

Mrs Fiona Collins

Bramley House Residential Home

Inspection report

Westcott Street
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Tel: 01306740003

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Ratings

Overall rating for this service

Good 

Is the service safe?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Bramley House Residential Home (Bramley House) is a care home providing accommodation and personal care for up to 16 older people. There were 11 people living in the home at the time of our inspection.

The inspection took place on 15 July 2017 and was unannounced.

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

We carried out an unannounced comprehensive inspection of this service on 15 June 2016. At that inspection we identified two breaches of legal requirements relating to the management of records within the service. We undertook a follow-up inspection on 3 May 2017 to check that the provider had taken the action they told us they had. At that time we found that the legal requirements had been met.

Since our last inspection we received some concerns about the service. In particular, we were informed that people may not always receive safe care at weekends and that records were not always an accurate reflection of the care provided at the service. Some concerns are still being investigated under a wider safeguarding investigation and as such we are not able to comment on these at this time. We are working in partnership with other agencies and will continue to respond to any new information which indicates that Regulations may have been breached.

Our findings from this inspection have been included under two key questions: is the service Safe and is the service Well-Led? You can read the report from our previous inspections, by selecting the 'all reports' link for Bramley House Residential Home on our website at www.cqc.org.uk".

At this inspection we found that records about the care people provided were not always an accurate reflection of the support they had actually received. Staff had an excellent knowledge of people's support needs and were able to describe the care people needed each day. This knowledge however was not fully reflected in people's care plans and in some cases information recorded in one part of the care plan was different to that recorded in another. Through discussions with people, staff and management it was clear that changes to people's needs had been responded to, but the records in place had not always been updated to evidence this.

Some records were completed retrospectively, rather than at the point support was provided. When we arrived at the service, the Medication Administration Records (MAR charts) did not reflect that people had received their medicines that morning. Discussion with staff, people and a review of the medicines trolley confirmed that people had received their medicines as prescribed. There was little risk of people being given their medicines again because only the staff member in charge of the shift handled medicines.

Internal audits had identified that some of the records were not being completed as required. Whilst this issue had been raised and discussed within the staff team, it had not secured the necessary improvements. The compliance with the legal requirements around record keeping that we found in May 2017 had therefore not been sustained.

The failure to maintain accurate records however was a breach of Regulations.

People's needs were met by a small number of staff who worked effectively together as a team. Staff were aware of the systems in place if people were unwell, injured or at risk of harm. People received safe care that was personalised to their individual needs and choices.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

The service was safely maintained and environmental risks had been considered and mitigated.

The service had systems in place to manage risks to people in a person centred way. Staff were aware of their role if people were unwell, injured or at risk of harm.

Staffing levels were sufficient to meet people's assessed needs.

Medicines were managed safely and staff ensured people received their medicines as prescribed.

Good ●

Is the service well-led?

The service was not wholly well-led.

The documentation in place did not always reflect the care and support that was actually being provided.

Requires Improvement ●

Bramley House Residential Home

Detailed findings

Background to this inspection

We undertook an unannounced focused (responsive) inspection of Bramley House on Saturday 15 July 2017. We inspected the service against two of the five questions we ask about services: Is the service safe? And: Is the service well-led? This was because some concerns had been raised with us about the care people received at weekends and that records were not always an accurate reflection of the care provided at the service.

The inspection was carried out by two inspectors both with experience in the regulation of services for older people.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because this was a responsive inspection only looking at specific concerns.

As part of the inspection we spoke with five people who lived at the service, three staff, the registered manager and the provider. We also spoke with one relative and two paramedics who were also in the service at the time of our inspection.

We reviewed some documents relevant to our concerns. These included two care plans, the Medication Administration Records for each person, incident and accident records and documents relating to fire safety.

Is the service safe?

Our findings

People told us that they felt safe living at Bramley House. People said that the staff made them feel safe and that knowing there was always someone around for them placed them at ease. One person commented; "Oh I certainly feel safe here. The girls do an excellent job at looking after me." Similarly, another person said, "Oh yes, I am very safe here. I used to have a lot of falls when I lived at home, but not since coming here." A relative echoed that they felt their family member was safe living at Bramley House. They told us, "I am very happy with the care provided by Bramley House. I feel that my [family member] is safe here."

