changes had occurred and told us they felt welcome to visit at any time.

A complaints procedure had been implemented since the last inspection. People felt able to talk to staff and told us they would speak to any of the staff if they had any concerns.

People were encouraged to spend their time how they chose. A varied activity programme was available for people and we saw people walking around the service, accessing the garden or sitting in their room as they chose.

Meals were well presented and people told us that meals provided were of a good standard, with alternatives available if they did not like what was on the menu that day. People's weights were regularly monitored, with a weights tracker in place to identify any changes and people were referred to other health professionals if required.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Safety checks and risk assessments had not been completed. This included fire, water temperatures and legionella.

Maintenance of services and equipment including electrical appliance (PAT) testing, water checks, maintenance of lifts and other services had not been completed.

Staff had not received fire training. Individual and environmental fire risk assessments needed to be reviewed to ensure people's safety was maintained.

Medicine procedures for 'as required' (PRN) medicines and medicines administration records (MAR) paperwork needed to be improved to ensure prescriptions were clear.

The response to accidents, incidents and wounds was not consistent. Individual risks to people were not always identified to ensure people remained safe at all times.

Staff recruitment files contained appropriate information to show that a new system was in place.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Some staff were working without an appropriate induction and training. Professional clinical competencies had not been assessed.

Not all decisions around MCA and DoLS were clearly documented in people's care files. Further training was required to ensure that all staff and management were aware of current guidance and protocols.

There was a programme in place to ensure staff received regular supervision.

People enjoyed the meals provided. Meal choices were available

and people were encouraged to maintain a balanced diet. People's weights were monitored.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not treated with dignity. Information was displayed in public areas and peoples rooms that used inappropriate terminology around peoples care and support needs.

Staff knew people well and displayed kindness and compassion when providing care.

Relatives felt welcome to visit and all times.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care and support documentation had not been completed consistently to ensure information about people was current and accurate. Care plans currently in place for people did not reflect recent changes to care.

Daily notes were task orientated, and did not evidence person centred care. When a person had an injury no evidence was seen regarding this in their daily records.

A complaints procedure was in place.

A varied activity programme was available for people.

Is the service well-led?

Inadequate

Bryher Court was not well led.

There was no registered manager in post. A newly appointed acting manager had worked at the service since December 2015.

Bryher Court did not have a robust system in place to continually assess and monitor the quality of service provided. A number of areas identified in the last inspection had not been addressed by the provider.

Some meetings had taken place and further staff meetings were planned.

Bryher Court Nursing 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 which took place on 21, 22 and 23 March 2016 was unannounced and was undertaken by two inspectors.

The last inspection took place in March 2015 where a number of breaches of regulation were identified.

Before the inspection we looked at information provided by the local authority. We reviewed records held by the CQC including notifications. A notification is information about important events which the provider is required by law to tell us about. We also looked at information we hold about the service including previous reports, safeguarding notifications and any other information that has been shared with us.

Many people living at Bryher Court Nursing Home were able to tell us about their experiences of living at the home. For those who were not able to talk to us, we carried out observations in communal areas and looked at care documentation to see how they had their care provided. We looked at the care documentation for four people and daily records, risk assessments and associated daily records and charts for a further three other people living at Bryher Court Nursing Home. All Medicine Administration Records (MAR) charts and medicine records were checked. We read diary entries and other information completed by staff, policies and procedures, accidents, incidents, quality assurance records, recruitment and weight trackers, meeting minutes, maintenance and emergency plans. Recruitment files were reviewed for four staff and records of staff training, and supervision for all staff.

We spoke with seven people using the service and eight staff. This included the acting manager, RN's, care staff and other staff members involved in the day to day running of the service.

We spoke with three relatives and two visitors to the home. Much of the feedback received was positive, with a few minor grievances regarding issues which had occurred. For example items of clothing going missing,

or meals needing to be warmer.

Inadequate

Is the service safe?

Our findings

People living at Bryher Court had a range of care and nursing needs. Many were reliant on staff for all their personal care and support needs. Others were more independently mobile but required prompting, nursing care and support throughout the day. People who lived at Bryher Court, visitors and relatives told us that they felt people were well looked after and that the home responded to health changes to keep people safe.

