Branch Court Limited

Branch Court Care Home

Inspection report

Livesey Branch Road
Blackburn
Lancashire
BB2 4QR

Tel: 01254682003

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This was an unannounced inspection which took place on the 31 July and 1 August 2018.

Branch Court Care Home 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.
Branch Court Care Home is a purpose build care home, situated just over a mile from Blackburn town centre. The care home provides accommodation to 30 older people who require support with personal care needs and specialises in providing care for people living with dementia. All rooms are en-suite.

At the time of our inspection Branch Court Care Home was providing support to 30 people. There was a registered manager in place at Branch Court Care Home. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons.' Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was supported in the day to day running of the service by a deputy manager.

At our previous inspection on the 11 and 13 July 2016 we found two breaches of the Regulations. We found people were not protected against the risks associated with the unsafe handling of medicines.The recruitment processes in the service were not sufficiently robust enough to protect people who used the service from the risk of unsuitable staff. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the management of medication and the staff recruitment process.

During this inspection, we found that improvements had been made to the recruitment processes. However, our findings demonstrated there were three breaches of the Heath and Social Care Act 2008(HSCA) 2008 (Regulated Activities) Regulations 2014. The breaches in Regulations were in respect to the implementation of the Mental Capacity Act, a lack of effective monitoring systems and a repeated breach in relation to the management of medicines. You can see what action we told the provider to take at the back of the full version of the report.

At the last inspection the service was rated as overall "good." At this inspection the rating had deteriorated to overall " Requires Improvement."
We found there were continued shortfalls in the management of medicines, including the frequency and recording of applying creams, as well as inconsistencies around thickening fluids. We also found concerns around the safe temperature of storage of medication and the interpretation of "as and when required" medication.

The provider was not undertaking mental capacity assessments. Therefore, they were not working within the requirements of the Mental Capacity Act (2005) to help ensure people's rights were protected.

Assessments of individual and environmental risks had been undertaken to ensure people's safety and well being. However, we identified a shortfall around the lack of Legionnaires risk assessment and water checks.

During our inspection we found shortfalls that had not been identified by the provider's monitoring systems. This meant the systems were not fully effective. People were given the opportunity to feedback on their experience. Where complaints had been made, these were investigated thoroughly and resolved. There was a positive culture in the home and the registered manager was clearly passionate about the service.

Changes in people's health were identified and appropriate health professionals were contacted. People had sufficient amounts to eat and drink and their nutritional and hydration needs were well met.

People's needs had been assessed, risk assessments had been undertaken and people were supported by staff who had been safely recruited and had received appropriate training and supervision.

People were supported by staff who were kind, caring and promoted their independence. People were treated with dignity and respect and had access to advocacy services if needed.

There were sufficient numbers of staff to meet individual need. People and their families were involved in the planning and review of their care. There were systems in place to ensure that people had access to meaningful activities.

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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 consistently safe.

The systems for managing medicines required improvement to ensure people always received their medicines as prescribed.

People told us they felt safe and there were enough staff to meet their needs.

Is the service effective?

Requires Improvement

The service was not effective.

The provider was not acting in accordance with the Mental Capacity Act 2005. This meant people's rights to freedom and independence were placed at risk.

People had access to appropriate healthcare professionals to ensure their needs were being met.

Is the service caring?

Good

The service was caring.

People were involved in making decisions about their care.

Staff supported people to maintain their dignity and independence.

Is the service responsive?

Good

The service was responsive.

Assessments were undertaken and care plans were developed to identify people's care needs.

There was a system in place to manage complaints. People we spoke to felt confident their complaints would be listened to and acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality monitoring systems had not identified shortfalls in medication management and the lack of mental capacity assessments.

There was a positive staff culture within the home.

Branch Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is making the legal requirements and regulations associated with the health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 31st July and 1st August 2018 and was unannounced. It was a planned comprehensive inspection.

On the first day of the inspection the inspection team consisted of an adult social care inspector, 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. The expert had experience of services for older people. The second day of the inspection was carried out by two adult social care inspectors.

Prior to the inspection we reviewed the information we held about the service including notifications that the provider had sent to us. A notification is information about significant events which the provider needs to send to us by law. We contacted the local authority quality team and Health-watch organisation to seek their views about the service. Neither organisation had any concerns.

