Mercer Care Ltd

Bramhall

Inspection report

1 Butt Lane
Tattershall
Lincoln
Lincolnshire
LN4 4NL

Tel: 01526342632
Website: www.mercercare.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 12 December 2017 and was unannounced. There were 24 people living at the home on the day we visited.

Bramhall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Bramhall accommodates 38 older people some of who may be living with dementia in one adapted building. Bramhall has recently had a new extension which is joined to the existing home and this has supported them to increase their numbers.

There was a registered manager in place. However, they were in the process of handing over their role to a new manager who had also applied to be registered. '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.'

This is the second consecutive inspection where the home has been rated as Good.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. People were able to access advocates to speak for them when needed and were supported to be involved in planning their care and able to make choices about their lives. People's privacy and dignity were respected.

Staff were kind and caring. There were enough staff to meet people's needs and safe recruitment practices ensured that they were safe to work with people living at the home. Staff received training and support which enabled them to care for people safely. Staff had received training in how to keep people safe from harm and were clear on the actions they should take if they had any concerns.

People received an assessment when they moved into the home and environmental and care risks were identified and action was taken to keep people safe. Care plans recorded the care people needed and were regularly reviewed to stay up to date. Medicines were safely managed and the food provided supported people's wellbeing. Systems were in place to support the sharing of information across services and people were supported to access appropriate healthcare when needed. People's wishes for the end of their lives were respected and support from palliative care professionals was available.

The provider had completed a new extension and had provided a bright and pleasant environment for people to live in. They had incorporated the use of technology to keep people safe. The home was clean and staff had received training in keeping people safe from infection.

The home was well managed and there were systems in place to monitor the quality of care provided. Lessons were learnt from any incidents and action taken to stop them reoccurring. The feedback from people living in the home was used to improve the care they received. The provider had put systems in place to support staff to provide care in line with good practice. Staff had received training to enable them to provide support to people which met their cultural and personal needs. Complaints were investigated and responded to appropriately.

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 and remained good.	**Good**
Is the service effective? The service was effective and remained good.	**Good**
Is the service caring? The service was caring and remained good.	**Good**
Is the service responsive? The service was responsive and remained good.	**Good**
Is the service well-led? The service was well led and remained good.	**Good**

Bramhall

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 meeting 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.

This inspection took place on 12 December 2017 and was unannounced. The team consisted of an 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 home.

In preparation for our visit we reviewed information that we held about the home. This included notifications (events which happened in the home that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority contracting and safeguarding teams. We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the home, what the home does well and improvements they plan to make.

We spoke with the registered manager, the new manager, the activities coordinator, the cleaner and three members of the care staff. We also spoke with seven people living at the home and a relative of a person who lived at the home. We spent some time observing the care in communal areas.

We looked at a range of documents and written records including five people's care files and two staff recruitment records. We also looked at information relating to the administration of medicines and the auditing and monitoring of care.

Good

Is the service safe?

Our findings

We found that people were safeguarded from situations in which they may experience abuse. People who used the service reported it as being consistently safe. People told us they felt safe using the service and raised no concerns of how staff supported them with any safety issues. One person told us, "I feel safe, they're very careful." Another person said, "The carers are good, I'm safe. "Records showed that care staff had received training and knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk.

We found that risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. For example, when people needed support to move around the home the equipment and number of staff needed was recorded. Staff monitored people as they moved around the home and offered advice and support when needed. An example of this was staff gently reminding a person not to move their walking frame too far ahead as they may fall.

Equipment was used to monitor people so that staff were alerted quickly to risks. For example, people at risk of falls had sensors or pressure mats in their bedrooms so that staff were alerted if they started to move around the room and could go to them and offer support. Equipment was also used to keep people safe from the risks of developing pressure ulcers. Staff were aware that people's pressure cushions were individual to them and ensured that they were sat on the cushion prescribed to them at all times.

Care staff were able to promote positive outcomes for people if they became distressed. Where people might be distressed there were appropriate risk assessments and care plans in place to support staff to provide appropriate care. In addition, records of each incident were kept so that the registered manager could identify if times of the day or events were causing the behaviour. This helped them to plan and minimise the incidents for people.

Environmental risks were also assessed and action taken to keep people safe. An example of this was the appropriate signage in place to remind people and staff that one person was using oxygen and this was a fire hazard.

People had a personalised evacuation plan in place. This was information to support the emergencies services to evacuate people if there was a fire of other emergency. There was an emergency grab bag by the main door. This included everyone's evacuation plans along with information on people's medicines and photographs for identification. This would support people's safety when being evacuated.

