Anchor Carehomes Limited

Berkeley Court

Inspection report

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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
Berkeley Court is a residential care home providing personal and nursing care to 59 people aged 65 and over at the time of the inspection. The service can support up to 78 people. Care is provided across six units, within one purpose-built building.

People's experience of using this service and what we found
We found an inconsistent approach to risk management. Risks were not always appropriately managed, relating to admissions, fire safety and following incidents. People received their medicines as prescribed although some improvements were required to ensure safe systems were in place relating to nutritional thickeners and blood thinners. We made a recommendation to ensure additional guidance was put in place for staff. Some limited incident analysis was undertaken but this needed to be more robust to examine whether there were any underlying themes and trends.

Systems to assess, monitor and improve the service needed to be made more robust to ensure that a consistent high-quality service was provided across all areas. Some care plans were out of date and training was not always up-to-date. An action plan was in place and additional management resources were available to help aid continuous improvement of the service. The service worked well with other organisations to provide stimulation and interaction for people who used the service. People and relatives said they were happy with the home and staff said they were happy to work there.

The home was clean, appropriate infection control procedures were in place and these were understood by staff. The premises were well maintained. There were enough staff to ensure people received prompt care and staff were recruited safely.

People and relatives provided good feedback about the service. They said care was provided in a safe way and said that it met individual needs. People said staff and management were kind, caring and communicated well with them.

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

Rating at last inspection
The last rating for this service was Good (published 17 March 2020)

Why we inspected
The inspection was prompted in part by notification of two specific incidents following which two people using the service died. These incidents are subject to an investigation. As a result, this inspection did not examine the circumstances of the incidents. The information CQC received about the incident indicated concerns about the management of choking and medicines. We also had received concerns about the management of safeguarding risk. This inspection examined those risks.

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.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report. Some of these areas were known to the provider and other areas were added to the services action plan during our inspection by the management team.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
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 required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risk management, failure to report incidents to CQC and good governance. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the quality of standards and safety. 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

Berkeley Court

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 Care Act 2014. 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 carried out by three inspectors including a medicines inspector 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
Berkeley Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
We gave the service 24 hours' notice of the first day of our inspection. This was because we wanted to make arrangements to visit safely during the COVID-19 pandemic.

What we did before the 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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
On 9th March 2021 two inspectors visited the care home to observe care, speak with staff and check records. On 11 March 2021 an Expert by Experience made video and phone calls to people who used the service and their relatives. On 17 March 2021, a medicines inspector visited the home to examine the medicines management system. Between 9 March 2021 and 29 March 2021, we reviewed care and management records remotely. In total, we spoke with four people who used the service and eight relatives about their experience of the care provided. We spoke with ten members of staff including the district manager, regional support manager, registered manager, senior care workers, care workers and the catering manager.

We reviewed a range of records. This included elements of six people's care records and multiple medication records. We looked at three 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.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was not full assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• We found inconsistencies in the management of risk. Following an incident which is subject to further investigation by the Commission, we did not feel fully assured that safe admission practices were in place. For a new resident, recently admitted to the home, there was a lack of evidence their dietary needs had been properly communicated to all staff. Handover records had not been completed and their dietary needs sheet had not been completed in a timely manner. This increased the risk they would be given an inappropriate diet. We also found one person's care plan had not been updated in a timely way with strategies to deal with behaviours that challenge, following a number of safeguarding incidents.
• During the inspection, the fire alarm was set off and safe procedures were not followed,, potentially putting people at risk. A number of staff were found not to be up-to-date with fire safety training. We referred our concerns to the Fire Service. Immediate action was taken to address this with fire safety training provided to staff and a number of additional drills carried out with a better response.
•A system was in place to log, investigate and learn from incidents, although some improvements were required. People and relatives told us they were informed when things went wrong. Further work was being undertaken with staff to improve the consistency and quality of incident report following an internal safeguarding and governance report.
•Whilst some incident analysis took place, this was inconsistent and there was a lack of routine, meaningful and timely analysis into themes and trends, to demonstrate the manager was fully reviewing this information on a regular basis.
•The provider had put additional resources into the service to help drive improvements to safety. Whilst we saw some of these had been effective, further work and assurance was required to ensure the service was consistently safe as there were still lapses in risk management which needed addressing.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. We did not identify an impact but there was a risk of harm if safe systems were not followed.