We used information the provider sent to us in the Provider Information Return. This is information we require providers to send to us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make.

On the first day of the inspection, we spoke to eight people who use the service and four visiting relatives. On the second day of the inspection, we spoke to the registered manager, a senior carer, two care staff, the housekeeper, laundry assistant, the chef and the activities co-ordinator. We also spoke with a visiting healthcare professional.

As some of the people residing at Branch Court Care Home were unable to share their views with us, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to

help us understand the experience of people who could not talk with us.

We carried out observations in the communal areas of the home. We had a tour of the premises and looked at a range of documents and written records including the care records of three people who used the service, six staff recruitment files and staff training records. We also looked in detail at the medication administration records of 15 people. In addition, we looked at policies and procedures, complaints records, accident and incident documentation, meeting minutes and the records relating to the auditing and monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection of 11 and 13 July 2016, we found the provider had failed to protect people against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time we found systems needed to be improved to ensure the safe handling of medicines. We found that prescribed creams had not been administered appropriately. Following the inspection, the provider sent us an action plan which set out the action they intended to take to improve the service.

During this inspection we found that medicines were still not being handled safely by the service. This was a continued breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A medicines inspector looked at 15 people's medicines and records to make sure that medicines were managed safely and people's health was not put at risk. We found that medicines management was not safe.

Since our last inspection, we saw some improvements had been made in the records about the application of creams and a system had been put in place. However, this system did not always work and there were still some concerns about the frequency of applying creams and recording of administration. There was a lack of information available for staff to refer to when they were applying creams, such as how often to apply creams or where they should be applied. The records showed that when there was information about how often the cream should be applied it was not applied as often as prescribed. We still found that there were some days where no record had been made to show that people had their creams applied properly.

The information available, to help guide staff as to how to administer medicines which were to be given "when required," did not contain enough personalised details. This meant that these medicines may not be given safely or consistently. When medicines were prescribed with a choice of dose there was no information recorded to explain the circumstances under which the higher or lower dose should be given. We also saw that when paracetamol was given, the time of the dose was not always recorded. This meant that people could be given doses of paracetamol too close together, placing their health at risk of harm.

Three people were prescribed thickeners to be added to their drinks to prevent them from choking. We found the information, from the speech and language team was, in their care plans about what consistency their drinks should be. However, the information on the notice board in the kitchen did not match their care plans. When we asked carers, who made the drinks, how thick each person's drinks should be, their answers did not match the information in the care plans. We spoke with the registered manager and carers about the new guidelines for thickening fluids. They were unaware that the manufacturers had changed the measuring scoops sizes and that they needed to check how may scoops must be used to achieve the correct thickness. The carers told us that they were still using the same number of scoops as they did before the new smaller scoops were introduced. They had noticed the fluids were not getting quite as thick as they used to. If people's drinks are not thickened to the correct thickness they are at serious risk of choking.

During the inspection the registered manager made sure that the information on the notice board reflected the correct consistency needed. She also the contacted speech and language therapist about providing training with regards to IDDSI. (International Dysphasia Diet Standardisation Initiative). We also saw that the tins of thickener were not stored safely which may cause harm if they are accidently swallowed.

We looked at the storage of medicines and found that they were stored securely but that they may not have been stored at the correct temperatures. The medicines in daily use were stored in two trollies in the lounge. The lounge temperature was not recorded. Medicines which needed cold storage were stored in a dedicated medicines fridge but staff had not recorded the temperatures properly and could not show that the medicines had been stored at the correct temperatures. On the day of inspection, we saw that there was melting ice in the fridge which had formed a pool of water inside the fridge. If medicines are not stored at the correct temperatures they may not be safe to use.

We saw that controlled drugs, which are medicines which may be at risk of misuse, were accounted for and stored safely. When the prescribers made change to people's medicines or their doses we saw that the changes were recorded promptly and clearly ensuring people were given the new doses or new medicines safely.

Medicines were not handled safely by the service. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection of 11 and 13 July 2016 we found the provider had failed to ensure the recruitment processes in the service were sufficiently robust enough to protect people who used the service from the risk of unsuitable staff. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time, we found that two members of staff had not included a full employment history on their application form. The registered manager had also failed to check why applicants had left previous employment involving work with vulnerable adults or children. This meant there was a risk that people might not be properly protected from the risk of unsuitable staff. Following the inspection, the provider sent us an action plan which set out the action they intended to take to improve the service.

