Review of compliance

Bupa Care Homes (CFC Homes) Limited **Branston Court Nursing Home**	
Region:	West Midlands
Location address:	Branston Road Burton upon Trent Staffordshire DE14 3DB
Type of service:	Care home with nursing
Publication date:	June 2011
Overview of the service:	The service is registered to provide accommodation for persons who require nursing or personal care and provide support under the regulated activities of diagnostic or screening procedures and treatment of disease, disorder or injury.

Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Branston Court Nursing Home was not meeting one or more essential standards. Improvements were needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews. We looked at the following areas of the essential standards of quality and safety.

- Respecting and involving people who use services
- Care and welfare of people who use services
- Meeting nutritional needs
- Safeguarding people who use services from abuse
- Management of medicines
- Safety and suitability of premises
- Requirements relating to workers
- Staffing
- Assessing and monitoring the quality of service provision
- Records

How we carried out this review

We reviewed all the information we hold about this provider and asked them to complete Provider Compliance Assessments (PCA's) for four outcome areas. PCA's are self assessment documents which the provider records how they are meeting the standards for each outcome area. Before our visit, we asked the provider to demonstrate how they were compliant with outcomes 1, 2, 4, and 16 of the essential standards of quality and safety.

We reviewed our quality and risk profile (QRP). This document is where we gather all we know about a provider in one place. It enables us to assess where risks lie and prompt regulatory activity, such as reviews of compliance. The QRP supports us to make robust judgements about the quality of services.

We carried out a visit 7 June 2011, observed how people were being cared for, talked to people who use the service and their relatives, talked to staff, checked the provider's records, and looked at records of people who use services and talked to professionals who visited the home.

What people told us

People who use the service and their relatives told us that they were happy with the care support in the home and staff treated them with respect. The staff team were always available and responded promptly to any areas of concern or changes to the support they required. People who use the service and their relatives told us,"We've no complaints, we're very happy with support given. They give the best care and we couldn't wish for better," and "This is one of the top homes the staff and care is very good."

People were dressed in their own style and if they needed support, staff helped individuals to apply make-up or to have a manicure; people were encouraged to continue to take a pride in their appearance on a daily basis and through beauty treatment sessions. Staff listened to people and spent time with them, talking and carrying out activities, as well as providing care. A range of daily activities was available and we were told, "There's always lots of activities here, lots of stimulation."

Relatives were able to continue to play an active role and support people and provide care. When important things happened people told us that communication was good and told us "I like being involved and I want to help. The staff here are great and I came here whenever I want, they don't leave me out," and "I always know what's happening, they're very good at telling us things."

What we found about the standards we reviewed and how well Branston Court Nursing Home was meeting them

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

- Overall, we found that Branston Court Nursing Home was meeting this essential standard.

People who used the service received appropriate care and support and the service was managed so people felt their welfare was protected and their needs were met

Outcome 7: People should be protected from abuse and staff should respect their human rights

- Overall, we found that Branston Court Nursing Home was meeting this essential standard.

People benefited from effective procedures in place to safeguard them from possible harm and keep people safe.

Outcome 9: People should be given the medicines they need when they need them, and in a safe way

- Overall, we found that improvements were needed for this essential standard.

People generally received their medicines as prescribed to keep well. The systems in place for new medicines needs to be reviewed to ensure people receive their medication in a planned and safe manner.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

- Overall, we found that Branston Court Nursing Home was meeting this essential standard.

People could be confident that staff were suitable to work in the home as effective recruitment and selection procedures were in place, to make sure they could work with adults.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

- Overall, we found that Branston Court Nursing Home was meeting this essential standard.

There were quality assurance arrangements to formally monitor and review the health, safety and welfare of the people who use the service.

Action we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

What we found
for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

Outcome 4:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

We talked with three people and their relatives about their experiences when they moved into the home and they told us they looked around the home, met people and were given information about the service. Two people informed us they had moved from other homes because they were unhappy. People and their relatives told us, “This is so much better here, I’m much happier” and “You can’t fault it here, you just couldn’t wish for better.”

We talked to people about the plans of care and people were aware the service had information recorded about them. Three people told us they did not want to look at the plans and were happy that the service kept this information. The registered manager told us that they kept evidence of lasting or enduring powers of attorney to ensure they knew were people had the right to access, or to give consent on behalf of others. The manager stated this information was reviewed to ensure it was kept up to date.