The service was safely maintained. Prior to the inspection we had received concerns that some hallways and stairways were cluttered and posed a risk to people as they moved around the service. We found that the environment was clean and all areas were free from obstruction. Staff were aware of the importance of keeping access routes clear so that people could move safely around the service and be evacuated in an emergency.

The service had commissioned an external fire risk assessment within the last twelve months and all identified actions had been addressed. Each person had a Personal Emergency Evacuation Plan (PEEP) and staff were clear about what support each person would need in the event of an emergency. The local fire service had also visited the service and recorded that adequate fire safety systems were in place.

Staff had an excellent understanding of people's needs and knew exactly how to support them safely. Staff knew people well and were able to describe the risks associated with each person and how they were managed. For example, one person enjoyed daily walks to into the local community. Staff had recognised that a change in the person's emotional wellbeing had increased the risk of them doing this activity safely. Staff and were able to explain the steps they had taken to enable this person to retain their independence, whilst keeping them safe.

Staff responded appropriately to people's changing medical needs. When we arrived at Bramley House, there were paramedics in attendance. We spoke with them and they informed us that they had been called because a person who had been unwell during the week had experienced further deterioration in their health. The paramedics confirmed that staff had acted appropriately in calling them and that they had received a good handover of information about the person. The staff member leading the shift told us that the person had been visited by the doctor and a plan of care was in place, but that this morning they felt the person had appeared, "Vacant and not normal self," and hence they made the decision to seek emergency medical advice. The daily notes for this person showed that staff had taken appropriate action to safely care for this person.

Staffing levels were sufficient to meet people's assessed needs. Everyone spoken with during the inspection confirmed that staffing levels enabled people to be supported safely and effectively. People told us that there was always staff about and they rarely had to wait long for support. Some people were independent with their care. We observed that because people were supported in accordance with their own routines they received their care when they needed it.

Staff worked well together as a team to support people and each other effectively. Whilst staff were rostered for a specific role in the service, such as care staff, cleaner or cook, each staff member had the training and experience to undertake any role. As such staff told us that that if something unexpected happened and additional care support was required, then one of the other staff or managers could step in.

The service had a good relationship with a local agency to provide staff cover when their regular staff were on leave. The rotas showed and staff confirmed that where possible the same agency workers were used in order to provide consistent support to people.

All medicines were delivered and disposed of by an external provider. The management and storage of medicines were safe and people received their medicines as prescribed. Staff were aware of people's allergies or when specific medicines required a particular approach to care.

Is the service well-led?

Our findings

At our comprehensive inspection in June 2016 we identified that whilst people liked the informal and relaxed way the service was run, that there were risks attached to the approach taken with record keeping. In May 2017 we completed a follow-up inspection at the service and found that the standard of record keeping had improved and as such the requirement we made had been met.

At this inspection, we once again found that records did not always provide an accurate and contemporaneous account of the care people received. When we arrived at the service at 10:30am, the MAR charts had not been signed in respect of the medicines given by a staff member earlier that morning. Discussion with staff, people and a review of the medicines trolley confirmed that people had received their medicines as prescribed. There was little risk of people being given their medicines again because only the staff member in charge of the shift handled medication. It is however important that MAR charts are accurately completed immediately following the administration of people's medicines.

Information contained in people's care plans did not always reflect the quality of care provided to people. Whilst staff and management were responsive to changes in people's needs, this was not always accurately recorded. For example, one person had recently become disorientated when out in the local community. In response to this, staff had increased the safety measures in place when this person went out independently. The risk assessment in respect of this had however not been updated.

Care records did not always provide a consistent account of people's needs. In some cases information recorded in one part of the care plan was different to that recorded in another. For example, the MAR chart for one person recorded that they were unable to have a particular food due to being prescribed a particular medicine. The nutrition care plan for this person however made no reference to this information. Whilst all staff spoken with were aware of this person's dietary needs, only those staff who administered medicines had access to the record which informed them of this.

Internal audits had identified that some of the records were not being completed as required. Staff meeting minutes highlighted that this issue had been raised and discussed within the staff team, however this had not secured the necessary improvements.

The failure to maintain accurate and contemporaneous records therefore placed people at risk of not receiving the right care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Failure to maintain an accurate, complete and contemporaneous record of the care and treatment provided.

The enforcement action we took:

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