During this inspection, we found recruitment processes had significantly improved. The application forms had been updated and amended to include a full employment history and two references had been sought, in line with company policy. We discussed with the registered manager, the way in which one of the files could be improved further and this was acted upon accordingly.

People told us they felt safe and free from bullying. One person said, "I have been here about five years now as I was having frequent falls at home. I ended up in hospital for four months and then came in here where I have been much safer and cared for very well." Staff had a strong understanding on how to identify and report any concerns to the management. The culture was open and the registered manager operated an open-door policy. We saw evidence of guidance being used to inform practice, such as Lancashire Safeguarding Adults Board Guidance 2017.

Policies and procedures including safeguarding, complaints and whistleblowing were designed to minimise the risk of harm. Staff spoken to, confirmed that they would have no hesitation in using the whistleblowing policy. (reporting poor practice). They were confident that the registered manager would take appropriate action. We saw evidence of disciplinary procedures in place and the process being utilised. All staff had been trained in safeguarding and those that had recently joined the service had training planned. Policies detailed the types of abuse, the staff's responsibilities in relation to safeguarding and local authority, police

and the Care Quality Commission (CQC)contact numbers. Appropriate safeguarding referrals were made. We saw evidence of a safeguarding that was raised recently due to someone rolling out of bed. Appropriate actions were taken, family were informed and a low-rise profiling bed was put in place to minimise the risk of future injuries.

People's preferences in relation to equality and diversity were consistently treated with respect. We observed staff confidently assisting people with moving and handling techniques. People were asked for consent and were informed every step of the way. We heard the staff reassuring people. "Ok, you're over your chair now, we will start to lower you down."

We saw evidence of staff assisting people to be as independent as possible and walking with them at their own pace. Relatives also felt their family members were safe. "It is much better for me knowing she is safe and I have been very impressed with the patience and care they give to my Mum."

All areas of the home were very clean and staff had regard for procedures to minimise the risk of infection. Staff were observed wearing appropriate personal protection equipment and staff we spoke to told us they attended regular training sessions including infection control. We spoke with the housekeeper who was very passionate about her role and saw evidence of cleaning schedules and audits in place. Staff understood the importance of food safety and had appropriate food hygiene training in place. The service had received a 5-star food hygiene rating.

There were regular recorded maintenance checks on equipment in relation to health and safety such as hoists, fire extinguishers, gas, electrical, portable appliance testing and emergency lighting. One staff member explained that a hoist had recently broken down which was having an impact on getting people ready in the mornings. However, the registered manager assured us they were in the process of sourcing another one.

We identified an additional shortfall around the lack of Legionnaires risk assessment and water checks. Legionnaires disease is a potentially fatal type of pneumonia contracted by inhaling airborne water droplets containing viable legionella bacteria. Health and social care providers should carry out a full risk assessment of their hot and cold-water systems and ensure adequate measures are in place to control the risks. Although water temperatures were being checked weekly, stating the room number and temperature, there was no information regarding the safe temperature range and whether action was needed or had taken place. The registered manager had previously identified this an issue and had already raised this with head office prior to inspection. Head office were contacted again during the inspection and authority was sought for a full risk assessment by a competent person.

The staff team felt confident having had training in fire safety. Fire policy risk assessments, personal evacuation plans and contingency plans were in place. Environmental and personal risk assessments were also in place. Individual risk assessments considered best practice in areas such as skin integrity, nutrition and falls. We discussed with the registered manager the need to individualise risk assessments in relation to managing the behaviour of people that may challenge. This would mean the risks could be managed more effectively and staff would have clear guidance to follow. Antecedent-behaviour-consequence (ABC) chart documentation was in place, but was not being consistently recorded. This was responded to immediately and risk assessments were amended during the inspection.

