Brampton View Limited

# Brampton View Care Home

## Inspection report

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Date of inspection visit:
06 September 2022

Date of publication:
31 October 2022

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

About the service
Brampton View Care Home is a residential care home providing personal and nursing care to up to 88 people. The service provides support to older and younger people with dementia or physical disabilities in four units within one adapted building.  At the time of our inspection there were 63 people using the service.

People's experience of using this service and what we found
The manager was in the process of implementing new systems and processes to ensure effective oversight of the service. However, these had not been sustained or embedded at the time of inspection. Audits did not always identify the concerns we found on inspection.

When people sustained an injury, records were not always clear on how the injury occurred, the size, shape or colour of injury or when the injury had healed. Investigations to establish the cause of an injury were not consistently in place.

Not all risks had been assessed or mitigated. We found some risk assessments were missing and not all actions had been recorded as completed. Some care plans held conflicting or had missing information recorded.

People, relatives and staff told us there were not always sufficient staff deployed to meet people's needs. People and relatives told us they were left waiting for support at times and temporary staff did not know people's needs.

Medicine management was improving since our last inspection. However, further improvements were required to reduce the risk of errors.

The home appeared clean. Cleaning schedules evidenced regular cleaning took place.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People, relatives and staff felt the improvements already made had changed the atmosphere within the home and staff and people felt more positive about the management.

The provider requested annual feedback from people, relatives and staff. Feedback received was reviewed and an action plan implemented.

The manager worked with external professionals to meet people's healthcare needs, make improvements to the service and keep their knowledge and skills updated.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 27 February 2021) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. This service has been rated requires improvement for the last three consecutive inspections.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to management oversight, medicine management, staffing and risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to the governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

Details are in our safe findings below.

### Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Details are in our well-led findings below.

# Brampton View Care Home

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by one inspector, a specialist nurse advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Brampton View Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Brampton View Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection the registered manager was no longer employed at the service. There was a manager in post who was applying to register with CQC.

Notice of inspection

This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service and four relatives about their experience of the care provided. We spoke with 10 members of staff including, the manager, deputy manager, clinical development nurse, regional director, maintenance staff, nurses and care workers.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- People were at increased risks from abuse. We found not all injuries had been recorded or documented and unexplained injuries had not always been investigated to identify a cause and prevent reoccurrence. The manager was implementing systems to mitigate the risk of reoccurrence.
- Records of injuries did not always contain information on the size, shape or colour of the injury or detail if and when an injury had healed. This information would support staff and health professionals to evaluate injures to ensure proper healing. The manager agreed to ensure additional information was recorded after the inspection.
- Staff told us, and training data evidenced staff received training in safeguarding. Staff understood the signs of abuse and how to report any concerns.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were at increased risks from known health conditions. Seizure records were not always completed with detailed information, and not all staff were trained in use of rescue medicines required to mitigate the risks of the known health conditions. The manager had implemented new systems and processes to ensure records were kept up to date and factual.
- People were at increased risk of choking. Records did not evidence the amount of thickener staff had used in fluids to reduce the risk of aspiration. The manager implemented recording of thickener immediately after feedback.
- Incidents and accidents were analysed to identify trends and patterns. The manager had recently implemented an action plan to reduce the risks found in specific areas. For example, falls had increased overnight so additional staff were deployed at night. However, due to not all injuries being recorded appropriately we could not be assured all incidents had been effectively reviewed.
- Equipment was in place and the environment was appropriately assessed to mitigate risks to people. For example, window restrictors and sensor mats were in place and regularly checked, wardrobes were attached to the walls and legionella checks were in place.
- People were protected from skin pressure damage. Records evidenced appropriate support with repositioning tasks was offered at regular intervals and pressure mattresses were in place and set at the specified setting.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Staffing and recruitment
● Staffing levels had not always been appropriate to meet people's individual needs. Staff told us that staffing levels were improving. However, staff stated people were still left waiting for care due to agency staff not knowing people or how to complete paperwork. The manager was in the process of recruiting new staff.
● People and relatives told us of situations when low staffing levels or high agency use impacted on their care previously. Relative's said, "[Person] is often in a position of trying to guide (agency) staff members through [persons] needs and had had several 'near misses' which almost resulted in a fall, which could have profoundly damaging consequences for [person's] mobility and independence, not to mention their health." And "There are too few staff, and the staff that are available are often temporary/agency staff who do not have the knowledge or training to meet [persons] care needs."
● Staff were recruited safely. The provider completed pre-employment checks such as references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Using medicines safely
● Medicine management was improving. The manager had investigated incidents of medicine errors and had put strategies in place to mitigate future reoccurrence.
● Medicines were stored, disposed of and ordered correctly. However, we found paperwork to evidence disposals had been completed was missing.
● Medicine administration records were signed and when people were prescribed 'as required' (PRN) medicine there was a protocol in place to identify the reasons this medicine should be given.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider followed government COVID-19 guidance on care home visiting. Visitors were given

appropriate PPE.

Requires Improvement

# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had failed to ensure systems and processes were effective and robust enough to monitor the quality and safety of the service This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

- The provider had failed to achieve to 'good rating' at the past four inspections.
- Systems and processes were not effective in identify and mitigating risks of unexplained injuries. The provider had not identified the missing information or missing investigations found on inspection. This put people at risk of abuse.
- Systems and processes were not effective in identifying the conflicting or missing information within care plans. Audits completed on care plans and risk assessments did not check the details within the care plans or risk assessments only if a section was missing.
- Systems and processes did not effectively monitor records to ensure information was clear, factual and up to date. For example, one person's seizure diary only had one recorded seizure however we found evidence in other documents that evidenced the person had three other seizures that had not been fully recorded. One person's falls assessment had not identified four falls that had been recorded elsewhere.
- Improvements to medicines audits had been implemented. However, a medicine audit completed in July 2022 found missing signatures on four people's records. There were no actions recorded to mitigate these risks.
- Staff, people and relatives told us that due to the amount of agency staff used staff did not always know people or how to support them. One relative told us "[Person] does not feel safe, especially at night when there are even fewer staff, and shifts can sometimes be made up entirely of agency staff." Another relative said, "I am concerned that temporary staff who have no knowledge of [person's] care needs, or health issues would be ill-equipped to spot warning signs of a sudden worsening in their condition"
- Systems and processes were not always effective in ensuring staff had completed the necessary training to meet people's individual needs. Training data evidenced 30% of staff had completed training on epilepsy

and 20% of staff had training on diabetes. The manager had a training plan in place to ensure all staff received appropriate training.

The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Although improvements were seen the systems and processes still needed to be embedded and sustained into practice
● People and staff told us the service was improving. People and staff felt listened to by management and told us issues they raised were actioned and information feedback. People and staff were kept up to date on the changes currently being made at the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The service apologised to people, and those important to them, when things went wrong
● The manager gave honest information and suitable support, and applied duty of candour where appropriate.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others
● People, staff and relatives were offered regular meetings to share information and discuss the service to make improvements.
● The provider requested feedback from people, relatives and staff annually. This information was reviewed and an action plan was implemented to make improvements based on the feedback received.
● Staff told us they felt supported by the new manager.
● People and relatives were involved in reviewing the person's care plan. Relatives told us they were kept up to date on any changes or significant events in their relatives' life.
● The provider worked with external professionals to ensure people's health needs were met and referrals were made as required.
● The manager ensured their learning was kept up to date by attending networking events, completing management training and linking with other senior managers.

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 | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. |

**The enforcement action we took:**

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