Despite this positive feedback we found that systems in place regarding the on-going safety of services and equipment to the home had not been suitably maintained.

At the previous inspection in November 2015, the provider was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because equipment was untested and uncertified as fit, serviceable and safe to use. An action plan was submitted by the provider that detailed how they would meet the legal requirements by
December 2015. It informed CQC that all documents relating to equipment for contracts/servicing and supply would be kept at Bryher Court. At this inspection we found improvements had not been made and the provider was still not meeting this regulation.

Providers must ensure the safety of their premises and equipment within it. The action plan received from the provider stated that a new robust calendar timetable would be implemented to ensure dates were highlighted when service contracts for equipment and safety checks were due. However during this inspection we found a number of equipment and service checks had not taken place. Personal Appliance Testing (PAT) had not been completed throughout the home since 2014, with a number of items showing no evidence of checks ever having been completed before they were used within the home. Electrical items being used within a care setting which have not been appropriately checked to ensure they are safe to use means peoples safety had not been maintained.

Legionella checks had not been completed. The provider had failed to ensure that a legionella risk assessment had been completed by an appropriately trained professional to identify areas of risk in relation to water contamination and regular maintenance of the water system. The provider had failed to assess the risk of legionella and prevent the risk of infection. This put people at risk. Water temperature checks had not been completed in the home since August 2015. This included safety checks to ensure appropriate temperatures were in place for all taps and showers used by people living at Bryher Court, visitors and staff. This meant people could be at risk of scalding or burns if safe temperatures had not been monitored and maintained.

There was no evidence that regular maintenance had taken place for equipment including the two passenger lifts which were in daily use. The acting manager did not know if servicing had been done. The provider were unable to tell us when servicing had last been competed or locate any documentation to show when this had taken place or when the next servicing was due. This meant that the provider had not ensured that equipment was properly maintained to ensure peoples safety.

A new maintenance employee had been begun work at Bryher Court in January 2016 and they had identified that a number of areas in relation to maintenance and servicing were not in place or out of date. However, they told us they had had to wait for equipment to be calibrated before they could start checks. It was unclear how long this was going to take. We were shown a maintenance folder. This included previous paperwork some of which dated back to 2009, this was not in any order and did not evidence any plan or structure to the maintenance. There was paperwork which we were told should have been completed for water temperatures and legionella checks, however, no information had been documented. Certificates could not be located to prove if or when maintenance and servicing had taken place. The acting manager was unable to tell us if any water temperatures or legionella risk assessments had been completed. The provider was contacted and they stated that a risk assessment was in place for legionella. However, this had not been completed. The maintenance employee had started a new maintenance plan to address some of the shortfalls identified but confirmed they still had a lot of areas to cover to ensure all safety standards were met. This included PAT testing and water temperatures in people's rooms and communal areas but these could not be started until the equipment had been calibrated and was fit for purpose.

Although the new maintenance employee was in the process of identifying safety concerns, the provider had failed to ensure systems were in place over the previous 12 months to identify and ensure premises and equipment had been properly maintained, this presented a risk to people's safety. Equipment and services were untested and uncertified as fit, serviceable and safe to use and this is a continued breech in relation to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people may be at risk as a fire risk assessment for the building and staff fire training was out of date. The fire risk assessment had not been reviewed since 2014 to identify if any changes were required. Not everyone currently living at Bryher Court had up to date evacuation information in place in the event of a fire or emergency evacuation. Staff fire training was out of date with some staff not having attended any fire training since starting work at Bryher Court. Other staff had not had any fire training updates since 2013. Staff we spoke with told us they had not had fire training for some time and were unaware when their other mandatory training was due. Further training including mandatory training required when new staff began work had not been completed for all new staff. It was therefore unclear how the provider had an overview to ensure all staff were competent and had the skills and experience to provide care safely to people.