We looked at the staffing rotas for the last 4 weeks and found staffing levels were adequate. However, there was mixed feedback received from people and their relatives. Although most people felt that staffing was adequate, two people did comment that they thought the staff were always busy and could do with more

help. The registered manager explained she based the rotas on individual need and did not use any staff dependency tools. Throughout the inspection we observed staff were attentive and answered call bells promptly. Staff themselves felt that staffing levels were generally fine, although one staff felt that an additional staff in the morning would be beneficial. Staff told us that they always covered for each other during holidays and did not use agency staff. This ensures consistency of staffing. The registered manager had previously informed us that she was currently in the process of recruiting new staff for the morning shift and had already had agreement to increase night time staffing.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the metal capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack the mental capacity to take decisions, such decisions made on their behalf must be made in their best interests. They should also be the 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 MCA. The application for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS).

Although staff had a day to day understanding of how the MCA 2005 worked and we heard staff seeking consent, there was a lack of understanding around the assessment process. Policies and procedures were in place and stated that the "home manager must ensure a person's mental capacity is assessed and apply for a DoLs if appropriate." We found assessments had not been carried out to assess people's capacity before DoLS applications were made. We also found no evidence of best interest meetings taking place around important decisions such as consenting to moving to a care home. This meant that there was no evidence of decisions being made with the people themselves and their families. The provider had failed to act in accordance with the MCA and people were at risk of having their rights and liberties restricted unlawfully. This was a breach of Regulation 11 of the Health and Social Act (Regulated Activities) Regulations 2014. We discussed this with the registered manager who responded swiftly downloading the MCA toolkit and reassured us that capacity assessments would be undertaken. We also noted that MCA training had already been planned for September 2018 and staff had already applied to attend the training. Six applications for DoLS had been made within the last 12 months.

People's care and support was planned effectively and needs were assessed. Before a person started to use the service, an assessment of their physical, mental health and social needs were undertaken to ensure their needs could be met. Most people, or their relatives, were enabled to visit the home and meet with staff and other people who used the service before making any decision to move in. This allowed them to experience the service and make a choice about whether they wished to live in the home and staff could determine whether the home was able to meet their needs.

We found technology was being used to enhance people's lives. For example, a smart speaker was used as a translation aid to assist one person with communication as the individual's first language was not English. By utilising this technology, the staff team could provide a person-centred service tailored to the individual's cultural needs.

People were supported to maintain their health and wellbeing through access to a range of healthcare specialists as required. The registered manager had good working relationships with other health professionals and appropriate referrals were made. We spoke with one visiting healthcare professional who told us that staff referred appropriately and followed the advice and guidance given. They told us "I have no concerns about people's care, they seem to be well cared for and seem happy." Staff also told us how there was a single point of access form for occupational therapists and they had very good relationships with the

district nurses. We saw comments from a speech and language therapist (SALT) in the compliments book stating, "Staff have confidently and appropriately placed residents on a pureed diet whilst waiting for direct SALT management. This is great care and puts the resident at the centre of the care by reducing risks of aspiration and choking and kept the resident safe."

We observed how swiftly one person received medical attention after complaining of feeling unwell. The senior carer contacted the general practitioners (GP) surgery and expressed her concerns, to which the GP responded and visited within the hour. Staff were well trained and people felt reassured, "They know what they are doing here and I have never needed to complain about anything."

Staff received appropriate training and induction. All staff including the domestic and kitchen staff received full training, which enabled them to be flexible to assist with care tasks if necessary. The housekeeper played a pivotal role in supporting people to hospital appointments. One relative commented, "Thank you to all the staff for the care of my mother. A special thanks to [name of staff] who escorted her to A and E and stayed until she was admitted to a ward. It was a great comfort to her and us. Keep up the good work!"

All staff received mandatory training such as first aid, infection control, fire safety, moving and handling and safeguarding and most staff would have completed their MCA training by early September 2018. A small percentage of staff (19%) had completed their end of life care training and 37% had been trained in dementia awareness. There were currently no people on end of life care at the service. Staff received quarterly formal supervision where performance, training and actions were discussed but were also aware they could request additional support at any time. No annual appraisals took place. There was evidence of medicine competency checks being completed. Staff told us, "Training is very good and you can ask for more. They encourage you to progress."

The service provided good quality fresh food with a variety of options to choose from. Staff were aware of people's individual preferences of eating and drinking and there was flexibility when needed. People told us they were happy with the food. They said, "I enjoy the meals, the food is very good and I know you can get alternatives if you don't like what is on offer but I have never needed an alternative."

