Borough Care Ltd

Bryn Haven

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Bryn Haven is a residential care home providing personal care to 38 older people at the time of the inspection. The service can support up to 42 people. Bryn Haven specialises in providing care to people living with dementia.

People's experience of using this service and what we found
Within the context of areas reviewed as part of this targeted inspection, 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 best practice.

Risks to people's safety had been assessed and reviewed. People had been recently assessed to identify if they were at high risk of falls and steps to mitigate these risks had been taken. Staff cared for people appropriately after they had fallen.

The management team had not consistently investigated and learnt from incidents. Improvements in response to recommendations made by Her Majesty's Coroner had progressed slowly. Appropriate referrals to other healthcare professionals had not always been made. There was a gap in manager oversight.

As part of CQC's response to the coronavirus pandemic we are also conducting a thematic review of infection control and prevention measures in care homes. As part of the inspection we looked at the infection control and prevention measures the provider had in place. Risks to people who used the service and staff relating to infection prevention and control, and specifically Covid 19, had been assessed and appropriate action taken.

We found no evidence during this inspection that people were currently at risk of harm from this concern. We have made a recommendation about how the provider implements improvement.

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 28 June 2018).

Why we inspected
CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We undertook this targeted inspection to check on specific concerns we had about the management of falls.

The inspection was prompted in part due to concerns raised by Her Majesty's Coroner. A Regulation 28 Report was issued to the service on 26 November 2019 relating to risks around falls. The Coroners and Justice Act 2009 allows a Coroner to issue a Regulation 28 Report to an individual, organisations, local authorities or government departments and their agencies where the Coroner believes that action should be taken to prevent further deaths. A decision was made for us to inspect Bryn Haven and examine those risks.

We also 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 coronavirus and other infection outbreaks effectively.

The overall rating for the service has not changed following this targeted inspection and remains good.

Please see the safe and well-led sections of this full report...

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question good. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question good. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Bryn Haven

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. This was a targeted inspection to check on specific concerns we had about falls.
As part of this inspection we also 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 undertaken by three inspectors. Two inspectors visited the service on the first day of the inspection. One inspector spoke by telephone with the general manager on the second day of the inspection.

Service and service type
Bryn haven 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.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
We gave a short period of notice of the inspection so that we could have some preliminary discussions around the use of Personal Protective Equipment (PPE) on inspection. The inspection took place on 8 October 2020 with a site visit, we continued on 9 October with a follow up telephone call to the general manager.

What we did before the inspection
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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and asked Healthwatch Stockport for their views on the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with the general manager, an area manager, the training manager and the nominated individual for Borough Care Limited. The nominated individual is the person appointed to represent Borough Care Ltd in it's dealings with CQC.

We reviewed a range of records relating to the concerns raised and the management of the service. These included risk assessments, care plans, daily records and incident/ accident forms.

After the inspection
We continued to seek clarification from the management team to validate evidence found. We looked at training data and records relating to monitoring, auditing and quality assurance.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the parts of the key question we had specific concerns about.

The purpose of this inspection was to check a specific concern we had about falls. We will assess all of the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management;
- Risk assessments were reviewed regularly and updated following a fall.
- The newly appointed general manager demonstrated a commitment to falls prevention and had individually assessed people's mobility and risk of falls.
- The general manager had liaised with the GP to arrange additional health checks for people who were identified as being at high risk of falls.
- People had access to appropriate equipment. For example, sensor mats had been placed in people's bedrooms, where required.
- Staff were trained in moving and handling which included information about falls prevention.
- The general manager and senior staff completed regular spot checks to ensure the environment was safe. Where concerns were highlighted these were documented and action taken.

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 meeting shielding and social distancing rules.
- 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 accessing testing for people using the service and staff.
- 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.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check specific concerns we had about falls. We will assess all of the key question at the next comprehensive inspection of the service.

Continuous learning and improving care

- In January 2020 the provider responded to a Regulation 28 report issued by Her Majesty's Coroner detailing how they planned to improve falls management at all their homes.
- Whilst we saw that some of these actions had been carried through, the provider did not formally update and fully implement the falls prevention policy, the falls pathway and their improved audit system until August 2020.
- On the first day of our inspection the outdated falls prevention policy had not been removed from the digital system and was still accessible to staff. The nominated individual immediately took action to rectify this and ensure only the updated version was accessible.
- Investigations into falls were not always completed. One person had fallen twice within a two-week period and did not sustain any injuries. Investigations had not taken place into the first two falls. The person had then had a more serious fall.

We recommend the provider learns from incidents and actions improvements promptly and diligently.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;

- The newly appointed general manager demonstrated they had comprehensive experience of falls management and an extensive knowledge of falls prevention strategies.
- The home had submitted all mandatory information about incidents to the local authority on a quarterly basis.
- Full provider audits were not consistently completed between January and July 2020. During this period we identified three people living at Bryn Haven who had fallen twice within a two-week period. Under the improvements indicated in the provider's Regulation 28 response to Her Majesty's Coroner in January 2020 these falls should have triggered a referral to a healthcare professional. However, provider systems had not identified that the updated pathway was not being followed.
- Falls assessment packs did not capture information relating to referrals.
- Staff had responded appropriately to care for people when they had fallen. However, information relating to aftercare, professional visits and monitoring were not always captured in detail on the digital care management system.
- The digital care management system did not provide clear oversight of professional visits which made it

difficult to track falls and subsequent treatment.