Care staff demonstrated a good knowledge around how to recognise and report safeguarding concerns and told us they could also contact the manager or RN on duty if they had concerns.
The manager was aware of the reporting procedure for any safeguarding concerns and a safeguarding policy was available for staff to access if needed. However, not all staff had received safeguarding training.
We found that not all nursing staff were aware of the correct reporting of accidents and incidents. We saw that one person had recently had an accident at the home which had resulted in a significant injury. The registered nurse on duty at the time had not documented the incident in the person's daily records, no body map or wound care plan had been completed. There was no report completed to the local authority and the incident form completed did not include any details regarding the size of the wound, actions taken and further follow up required for the injury. We spoke to an RN who told us that the wound had been mentioned in the handover at the end of the shift when the incident took place. However, this had not included details of the size of the wound. Documentation had been written by another RN when the first dressing change took place two days after the wound was sustained. We read all daily records for this person for the days following the incident. No mention was made of the injury, there were no details of follow up checks by staff during care provided for the individual, whether the person was experiencing any pain or discomfort or any risk assessments implemented or reviewed after the incident. Incidents that affect the health, safety and welfare of people using the service must be reported internally, and to relevant external authorities. Care and risks must be reviewed by competent staff and the situation monitored to prevent further re-occurrence

and make sure improvements are made as a result. Staff who were involved in incidents should receive information about them and this should be shared with others to promote learning.

Systems in place for the safe administration of medicines needed to be improved. Policies for medicines including 'as required' medicines known as PRN medicines were in place however, PRN protocols had not been completed for all medicines being given to people. Protocols should be in place for each PRN medicine prescribed to inform staff what the medicine is for and the correct dosage. We found that PRN medicines were being signed for on the medicines administration record (MAR) however, no information was being completed on the rear of the MAR to identify the dosage, time of administration and why the medicine had been given. This ensures that any new health related concerns can be easily identified and follow up visits from GPs can be arranged in a timely manner if required. This meant that people may not receive their medicines in a clear and consistent manner regardless of who is administering them. We found one medicine which was out of date and this was removed by the RN from the cupboard immediately. We were told that a number of checks on stock and equipment took place but not all of these were documented. MAR charts needed to be tidied; pages were falling out of the folder which meant it could get lost. Some prescription information for people was difficult to read due to paperwork becoming torn and creased. We also found that charts used to document the application of medicines in the form of creams and maps to show where creams should be applied where not completed clearly. Gaps where found when it was unclear if the creams had been applied. Additional creams added to lists and body maps had not been dated so it was unclear when changes had started. Medicine procedures needed to be improved to ensure people received their medicines safely.

The above issues in relation to staff competencies, correct reporting and documentation of incidents and medicines are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Processes were in place for the safe ordering, storage and disposal of medicines. We observed medicines being administered and saw that this was done safely. We were told that no one currently looked after their own medicines, but there were policies in place regarding this if someone wanted to. Further polices were in place relating to controlled medicines, homely remedies and covert medications.

Dependency assessments were completed in people's care files, the acting manager told us that this was to determine safe staffing levels. However, it was unclear how this information was used. The acting manager told us that the form provided an overall score for people in relation to their care needs. There was no analysis of this score or information to show how this corresponded with current staffing levels. Staff told us that most people needed assistance with personal care and many required the assistance of staff for moving and handling and care needs. People whose needs were higher were assessed to require support by two care staff when repositioning, using equipment to aid mobility or for personal care. Staff told us that staffing levels seemed appropriate at the moment to meet people's needs. One told us, "It's busy but we manage, you just need to be organised." It was unclear how the provider had reviewed and monitored staffing levels to ensure they were appropriate.

Staff told us they felt they had time to spend with people when required. We saw that people had call bell systems in their rooms and call bells were fitted in toilets and bathrooms. People told us that when they used their call bell staff responded. One person told us, "They come as quickly as they can, it depends if they are busy, but they always pop in to say they won't be long." We saw people who were independently mobile but just needed a staff member to support and reassure them had this provided.

At the previous inspection in November 2015, the provider was in breach of Regulation 19 of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because appropriate checks and references were not in place in staff recruitment files. An action plan was submitted by the provider that detailed how they would meet the legal requirements by December 2015. At this inspection we found that improvements had been made. References were in staff files; this included the most recent employer or education provider. Disclosure and Barring checks (DBS) recorded before people started work and interview information documented. Further systems had been introduced to ensure that an appropriate recruitment procedure was in place.