We observed the lunchtime experience, which was pleasant and not rushed. Staff offered appropriate assistance which was, tailored to individual needs and promoted people's independence. We saw positive examples of people being assisted to eat respectfully, asking if they were ready for more, taking it at their own pace. We also witnessed staff encouraging people to eat by suggesting they put their babies (dementia dolls) down for a sleep. "You've got to keep your strength up and eat to be strong for that baby." We saw evidence of food and fluid charts and staff were aware of people's personal preferences.

Staff were respectful of people's wishes and people felt listened to. All relatives spoken with told us that their relative had been involved in decisions about the care plan, that healthcare needs were being met and they were kept informed on any changes in their relatives' condition. One relative told us, "She loves the staff but, if things are not right she will let them know. She has managed her diabetes herself for years so, when the staff told her she could not have something which she wished to eat she rebelled. It was discussed with the manager and quickly sorted out to her satisfaction. I think she realises they were erring on the safe side to protect her."

Systems were in place for feedback on the service. We saw monthly newsletters, suggestion boxes and relative satisfaction surveys. The registered manager had developed a manager effectiveness evaluation form and we saw of evidence of resident /relative meetings taking place.

The environment was vibrant and welcoming with appropriate dementia signage, memory boxes and different coloured doors to aid with orientation. There was also a small bar area, set up in memory of a previous resident. This was utilised mainly for fundraising events which helped to pay for trips out.

Good

Is the service caring?

Our findings

The staff team provided a caring and compassionate service. People described how they had previously experienced good care at Branch Court Care Home and wanted the same level of quality for other family members. One relative told us, "Mum has been in here for two months now and some time ago dad was in here. The care and treatment he got was fantastic, second to none, so when mum needed somewhere this was our first choice. As before, the care and treatment is excellent throughout and she is now enjoying living here."

We observed that people were caring and kind to people. Staff took the time to talk to people and ensure their needs were taken care of. We overheard staff asking if people were warm enough and "if they wanted a blanket." They also gained consent before assisting people, "Can we make you comfy and pop you back in your chair." We observed staff using appropriate humour and tactile gestures with people. We saw that staff interacted with people at every opportunity. Staff looked happy in their work and every member of staff we spoke to said, "I love it here!"

We saw lots of thank you cards and compliments from people. Comments included, "I'd just like to say wonderful staff and great environment – 5 stars!" and "Branch Court is the best home I have ever been to. I would 100% recommend family members to come here."

We observed positive interactions between the staff, management and the people living at Branch Court Care Home. The was a positive person-centred culture within the home and the staff worked as a cohesive team. One staff said, "I've never worked in a place where we're so close. It's good for people living here too."

Staff demonstrated good listening skills and demonstrated empathy for people. We saw various examples of staff being respectful and reassuring people. Staff promoted dignity and respect by knocking on bedroom doors and getting down to people's levels to talk to them discreetly. One person said, "They are all so kind and caring that I am happy with everything."

People's personal histories were clearly documented. We saw an excellent example of one person's My Life Story completed with pictures over the years. This level of detail about her working life, significant relationships and life events helped staff to see the person as an individual. People also felt supported and the registered manager explained an allocated key worker system was in place. This meant that a named member of staff worked closely with people to ensure their needs were being met appropriately. This meant that consistency of care was achieved.

Communication was strong across the service and we were told new staff were always introduced to people through shadowing and at the resident/ relative meetings. People told us, "This place is really very good though and I can't fault any of the people who work here." One relative said, "Everyone is so welcoming to us and keeps us up to date with what's going on. I felt you should know as some homes get bad press and we couldn't be happier with the love, care and dedication of all at Branch Court." Feedback about the registered manager from staff was also excellent. One staff commented, "She is an amazing person with a

big heart as well as an amazing manager." We also saw an appreciation board in the hallway where people could post notes of gratitude and thank others, which helped to increase staff morale. There was a positive culture running throughout the service which was a direct result of the passion and drive of the registered manager.