We looked at five plans of care in respect of support required with eating and drinking and nutritional assessments. We observed how the people were supported during the lunch time meal and saw that people were asked what they would like to

eat and the food was prepared as was recorded in the plan of care. For example one person required meat cut up into small pieces and one person required a soft diet, and we saw this happened. Staff and visiting relatives confirmed that where people needed a soft diet people had a choice of foods and this was presented in an attractive manner with each food pureed separately so people could still experience the different tastes. People were able to eat at the table or used a raised tray. We saw three people supported by family members to eat their meal and relatives told us, “I like being involved and I want to help. The staff here are great and I came here whenever I want, they don’t leave me out.”

People were not dependant on relatives for support as there were generally eight care staff on duty. Staff confirmed they were able to have time to carry out necessary duties and spend time with people talking or were involved in one to one activities.

People were able to participate in a range of activities each day including, knitting, bingo, making art and crafts, dancing and gardening. Two people talked about how the garden had been designed to enable people to participate in gardening with raised flower beds, vegetable plots and there were chickens. Relatives told us that people were encouraged to use the garden facilities and would often eat meals outside or enjoy the scenery in the garden on sunny days.

There were two activity co-ordinators who worked across the shifts to organise activities and support people to be involved in community activities. During our visit one person went for a walk and staff and relatives told us people had the opportunity to go into the local town shopping or have a drink or meal out. Relatives said “There’s always lots of activities here, lots of stimulation.” People who use the service told us they had visited Chasewater Railway with family members and one person said, “we had a really good day there.”

Other evidence

We saw an assessment of need was completed for each person prior to moving into the home, and a copy of the assessment was in the plan of care. The service used an assessment process that explored people’s choices and preferences to ensure they were a suitable service. The manager confirmed to us that they made a judgement based on this information to determine whether the service could meet the person’s needs and provide the care and support required.

We looked at five plans of care which confirmed that nutritional assessments, moving and handling and tissue viability assessments were completed when a person moved to the home. Staff informed us that this information along with the initial assessment helped them to develop a plan of care.

Each person had a plan which identified the support needed and assessments of risks which included information about how people wanted to be supported with bathing, eating and drinking, personal hygiene and mobility and health needs.. The plans were lengthy and it was sometimes difficult to find the information we needed during our visit; staff agreed the information was sometimes difficult to find. During a visit by the provider in December 2010 it was identified that the plans could be

improved and be more person centred. A more concise plan was being developed which would involve all staff with recording information and be easier to use on a daily basis and for people to understand. Visiting health care professionals told us "information was recorded within the notes and the staff and manager were extremely helpful".

Personal records for people who use the service and staff files were kept on open display in an unlocked office. We discussed this with the manager who arranged for a key pad to be fitted to ensure all records were maintained securely in line with the requirements of the Data Protection Act 1998. The manager confirmed this work had been completed following our visit.

The service has recently undergone a major refurbishment in the bedrooms and bathrooms and the manager acknowledged that this was difficult at times when carrying out the tasks. Visiting professionals confirmed that the service worked hard to minimise any disruption to people whilst the work was being carried out. Relatives told us, "Everywhere looks so much better now, it was all getting a bit tired, it looks great now."

We walked round the home with the registered manager and looked at communal areas, bathrooms and toilets and bedrooms; the standard of cleanliness was good and the registered manager told us that the home had a team of domestic staff who ensured that cleaning had been undertaken to a good standard. We saw staff were quick to respond to any adverse event and took measures to ensure everyone was safe while cleaning took place.

Our judgement

People who use the service received appropriate care and support and the service was managed so people felt their welfare was protected and their needs were met. The service has identified the plans could be developed to be more person centred.

Outcome 7:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:

- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with outcome 7: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us

We spoke to three people who use the service and four visitors and people told us they felt safe and would talk to staff if they had any concerns. Relatives told us that they were confident people were safe and if there were any concerns identified staff would act on this to improve the service. One relative told us they were kept informed of all events in the home and staff contacted them promptly to alert them to any concerns. People were confident that staff acted in a manner which would safeguard people from harm.

Other evidence

Staff at the home had been given information about the Mental Capacity Act 2005 and staff had received training for deprivation of liberty safeguarding legislation. The Act governs decision making on behalf of adults, and applies when people do not have mental capacity at some point in their lives for specific decisions. Two people receiving a service had an order to deprive them of their liberty. The home had made the referrals to keep people safe and we were notified of the events and received information about how the decision was reached by the assessor. The

order had been granted by the deprivation of liberty safeguards team who under the Mental Capacity Act 2005 have the authority to decide whether it is in the best interests of people to deprive people of their liberty and this decision was made in consultation with people who were important to the person.

The registered manager notified us of the application and we have liaised with the service to ensure the decision made was in the person's best interests. The order has been reviewed with the team and extended. The service acted appropriately to safeguard the person and decisions were made to maintain the person's well being and their safety. During our visit we saw the person and spoke with a relative, who told us the staff were supportive and they were happy the decision had been made and were confident the person's safety and well-being was maintained.