People told us that there were usually enough staff on duty to support them. One person told us, "Response times are good, sometimes there are only two on duty then you have to wait." There was no formal system in place to identify the numbers of staff needed to provide care for people. However, the registered manager told us that they continually monitored people's needs and the needs of new admissions. If they felt that staff were struggling to meet people's needs at certain times then they would increase staffing for a period. The registered manager explained that they were waiting to get more staff employed and trained before

they increased the number of people living at the home. The registered manager told us that they were not prepared to have agency staff as they felt it was detrimental to the people living at the home.

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the registered manager had completed structured interviews. Any gaps in people's employment history had been identified and investigated. The required checks had been completed to ensure that staff were safe to work with people who lived at the home.

People living at the home and their family members confirmed that staff were good at giving medication on time, In addition, staff remained with people to ensure the medication had been taken. One person told us, "'I get my tablets on time. The carer stays while I take them."

We found that suitable arrangements were in place to safely order, administer and dispose of people's medicines in line with national guidelines. An example of this was medicine administration records having a photograph to assist with identifying the correct person and a record of any known allergies. Systems were in place to monitor that the storage of medicines met the national standards.

Medicines were administered to people in a methodical manner which reduced the risk of making a mistake. There were some protocols in place to support staff to consistently administer medicines such as painkillers which were prescribed to be taken as required. However, there were some protocols missing and we raised this with the registered manager. They told us that a recent pharmacist audit had identified the same concern and action was being taken to resolve the issue. In addition, we saw that staff took time when offering these medicines to people to discuss their pain levels and assess their need for the medicine.

We found that suitable measures were in place to prevent and control infection. The home was clean and there were no unpleasant odours. The registered manager attended the infection control meetings health by the local authority to ensure that they remained up to date with best practice Staff had received training in keeping safe from the risk of infection and ensured that they used protective equipment such as gloves and aprons appropriately.

There was a cleaning schedule in place. It had daily, weekly and monthly tasks. One room a day was deep cleaned. This mean that all the furniture was moved and high dusting was also completed. The cleaner also told us about how they used different coloured equipment in defined areas to reduce the risk of infection.

We found that the registered manager had established suitable arrangements to enable lessons to be learned and improvements made if things went wrong. This included the registered manager carefully analysing accidents and near misses so that they could establish why they had occurred and what needed to be done to help prevent a recurrence. Any learning was shared with staff at team meetings so that it could be embedded in to the care provided.

Good

Is the service effective?

Our findings

The provider had a holistic approach in meeting people's needs. Prior to receiving any care and support people's physical, mental health and social needs were discussed with the person and their relative or representative as appropriate. This followed current legislation and best practice guidelines. Care was provided to achieve effective outcomes. The home had a best practice handbook that staff were given when they started at the home. They were able to use to use this as a reference if they had any concerns over how they should be providing care. The handbook also contained information on different types of religion so that staff were able to see how care needed to be tailored to support people's beliefs. The manager was an accredited assessor for the care certificate. This meant that they were able to recognise if care met the standards needed to keep people safe set by the government.

Staff were positive about the induction, ongoing training and support they received. Records showed that new care staff had received introductory training before they provided people with care. In addition, they had also shadowed a more experienced member of staff to get practical support on their training. We spoke with a new member of staff who told us that the induction had supported them to provide safe care. They explained how they had been working towards the care certificate and that senior staff had observed them providing care to check that they were performing tasks safely and in line with people's care plans. The care certificate is a national set of standards set by the government to ensure staff have the skills needed to provide safe care. A new member of staff told us, "The senior is always available for support and the manager is very approachable."

Staff also received on-going refresher training to keep their knowledge and skills up to date. Staff were also supported by having regular supervisions with a senior or the registered manager. A member of staff told us that they were always asked during their supervision if there was any further training they needed.

People told us they were happy with the food and drink provided to them. One person told us, "They keep us well supplied with drinks, we can get them at any time." Another person said, "They make sure we get plenty of fluids." Lunch and tea choices were displayed on a chalk board and people were asked about their choices each day. One person told, "The food's good. We make a choice in the morning." Another person said, "We have plenty to eat." People's food likes and dislikes had been recorded along with their preferences for hot and cold drinks.

People's ability to eat and drink safely was recorded. Where people needed support this was recorded in their care plan. For example, one person's care plan recorded that they needed help to cut their food into bite size pieces. Staff understood the difference between different types of soft diet for example, fork mashable and pureed diets. The appropriate food was provided for people to keep them safe while eating.