Visitors were encouraged to call at the home and felt welcomed. Relatives we spoke with, confirmed that they could visit without any restrictions. We noted the home had very strong links with relatives and families and kept them regularly updated. People were supported to maintain links with family and friends. We observed one relative whose family member had since passed away, being welcomed into the home for lunch and a game of bingo. This was a regular occurrence and demonstrated the caring and supportive nature of the staff team, going above and beyond their duty.

Staff were passionate about their work. They helped people to feel valued and important. Staff we spoke to, had a good understanding of treating people fairly and respecting people's human rights and supporting people with their cultural needs effectively. The registered manager and the staff also knew how to assist people to access advocacy services. and leaflets were clearly on display in the reception area. An advocate is a person who works with people who may need support and encouragement to exercise their rights.

We saw that records were kept securely and could be located when needed. This meant only care and management staff had access to them, ensuring the confidentiality of people's personal information. However we noted that the registered manager's office was extremely small and could not accommodate two chairs effectively. This meant that we had to discuss our findings outside in the garden, due to the lack of available, internal space.

Good

Is the service responsive?

Our findings

Staff took the time to get know people so they knew how people liked to be supported. People's needs had been assessed prior to their admission to the home and people, where possible were involved with planning their care. Care plans contained a variety of appropriate information about people's needs and preferences. Falls assessments, skin integrity risk assessments and malnutrition universal screening tools (MUST) were in place. This was complimented by an out of area social worker leaving a message saying, "Thank you very much for making me feel very welcome. Care plans are very detailed and well planned."

Staff were aware of the communication needs of the people they supported from the information in the care plan. It was documented whether people were interacting and expressing their needs. Staff demonstrated how they would know a person was in pain. Staff said "They can't communicate verbally but we would know from their body language, if they were in pain, they would grimace or make small noises." The registered manager had awareness of the accessible information standard and discussed how she would utilise large print or easy read information to ensure people receive accessible information.

There were regular resident/relative meetings so that the staff could make sure people were kept up to date with information about the home, forthcoming events and have an opportunity to have their say. Care was regularly reviewed and there was evidence of families being regularly consulted and updated on the welfare of their relatives. We also saw of evidence of people's final wishes. Although no one was on end of life care at the time of the inspection the registered manager was able to illustrate some recent examples which demonstrated good practice. One example demonstrated the learning of cultural considerations at the end of life. We also saw evidence documented of another example where staff played someone's favourite music and supported them with compassion and dignity. The registered manager explained how they liaised closely with the district nurses providing the care and how some of the staff had received end of life care training.

People were encouraged to make choices and people choose times when they wanted to get up and go to bed. We observed staff encouraging people to make their own decisions around meal choices, drinks and activities. Staff told us "We have the time to support people with choices and decision making. It's good to help them to pick their own clothing and jewellery." All people living at the home were well presented.

We observed staff interacting and engaging in an inclusive way with people. One gentleman started dancing to his favourite music with his frame. He was joined by the activities coordinator who danced with him, both smiling away. The gentleman then twirled the staff around and showed her a different dance. This interaction demonstrated warmth, humour and inclusive sharing.

People could call for staff assistance at all times to respond to their needs and staff were very visible. We observed staff responding appropriately in an emergency whilst we were having a tour of the building. One person had fallen in her room on her crash mat and the emergency call bell activated. The staff member immediately went to her room and spoke reassuringly to her in a respectful manner, asking if she was hurt. The staff had to speak loudly and repeat the information. The tone of the interaction remained calm and

respectful.

People were offered the opportunity to take part in a range of activities, such as trips, quizzes, indoor gardening, board games and arts and crafts. They appeared to enjoy the bingo, with the activities coordinator actively encouraging people to participate. All relatives said that their loved ones did take part in activities but particularly enjoyed the trips out. They had recently organised a trip to Cleveleys which they had fundraised for and everyone told us they had thoroughly enjoyed.

One person said "I am not too bothered about activities but they are doing arts and crafts today so I would have given it a go. My friends are not interested and I am not doing it on my own so I will be giving it a miss." We saw evidence of activity plans and logs, detailing who had been asked to participate and their engagement levels. We saw photographs of people taking part in activities displayed in the hallway and regular newsletters which gave information about activities and planned future events, such as the summer fayre.