• People and relatives told us that they felt people were safe in the home. Most staff we spoke with knew people well and the risks associated with each person's needs. Risks, concerns and incidents were discussed with people and their relatives demonstrating they were involved in risk management.

Using medicines safely
• Systems were in place to support the safe use of medicines however some areas for improvement were identified. The service had no process to record the use of fluid thickeners in people who had swallowing

difficulties and there was a lack of guidance available for staff when people were taking blood thinners.
• People received their medicines as prescribed. As and when required guidance was in most cases person centred and provided information to assist staff in administration. However, medicine administration charts (MARs) which were handwritten were not always signed or counter signed on the third floor of the home which was not in line with the providers policy.
• There had been a significant number of medicine errors within the home over the past 12 months. Whilst this was of concern, we saw there had been a reduction in these over the last few months with new systems put in place to improve the service. These improvements need to continue and be sustained for us to be assured that medicines were managed safely. One relative said "The medication seems fine. There have been two mistakes and they rang up to tell me. It was not a big issue. It was properly dealt with. "

We recommend additional guidance should be put in place to support staff in the safe administration of thickeners and blood thinners.

Systems and processes to safeguard people from the risk of abuse
• Systems and processes were in place to protect people from the risk of abuse but there were inconsistencies in practice and some improvements were required. Although we saw some good behavioural support plans in place, not all care plans had been promptly updated following incidents. There was also a lack of robust analysis of behavioural incidents.
• Staff had a basic knowledge of safeguarding although they were not always confident of whom they could go to outside the home to report incidents. At the time of the inspection, 70% of staff were up-to-date with safeguarding training, the service had fallen behind with this as it was face to face training and had been impacted by the COVID-19 pandemic. Enhanced safeguarding training was in the process of being rolled out to staff.
• People and relatives praised the home and said people were safe, they all said any safeguarding incidents were dealt with in an open and transparent way. One relative said, "Staff are absolutely wonderful. They ring us, every little incident. They've always got a plan." Another relative said "She's as well looked after as possible. The bottom line is, she's safe."

Staffing and recruitment
• Overall we concluded there were enough staff to ensure people received care and support. People and relatives said that usually there were enough staff to support people, although they were busy. One person said, "I think there's enough staff. Sometimes they might be overworked." Most staff told us staffing levels were sufficient and we saw evidence they were regularly reviewed depending on people's needs and the occupancy of the home.
• Rotas showed that on some days, the target team leader staffing levels had not been met. Following the inspection the district manager told us this was due to the recent COVID outbreak and sickness. The service was currently recruiting to overstaff to the team leader position to help ensure more consistency in team leader deployment from day to day.
• Safe recruitment procedures were in place to ensure staff were of suitable character to work with vulnerable people. People praised the staff who supported them and said they had the right attributes to be working in care.

Preventing and controlling infection
•The home was clean and hygienic and best practice guidance was followed in relation to infection control. Enhanced cleaning was in place. Personal Protective Equipment (PPE) was readily available to staff and we observed staff wearing it appropriately. One person said of the home "It's very clean, [they are] very thorough."
• Risk assessments and guidance were in place describing how risk associated with the COVID-19 pandemic