Requires Improvement

Is the service effective?

Our findings

People felt that staff responded to their changing needs. Visitors told us they were kept informed when their friend had become unwell. Relatives told us that other healthcare professionals had been contacted when a person became unwell, and they, "Were always told what was going on."

Despite this positive feedback we found areas of concern during this inspection.

At the previous inspection in November 2015, the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because supervision and appraisals had not taken place. An action plan was submitted by the provider that detailed how they would meet the legal requirements by September 2014. During this inspection we found that this area of the breach had been met as a system had started and was on-going to provide regular supervision for all staff. However, further areas were identified as a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the training records for registered nurses (RNs) we saw that five RNs had not completed all their mandatory training. One of these had been working at Bryher Court Nursing Home since November 2014. Two had started work in August 2015, one of these had no completed mandatory training and the other had attended safeguarding training in 2015. Another RN who began employment in January 2016 and was working unsupervised had only attended one training which was for moving and handling. There were no evidence and the acting manager was unaware if they had attended any other training. This included safeguarding, fire, mental capacity and basic food hygiene training. The acting manager told us that they did not think the training schedule was up to date.

When new RNs had started work they had not completed an induction. In some files we saw that an initial induction checklist had been ticked on their first day to show they had been shown policies, and general topics had been discussed including a tour of the home and introduction to staff and service users. However, no further information was available to evidence they had completed a period of induction at the home or completed appropriate 'in-house' training. There was no information to show that newly employed RNs competencies had been assessed to ensure they were safe to work unsupervised at Bryher Court. Further concerns were identified in relation to staff training. We found that the training programme at Bryher Court Nursing Home had not been kept up to date. The acting manager showed us a pile of certificates for staff, there was no clear system to show when staff had attended, failed to attend or were out of date with required training. This meant that the provider had not ensured that RNs and care staff were suitably qualified, competent, skilled and experienced to make sure that they can meet the needs of people living in the service. This meant that people may be at risk if staff were not appropriately assessed as competent to provide nursing care. This is a further breech of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The training schedule identified that a number of staff had not had any training around MCA and DoLS since 2014. There was no record of when the acting manager had attended training. Information was available to

support MCA and DoLS for example policies and procedures in place, but staff demonstrated some gaps in their knowledge around this subject. Mental capacity assessments had been completed to support some decisions around peoples care, treatment and support. Care documentation reminded staff to remember that even if a person had been deemed to lack capacity to go out alone they should be asked if they were in pain so pain relief medicine could be provided, and involved in day to day decisions about how they spent their time. However, when a best interest decision had been made this information was not in the persons care plan, but in a sealed envelope in the manager's office. Two members of staff were aware a best interest decision had been made but were unclear of its purpose. Staff gave us differing opinions as to why a DoLS had been put in place for this person. The staff were aware that further information was in the manager's office, but not of the contents. This was an area that needed to be improved to ensure all staff were aware of the specifics around any decisions made regarding people's capacity and the rationale behind all decisions made in a person's best interest.

Care staff had completed a period of shadowing and induction. At the end of the induction, documentation had been signed by senior care staff to evidence that they had observed the inductee carrying out a range of care tasks. Once deemed appropriate to provide care alone they had been signed off as competent.

Staff told us that they had supervision and we saw that a programme had been implemented and was on-going. Staff felt able to speak to the manager if they had any concerns. The acting manager told us they would be training senior staff to carry out supervision on others to ensure that the programme was sustainable and people received regular supervision and support.

People were supported to maintain a balanced and nutritious diet. People's weight and nutritional intake were monitored. The acting manager had implemented a weights tracker to identify when people's weights changed and whether further actions were required. Staff told us if someone was not well or not eating much then this information would be fed back to the RN on duty and at handover. Any changes to weights would then be monitored and reported to other health professionals if required. We saw that the tracker was in use and that changes to people's weights had been noted by the acting manager.