Another person told us "I am not too bothered about activities but, if any do take my interest, then I would happily join in."There were robust arrangements to ensure that people's complaints were listened and responded to improve the quality of care. These included informing people about their right to make a complaint and how to go about it. We saw evidence of complaints investigated and resolved. We saw copies of the complaint procedure were accessible, with a copy being available in each person's room. All the people we spoke with said it was easy to talk to the staff if they did have any concerns.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. "A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered provider, 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. "

People and staff spoken to told us the service was well organised. There was a positive culture within the service and the registered manager led by example. People knew who the registered manager was and it was evident that she knew the needs of the people very well. The management team were passionate about the service and their core values were shared within the whole staff team.

Audits were in place covering accidents, incidents, safeguarding, falls monitoring, care plans, medication and maintenance. However, on this inspection we found some shortfalls in the service which had not been identified through the audit and quality assurance monitoring systems in place. We were concerned about the repeated breach found at this inspection around medication. The registered manager was open and honest during inspection and took immediate steps to rectify some of the issues raised. The registered manager made sure that the information on the kitchen notice board reflected the correct consistency assessed by the speech and language therapist and contacted them regarding further training. Tins of thickener which were found not to be stored safely were securely sealed away. We found the registered manager responded appropriately to our concerns and assured us that Mental Capacity assessments would be undertaken, in line with legislation. The registered manager had previously raised issues around the lack of legionella testing, with maintenance and head office. She contacted head office during the inspection, to confirm that she had raised this previously and no action had been taken as yet. We were given assurances that a full system test and associated sterilisation would be actioned as a priority.

The registered manager discussed how she was in the process of improving some of the audits and would look more into the analysis of incidents to ensure lessons were learned. Further work needed to be undertaken around the monitoring of behaviour management as we found documentation was not being consistently recorded. The external quality audits undertaken by head office did not highlight the shortfalls found during inspection.

The provider had failed to operate an effective quality assurance system in order to improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was supported by a senior person from the organisation. They visited and monitored the registered manager's practice. All people who used the service said that they felt listened to. People and their relatives were able to express their views at resident/relative meetings and take part in customer satisfaction surveys. They were happy with how the service was managed. One person told us, "I find everything to be excellent, everyone on the staff is very good, we are safe and well cared for and I am definitely happy here." Families were also very complimentary of the service and we read compliments from

satisfaction surveys saying, "The culture of everything is spot on, staff are friendly, knowledgeable and accessible."

The service worked well with other health care professionals, in line with people's specific needs. Staff commented that communication between other agencies was good and enabled people's needs to be met. Care files showed evidence of professionals working closely together and appropriate referrals had been made to SALT and moving and handling falls team.

All staff we spoke to said they loved their jobs and morale was good. People felt well supported and inspired by the registered manager. They consistently spoke highly of her. One staff told us, "The management, they're brilliant. [Registered manager] is great. Anything I need she's bob on. She's just put me down for level 5 NVQ leadership, I'm now half way through, she's motivating." Another staff said, "The management are very organised they're both very approachable. We feel valued and treated fairly."

There was an open culture of learning from mistakes and incidents, accidents and falls were monitored. The registered manager told us systems to analyse accident and incident information was being improved in order to better identify any pattern or trends and to determine whether there was any action that could be taken to prevent further occurrences. Systems were in place for feedback on the service. We saw monthly newsletters, suggestion boxes and relative satisfaction surveys. The registered manager had developed a manager effectiveness evaluation form and we saw of evidence of resident /relative meetings taking place. Regular staff meetings took place and we saw evidence of staff handovers. Staff told us they felt listened to and felt confident raising any concerns with management. The registered manager had notified CQC appropriately of incidents within the service. We use this information to monitor the service and ensure they respond appropriately to keep people safe.

The registered manager explained her biggest achievement was she felt she had recruited, led, guided and supported a very strong, passionate team. This was evident throughout the inspection. She also discussed how she had built excellent and trusting relationships with people and their families and felt they were one big happy family. This was supported by compliments from relatives. They said, "She has been a wonderful support to us and works tirelessly for the residents."
The registered manager discussed her future challenges, how she felt that with continued hard work and support, she would eventually like Branch Court Care Home to achieve a rating of outstanding.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act in accordance with the Mental Capacity Act 2005. Regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate an effective quality monitoring system. Regulation 17.