was to be reduced. However, infection control audits had not consistently been completed in 2021, this had been identified by the service and was now being addressed.
• Visiting to the home was permitted in line with national guidance and relatives complimented the home on their approach to visiting. One relative said, "Visits are all excellent; in the garden at first and very cold. Then we had a gazebo; then we were inside in the 'glass room.' It's lovely to see [person], see how relaxed, comfortable, happy, clean and tidy they are." Whilst we were assured there were plenty of social opportunities for people, visiting and social care plans were not always in place describing how people's social needs would be met during the COVID-19 pandemic.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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; Continuous learning and improving care
• Whilst the service had notified us of most events in line with its statutory duties, we identified five safeguarding incidents which had occurred over the last year which had not been reported to us in line with the providers statutory duties. The district manager told us they would investigate why these incidents had not been reported. This is being dealt with by the Commission, separate to the inspection process.
• During the inspection we identified that risks relating to admissions and fire safety were not properly mitigated. We also found systems to ensure care plans and risk assessments were kept up-to-date were not sufficiently robust. Some care plans had not been regularly reviewed, however, some documents such as relating to End of Life care were missing and social and visiting care plans were not always relevant or up-to-date. Audits and checks had not always been carried out in line with the required frequency, incident analysis was not suitably robust and some training had not been kept up-to-date.

This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We did not identify any impact on people but there was a risk if safe systems were not followed.

• The service had experienced a COVID-19 outbreak during January and February 2021. We found this had been managed appropriately, with the home able to restrict the outbreak to one floor of the home. People, relatives and staff said they had been well supported throughout the pandemic and we found staff and management had a good understanding of government guidance.
• An action plan was in place to improve the service. A number of the issues we found on inspection had already been identified by the provider and others were quickly added to service improvement plan by the provider. Additional support was in place to drive forward improvements. The home was being supported by a regional support manager and specialists in dementia, governance and safeguarding to make the required changes.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People and relatives provided positive feedback about the home and the way it was managed. One person said "[Registered Manager] is an excellent manager, very helpful. The staff seem happy, they care." Relatives we spoke with knew of events that had been going on within the home and said they were regularly

communicated with. The level of detail they informed us about events in the home made us assured they were kept up-to-date.
• People and relatives told us the service had worked hard to ensure there was plenty to do within the home throughout the COVID-19 pandemic. One relative said "They have an entertainer, keep fit, bingo and art days, they are busy all the time. There is always choice; and they have a shop."
• Staff demonstrated to us they had good caring values and practiced a person-centred approach in providing care and support. A person said, "Staff seem happy, very positive and friendly."
• People and relatives we spoke with said that good outcomes were received by people and a high-quality service was provided. However, we concluded work was needed to address some of the risks identified both by our inspection, other agencies and the findings of internal reviews for us to be assured that this was consistently the case. The home also needed to review systems and processes to ensure a consistent level of visible leadership was present within the home.

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
•We found the service was open and honest with people about known incidents or failings. For example, relatives told us how they had been informed about medicine errors and behavioural incidents. One relative said, "They are very open." Another relative said "I contacted them to make an appointment to look round and they said no appointment is needed as we have nothing to hide." The management team were transparent with us about the quality of the service and the actions they planned to take to drive improvement to the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•People and relatives told us they felt involved in care and support and it was clear people and relatives were consulted with on a range of matters. One relative said, "We feel very much part of the network of care around (resident)." However, there was a lack of evidence of more formal engagement with people. Resident meetings, care reviews and surveys had not been done completed recently. We spoke with the district and regional support managers about the need to ensure these processes were in place.

Working in partnership with others
• The service had developed strong links with the local community to help provide interaction and stimulation to people who used the service. For example, links with the local community ensured a church service each Sunday and the home had been involved in the Christmas lights switch in the community.
• The service had signed up to the Step into Care scheme, which aims to find employment for people in social care. This had resulted in the home now meeting its staffing requirements for care staff with all care worker vacancies filled.

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 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 (1) (2a) Safe care and support was not always provided as risks to people's health and safety had not always been assessed and/or mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance (1)(2a) (2b) (2c) Systems and processes were not in place to ensure compliance with the regulations. Systems to assess and manage risk were not always in place. Accurate and up-to-date records were not always kept.