At lunch time we saw that a number of people chose to eat at the dining tables in the conservatory, whilst a few chose to sit in armchairs in the lounge and others stayed in their rooms for their meals. This was people's personal choice and one person told us, "I change my mind from day to day depending on how I feel." Tables were nicely set, with napkins available and condiments provided. We saw that most people chose to have breakfast in their rooms, and more people came to the dining area or lounge at lunchtime and for their evening meal. We received positive feedback from people about meals. Most people told us they enjoyed the meals provided. One person commented that meals were not always as hot as they would like. But they said they had told staff this and that things had improved.

The cook and kitchen staff had information provided regarding peoples dietary requirements. This included soft diets, likes and dislikes. People were offered a selection of meal choices, with alternatives available if required. Staff told us they knew people's specific likes and dislikes and who liked to drink what with their meals. Meals looked appetising and well presented. People who needed assistance with eating their meal had this provided in an unhurried supportive manner. Staff spoke kindly to people explaining what the meal was and offering help as needed. At lunchtime we saw that people were offered a choice of soft drinks and water. Hot and cold drinks were offered throughout the day and could be requested at any time. Water and refreshments were also seen in people's rooms.

Requires Improvement

Is the service caring?

Our findings

People felt supported by staff. Telling us, "Staff look after me well," And "Staff are kind". One visitor said, "It has a really good atmosphere here", and a relative told us, "I feel the staff know my husband," "I can have as much input as I like, the care here is excellent truly excellent."

Despite this positive feedback we found that documentation and personal information was not stored safely and securely taking into consideration people's privacy and dignity. People's care plans were stored in a ground floor office on the main corridor. We saw that the door to this office was not kept closed or locked when not in use. On each floor opposite the lift there was a handwritten white board and a notice board on the wall. Some of this information used room numbers to maintain people's privacy. However notes pinned to the noticeboard in relation to diet and nutrition and weekly bathing/showering information for people included people's names. We found that terminology used did not maintain people's dignity and included terms such as 'assisted feeds' and 'feeds' in relation to supporting people to eat at meal times. Information was also seen displayed on the walls in people's bedrooms. In one room a detailed report and instructions on how to support the person was taped to the wall above their bed. This meant the information was easily visible from the doorway of the room. No information was found in care files to determine whether people or their next of kin had been asked whether they were happy to have this information displayed on the wall. When people spent time in communal areas their room folders were taken with them to ensure staff were able to document regular checks and any care provided. We found on two occasions that folders had been left open on tables next to people and personal care information was clearly visible to anyone entering the communal lounge. This had not ensured information was kept private and ensuring people's dignity had been maintained.

These issues meant that the provider had not ensured service users were treated with dignity and privacy at all times. This is a breach of Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect.

Despite these concerns we observed staff supporting people with kindness and compassion and responding to people in a polite and kind manner. One staff member told us, "I take my job seriously, it is important that care is good for people." Staff showed concern for the well-being of people. A relative told us when one person became unwell they were informed promptly and medical professionals had been contacted appropriately.

We saw that Bryher Court had a protected meal time protocol in place which was flexible for the needs of people living at the service. For one person who had recently been unwell, relatives were able to visit and support the person with their meal. It was evident the person was comforted by this and they responded to having their relative with them.

Staff in the communal areas stopped to speak to people and engaged them in conversations about their families and memories from their past or conversations about what was happening that day. People were familiar with the staff who greeted them by name and responded positively. The overall atmosphere was relaxed and pleasant. People were able to get the attention of staff easily in communal areas and were

supported to do what they chose and were reminded of activities taking place and of what was happening that day.

We saw people were able to access the garden supported by staff when they wished to do so. People's independence was encouraged and supported whenever possible, for example, one person wished to go for a walk from around the building. They were reminded by staff to use their walking aid and a staff member accompanied them on the walk, offering support and prompting to ensure they remained safe.

People's needs were supported in respect of their religion or belief. We saw in care files that people's religious needs had been explored when they had moved into Bryher Court. For example, one person had informed staff of their chosen religion and their needs in relation to this, and we saw that they had been supported to access and engage in religious activities of their choice.