Food for people was fortified to help people maintain a healthy weight. For example, potatoes were mashed with cream and butter to increase the calories people consumed. One person at the home needed support to maintain a healthy weight and receive calorie rich drinks prescribed for them by the doctor. Their weight was being monitored on a weekly basis. Other people were offered the opportunity to be weighed monthly.

In addition, the registered manager had identified the link between people's fluid intake and infections. One care plan noted that the person needed to be encouraged to drink as they were prone to urinary infections.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. Systems were in place to ensure that if a person went to hospital or moved to another home that the information about their medicines was available to the people who would be supporting them. Care plans contained emergency grab sheets so that all appropriate information was ready to hand over to other healthcare professionals in an emergency situation.

All the staff work together to care for people. At each shift there was a handover during which the head of care would allocate tasks to staff so they were clear of their responsibilities for the shift. The registered manager had spent time at the staff meeting talking about team work and how the staff needed to help each other if they were struggling as this improved the care people received.

People were supported to live healthier lives by receiving on-going healthcare support. People told us they were supported by healthcare professionals who visited the home. Records showed that people had been supported to access healthcare advice from their doctor and community nurses as well as professionals such as opticians and dentists.

We found that the accommodation was designed, adapted and decorated to meet people's needs and expectations. The provider had recently completed a new extension to the home. It had been designed by provider and an architect to support people's independence and included technology to keep people safe. Each bedroom had a ensuite bathroom with a shower. There was underfloor heating in the new wing which meant that there were no hot surfaces such as radiators for people to burn themselves on. Heating was able to be set at the desired temperature for each individual bedroom. Furniture was all fastened to the wall so that it was not able to fall on people. Each room in the new extension had sensors in the ceiling. These could be put on to alert staff when people got out of bed. There were secure garden areas which people could access independently.

The bedrooms in the new wing had been pleasantly decorated and there were three coordinating colour schemes that the provider had used. The new communal area was big and bright and set out in a dining area and a living room area. The living room seats were set out so that people could sit in friendship groups and talk to each other. The communal area had glass walls which looked out onto a secure garden area for people to enjoy. There was a dedicated hairdressing room in the new wing.

In the original home there was some signage in place to support people living with dementia but it did not fully support people's independence, For example, toilet doors were not easily identifiable from bedroom doors and the signage on some doors was small. The registered manager told us that the provider had plans in place to refurbish the original part of the home now the new extension was completed.

The provider had a computer systems in place which helped them monitor that checks had been completed in line with people's care plan at night. Staff were required to check into each room on the system and this logged the time that the care was given.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental 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 mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had not been aware that people who were not exit seeking but were unable to choose to live at the home needed a DoLS application. We raised this with the registered manager and they told us that they had identified all the people who were unable to consent to living at the home. Following our inspection they confirmed that they had submitted appropriate applications for DoLS assessments for all these people.

Where there was some doubt over people's abilities to make decisions, a mental capacity assessment had been completed. Where people had been unable to make a decision, most decisions had been made in people's best interest and the registered manager had ensured that appropriate staff, family and healthcare professionals had been included in making decisions on their behalf. Care plans recorded where people had legally arranged for named individuals to be able to make decisions of their behalf when they were unable to make a decision anymore.

Good

Is the service caring?

Our findings

We saw that the staff ensured that people were treated with kindness and that they were given emotional support when needed. One person told us, "They (carers) are wonderfully patient." Another person said, "The staff great, I have a good relationship with them." A relative told us, "I'm really happy mum's here. It's always clean and the staff are very friendly. I'm greeted with tea and coffee." They also commented that their mother was so happy at Bramhall that she now tells them they can go home and leave her with the staff.

The provider was caring and wanted people at the home to be happy and have everything they needed. People's emotional wellbeing was recorded in their care plans for example, one person's care plan noted that they were inclined to worry and needed reassurance. People's religious beliefs were recorded along with if they wished to take part in any religious services held at the home.

The provider had purchased Christmas presents for everyone. They had taken the time to identify what each person would like for Christmas and provided this for them. For example, one person needed new slippers and so that was what the provider had brought them.

Staff also wanted people living at the home to get as much as possible out of their lives. One person living at the home had been admitted as being unable to get out of bed. However, with support and using appropriate equipment the person had been supported to get up and listen to a singer in the lounge. They enjoyed themselves and were now choosing to get up on some days.