The plan of care included information to alert the staff to the order and a record of how the person was supervised and the care and support required was available. We spoke with staff who informed us that they knew about the order and understood the plan of care. and knew the information required to keep the person safe.

We talked to staff about how they would raise concerns about risks to people and poor practice in the service. Staff told us they were aware of the whistleblowing procedure and felt they would be able to raise concerns and supported by the management team. This means suitable action would be taken to protect staff if they raised a concern in good faith, to protect people in receipt of care or from potential harm.

Our judgement

People benefited from effective procedures in place to safeguard them from possible harm and keep people safe.

Outcome 9:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are moderate concerns with outcome 9: Management of medicines

Our findings

What people who use the service experienced and told us

The people we spoke with did not comment about the medication they received or how they received it.

Other evidence

We looked at the way medicines were managed to check that people were receiving their medicines safely and as prescribed. The service had secure storage for medication and the Monitored Dosage System (MDS) was used for most medicines which means medicines were dispensed into monthly blister packs. The registered manager told us that only qualified nursing staff administered and audited medication. Medication was stored in a locked cupboard and the Medication Administration Records (MAR) were inspected along with the medication systems.

We looked at four people's medication records to ensure people were receiving their medicines as prescribed. We found that where people had been resident in the home four over four weeks, medicines had been dispensed into blister packs and the MAR sheets had been completed and there was an accurate audit of medicines

remaining in the home. One person had been recently admitted with boxed tablets from a hospital. There were two medicines where the number of tablets remaining in the home did not correspond with the audit. The MAR sheet recorded a number of occasions where medicine had been refused but did not record whether the tablets had been administered from the box and later destroyed. We audited the tablets again with the registered manager and deputy who agreed suitable systems needed to be implemented for people coming out of the hospital or moving into the home to ensure people received the medicine required and an appropriate record was in place to check.

Our judgement

People generally received their medicines as prescribed to keep well. The systems in place for new medicines needs to be reviewed to ensure people receive their medication in a planned and safe manner.

Outcome 12:
Requirements relating to workers

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

The provider is compliant with outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us

We did not talk to people who use the service about the staff recruitment process.

Other evidence

We looked at two staff files of people who had started working in the home since our last visit. We saw that staff did not start employment until all required information had been received. This included two written references, and a criminal record check (CRB). Records of interviews had been retained in staff files and these showed that any gaps in employment history had been explored. This means that people who use the service were protected because the provider carried out suitable checks to make sure staff could work with vulnerable adults.

Our judgement

People could be confident that staff were suitable to work in the home as effective recruitment and selection procedures were in place, to make sure they could work with adults.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:

- Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us

An annual survey was conducted by an independent company who contacted relatives directly about their views on the service. We saw the last results of this survey which has been made available to people in the home. The registered manager told us that due to the needs of people using the service their opinions about the service were sought through one to one discussions or at residents meetings. We talked to people who use the service and their relatives about the service who told us,"We've no complaints, we're very happy with support given. They give the best care and we couldn't wish for better," and "This is one of the top homes the staff and care is very good."

Other evidence

The service had a variety of systems in place to assess and monitor the quality of the service provision. The registered manager told us there were internal audits that covered annual health and safety checks, accidents and near misses and we saw copies of these. We looked at records for portable appliance tests (PAT), and fire records and maintenance of equipment and these were up to date.

The registered person told us before our visit within the PCA that there were audit systems in place for reviewing care plans and medication. We saw some plans had been reviewed during the monthly visits by a nominated senior manager from within the company. We looked at the reports of these visits which recorded positive outcomes for people as well as areas that could be improved. The visit in December recorded the plans of care could be more person centred and since this visit the registered manager demenostrated to us that these are being reviewed and for all staff to be involved with care planing and recording. As part of these visits the nominated person recorded where they had spoken to people who use the service and any visiting relatives or professionals.

The registered manager told us that they use the Provider Compliance Assessments as a working document and keep these updated to evidence how they were compliant, and actions that were required. The monthly visits by a nominated individual reviewed who these documents and any identified actions. This means people were able to benefit from receiving a service from a provider who continually reviews their performance and strives to make improvements.

Our judgement

There were quality assurance arrangements to formally monitor and review the health, safety and welfare of the people who use the service.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	9	4
	Why we have concerns: People who use the service received appropriate care and support and the service was managed so people felt their welfare was protected and their needs were met. The service has identified the plans could be developed to be more person centred.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent within 14 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	13	9
	How the regulation is not being met: People generally received their medicines as prescribed to keep well. The systems in place for new medicines needs to be reviewed to ensure people receive their medication in a planned and safe manner.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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