People received care in a kind and compassionate way. Staff had a good knowledge on how to provide care taking into consideration people's personal preferences. People were supported to wear clothing of their choice and we saw that women had handbags close by and were supported to wear jewellery if they wished to. When staff were assisting people with personal care their room doors were closed and the curtain drawn over the door window. When people required assistance in the communal lounge screens were used to shield them from others whilst they were moved using lifting equipment. When one person had spilt their drink down their clothing, staff alerted the person discretely and the person was assisted to their room to change.

Bryher Court provided end of life care for people. Care Plans considered end of life wishes and do not attempt resuscitation (DNAR) were in place when appropriate. We saw that people identified as requiring end of life care had advanced care plans in place, although not all end of life documentation had been reviewed regularly. The acting manager and other staff were in the process of completing Gold Standards Framework for end of life care. This was to ensure good practice and support end of life care provision at Bryher Court.

Requires Improvement

Is the service responsive?

Our findings

People told us that they felt that staff were aware of their preferences and always kept them informed, for example, people were told throughout the day what activities were going to take place so that they could attend if they wished. We were told, "I'm very happy in general, no complaints." And a relative told us, "They do let me know if there are any changes, I'm in most days so I speak to staff when I come in." We saw that one person had recently been supported to move bedrooms. This had been done with the full agreement of the person and staff told us they were much happier in their new room.

Despite this positive feedback we found that the service was not always responsive. At the previous inspection in March 2015, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plans did not reflect people's involvement, agreement or support in reaching the decisions recorded. An action plan was submitted by the provider that detailed how they would meet the legal requirements by December 2015. At this inspection we found improvements had not been made and the provider was still not meeting this regulation.

People had care plans in place regarding smoking. We saw that staff assisted people to access the garden smoking area throughout the day. One person's cigarettes and lighter were kept on a shelf in the nurse's office. Staff told us this was to prevent the person smoking too frequently and they had to be kept out of reach for this person to prevent them from taking them. No risk assessment had been written to review how and why this decision had been made. There was no information provided within this persons care documentation to show the decision making process or who had been involved in this. And it was unclear if the person or others involved in their care decisions had been consulted. Staff told us a best interest meeting had not taken place.

We found that one person had a behavioural chart in their room folder. This had been started by care staff when the person had displayed certain behaviours. There was no corresponding care plan or rationale in place to explain why this chart had been started and who had been involved in this decision. Entries on this form included that the person had been aggressive to a member of staff. We spoke to senior care staff and were told that this person had a specific health condition which meant that they became unwell and this led to them being anxious which could present itself as agitation if staff did not pick up the signals that they felt unwell. The senior care staff felt that this had been the reason for the recent documented behaviour but was unclear why this had led to a behavioural chart being put in place. We were told they had questioned this in handover at the beginning of the shift as they did not feel it was appropriate. A second entry on the behaviour chart detailed that the person had pushed the spoon away whilst being assisted at lunchtime. Staff did not know why this had been included on the chart as this would be an indicator that the person was not hungry. We discussed this chart with the manager and were told that it had been removed, and they were unclear why this had been implemented as it was not appropriate.

For one person receiving end of life care we saw the advanced care plan was dated 2010 and no further updates to this could be found. Staff told us they did not think there had been any changes. However, it was unclear how people's wishes were being reviewed and updated appropriately to reflect their current wishes.

Care files had numbered care plans in place for identified needs. Information in care files was task and care need orientated. With minimal information regarding peoples behaviours, character and preferences. This task oriented approach was reflected in the daily records. These were written to show which numbered care plan had been met. For example listing that personal care, washing and dressing had taken place with no reflection of the person's mood, how they had spent their time and any discussion or interaction that had taken place. One care plan for someone who had been at Bryher Court for about two weeks stated, 'Engage in conversation about subjects that interest him'. However no information had been sought from the person or documented to inform staff what this might be. We asked staff what they knew about this person's background and life before they moved to Bryher Court and they told us they did not really know them yet. Care plans currently in place for people did not reflect recent changes to care. For example one mentioned the person was prone to anxiety, but no details were given regarding how this may present itself, what might trigger this anxiety, or what actions staff should take if this occurred. This meant that care and treatment provided was not person centred or relevant to the individual.

We saw that some risk assessments and consent forms had been signed by individuals or their next of kin however this was not consistent with many decisions made and reviews completed without any information to show this had been discussed with the person or those legally entitled to make decisions on their behalf. The above issues are a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's daily charts for identified care needs, including repositioning had not been completed at stated timescales. For example, one care plan said that the person needed 'four hourly turns' We saw charts which had not been completed properly at night to show this had been followed, with a gap of seven hours seen on the previous night and no night turns documented at all for the night before this. We discussed this with care staff who told us if the person was asleep staff may not turn them as this person currently had no pressure area problems. However, the care plan for this person documented on the 15 March 2016 that they had a pressure sore on their heel. It was therefore unclear how peoples care and treatment had been provided appropriately and in accordance with their needs. The acting manager told us they were looking at changing the care planning documentation to a computerised version, however this had not yet commenced. These issues meant that the provider had not ensured people had accurate, contemporaneous records maintained in relation to their care and welfare. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People appeared relaxed and content and knew staff well, greeting them warmly by name when staff came into the communal lounge or knocked on their door. Staff responded well when people seemed anxious or disorientated. Taking the time to stop and chat to them and tell them what was happening. People were encouraged to spend time how and where they chose. One person liked to come out to the communal lounge in the day but chose to return to their room for all their meals. They told us that this was their personal preference as they preferred to eat alone. We saw that staff supported them to do this.

There was a designated activity person employed by the home who worked Monday- Friday and occasionally at weekends if a special event or trip was organised. An activity plan was displayed with in house games, entertainers and visitors to the home. During the inspection we saw there was music playing in the lounge and people had access to daily newspapers and books and magazines. In the afternoon people were playing Bingo and involved in general conversation about news and current events. The overall atmosphere in communal areas was relaxed and homely. People could be taken out shopping if they wished to go and we were told that future trips out were being arranged. This included a visit to tea rooms and an Easter party was scheduled for the weekend following the inspection. People who were not able to join in group activities were visited in their rooms by the activity person. They told us, "Not everyone can

come to the lounge or wants to play games, sometimes we just sit and chat, or I read to them, everyone is individual." People told us they sometimes attended activities, "It depends what it is, if it's something I want to do."

The acting manager had introduced meetings to ensure people's views and feedback was gained. A residents meeting was scheduled to take place on the 19 April 2016 and a suggestions box was available for people to use if they wished to share any information. Throughout the inspection we saw that people, relatives and visitors came to the acting manager's office to say hello and to have a chat. The acting manager was unaware if any previous questionnaires had been sent out to people for further feedback but they had now implemented a customer service satisfaction survey and food survey to be given to people to ensure that relevant feedback could be sought to make improvements if required. The activity co-ordinator wrote a monthly newsletter, these included details of past and future events and activities, people's birthdays and relevant news to share with people.

The previous inspection in November 2015, the provider was in breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems had not been followed for identifying, receiving and recording and handling of complaints. An action plan was submitted by the provider that detailed how they would meet the legal requirements by December 2015. At this inspection we found that no complaints had been received by the acting manager. Previous complaints had been dealt with by the previous manager and had been concluded. The acting manager was able to show us systems they would follow to ensure any complaint received would be responded to in accordance with the homes policy and procedure. A copy of the complaints procedure was available in the main reception area and people told us they would raise any concerns if they needed to.

Inadequate

Is the service well-led?

Our findings

At the time of the inspection there was no registered manager at Bryher Court. The previous manager had recently deregistered and a new acting manager was in post since December 2015. At the time of writing the report the acting manager had contacted CQC to start the process of registration. The acting manager was in day to day charge of the service. We were told the provider visited each week.

At the previous inspection in November 2015, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because appropriate systems and processes were not in place to assess, monitor and improve the quality and safety of services. An action plan was submitted by the provider that detailed how they would meet the legal requirements by December 2015. However, at this inspection we found that insufficient action had been taken and the breach of regulation had not been met.

Although the provider visited each week shortfalls found at the previous inspection had not been adequately followed up and actioned. There had been a lack of provider oversight and the action plan which had been sent to CQC stating when Bryher Court Nursing Home would meet regulations had not been achieved. New systems which had been described in the action plan sent to CQC had not been implemented and no alternative systems had started to evidence how the registered provider had oversight and ensured that all required maintenance, servicing and improvements had been achieved. The action plan sent to CQC said that a new robust quality assurance system would be in place by December 2015. And informed CQC that all documents relating to equipment for contracts/servicing and supply would be kept at Bryher Court and a new calendar timetable would be in place both on excel and paper based to ensure a date is highlighted two months prior to expiry date on all service contracts for equipment and safety checks. However at this inspection we found that there were no clear systems in place to show on-going monitoring to continually improve the service provided and the care people received.

The acting manager did not have the current CQC Guidance for Providers on Meeting Regulations which had applied since 1 April 2015. The acting manager did not demonstrate an understanding around changes to regulation requirements. For example, they were not aware of 'duty of candour'. Duty of Candour is a regulation that all providers must adhere to. The intention of the regulation is to ensure that providers are open and transparent and sets out specific guidelines providers must follow if things go wrong. The failure to provide appropriate systems or processes to assess, monitor and improve quality and safety of services are a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An incident had taken place a few days prior to the inspection. We spoke to the acting manager who told us that the incident had not yet been reported to the local authority or to CQC. It is a regulatory requirement that CQC are notified immediately of events that occur within the home, this includes significant injury and a number of required notifications in relation to people's care and welfare as well as things to do with the day to day running of the home. The acting manager confirmed they had reported the concern to CQC and the local authority the following day.

The acting manager had started holding staff meetings. This included senior care staff meetings and this had taken place in February 2016. Further meetings planned included RN and heads of department. The provider visited Bryher Court Nursing Home every Thursday and spent time with the acting manager, however these visits were not documented to evidence areas discussed and any actions set for follow up.

The acting manager told us they were available at the home most days and this meant that they knew people well and were aware of any issues that arose throughout the day. However, there were limited systems in place to formally assess and monitor the standard of care provision. Regular auditing can identify areas of improvement. We found that some auditing had taken place for example the acting manager carried out a daily walk around, spot checks at night and medicines were audited although not all of these areas had been documented.

We discussed systems introduced by the acting manager to analysis and review falls and accidents/incidents in the home. We saw that falls were listed on a form and a graph completed. However, no analysis of the findings was completed. We also found that a fall which occurred in February had not been included on this form. Urinary, respiratory, skin, soft tissue and gastro-intestinal occurrences were also logged; however there was also no overview of findings completed or analysis for these areas. Analysis can help identify any trends or themes which may develop. Identifying areas which can be improved can help prevent incidents from re-occurring and improve the overall health and safety of people using the service. There was currently no overview or analysis in place for accidents and incidents within the service.

The acting manager told us about a number of improvements they hoped to introduce over time. However, the emphasis had been on the urgent things that had needs sorting when they started work at Bryher Court. Further meetings and feedback would be sought from people to evaluate any changes and help to take the service forward over the coming year.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured service users were treated with dignity and privacy at all times supporting their autonomy and involvement. Regulation 10 (1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Accidents and incidents had not been responded to or reported to appropriate external bodies. Medicine procedures needed to be improved. Regulation 12(2)(b)(h)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Rationale for decisions made was not clear. Care was not person centred or based on the individual's preferences and needs. People had not clearly been involved in decisions made about their care and treatment. Regulation 9 (1)(a)(b)(c)(2)(3)(a)(b)

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People's safety was at risk as services and equipment had not been appropriately serviced and maintained. Regulation 15 (1)(c)(e)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Appropriate systems and processes were not in place to assess, monitor and improve the quality and safety of services. Regulation 17 (1)(2)(a)(b)(c)(f)

The enforcement action we took:

Warning Notice

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

Registered nurse had not had required 'in house' training and competencies had not been assessed to ensure they were able to meet peoples nursing needs.

Regulation 18 (1)(2)(a)

The enforcement action we took:

Warning Notice