The provider supported staff so that they were happy at work and could support people to the best of their abilities. An example of this was staff working eight hour shifts instead of twelve as favoured by some care homes. This supported staff so that they did not get too tired to provide a high quality of care throughout their shift. Staff were also supported to have a number of weekends off each month to support their family lives. In addition, if people were having problems at home the provider would work with them to ensure their shifts supported their work life balance as much as possible.

Staff demonstrated they knew people they supported very well; they spoke in a caring and sensitive manner showing compassion and kindness. Staff were positive they had sufficient and detailed information about people's support needs and how they wished to receive their care and support. This told us that people could be assured their individual needs and preferences were known, understood and respected. People were supported to have choice and control in how they lived their life.

People's equipment to aid communication such as glasses and hearing aids were recorded. In addition, care plans recorded how staff could improve their communication skills to aid people's understanding. For example, one care plan noted that staff needed to ensure that their face was at the same level as the person's to get their attention and to ensure that they had understood the information.

People's privacy, dignity and independence were respected and promoted. During lunch one person with a known problem of acid reflux unfortunately vomited some of their meal back up. The staff quickly controlled

the situation by firstly getting a bowl and then moving the person round in their chair so that they were not facing the others at the table thereby giving some dignity to all concerned while the person recovered.

People who were unable to make decisions about their own care and who did not have a close friend or relative who they wanted to support them were able to access an advocate. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known. Records showed and advocate had been able to review a person's care plan for them to ensure it met their needs and protected their rights.

Staff had received training on understanding equality and diversity and understood that it was about ensuring that everyone was treated as an individual. An example of this was one person who due to their beliefs did not want to celebrate Christmas and chose to spend the day away from the party atmosphere in the communal areas. There was currently no one in the home who had identified themselves to the staff as being part of the lesbian, bisexual, gay and transgender community. However, staff were clear that they would support people's lifestyle choices.

Suitable arrangements had been made to ensure that private information was kept confidential. We saw that written records which contained private information were stored securely when not in use. In addition, computer records were password protected so that they could only be accessed by authorised members of staff.

Good

Is the service responsive?

Our findings

The registered manager told us how they visited people prior to them moving into the home to complete an assessment of their needs and to discuss and agree what support people required. People confirmed they and their relative where appropriate had been involved in the development of the care plan.

Care plans contained the information staff needed to provide safe care. However, they did not support care to be tailored to people's individual needs. For example, there was no record of how much the person was able to do for themselves or if the person may experience pain when being moved. Nevertheless, staff were able to tell us about people's preferences and abilities and how they altered the care provided to reflect people's individual needs. Care plans had been regularly reviewed so that they always reflected people's needs. We raised the concerns about the lack of detail in the care plans with the provider and registered manager. They had already identified this as a concern and had started to take action to rectify the situation.

Care plans contained the information needed to support people living with long term conditions. For example, where people were living with diabetes their care plans recorded the how often their blood sugars should be checked. Care plans recorded where people may experience pain and the actions staff should take to monitor their needs and provide support. In addition, there was a pain assessment tool for staff to use.

People showed us and records confirmed that they were offered the opportunity to pursue their hobbies and interests and to enjoy taking part in a range of social activities. One person told us, "There are plenty of activities if I want to do them." A relative showed how important activities were to people when they commented, "My mother is much brighter now she can join in with activities."

People's interests before they moved into the home were noted and they were encouraged to continue with their social lives as much as possible. Some activities that were suitable for people were suggested in their care plans. For example, one person's care plan recorded that they liked to talk about the past.

The home had an activities room, this was a large bright room and a number of people chose to spend their time there. We saw some people were reading the paper, others were talking and some were engaged in craft projects. The new extension also had an activities room which also included a day care centre for people who don't live at the home. However, people living at the home will be able to access the activities.

Suitable provision had been made so that people could be supported at the end of their life to have a comfortable, dignified and pain-free death. People's wishes at the end of their lives had been discussed and recorded. Where people and their families expressed a wish for resuscitation not to be attempted at the end of their lives appropriate paperwork was in place to support this decision. The registered manager was able to tell us how they supported people by ensuring they had effective pain relief when needed and by liaising with other agencies such as the GP and Marie Curie nurses.

People's communication needs were not currently recorded in the assessment process and although any aids to communication such as glasses and hearing aids were recorded in people's care plans the availability of accessible information was not covered. We discussed this with the registered manager who was aware that it was an area that needed more work.

There were robust arrangements to ensure that people's concerns and complaints were listened and responded to in order to improve the quality of care. Information on how to raise a complaint was listed in the brochure people received when they moved into the home and was also on display in the home. People told us that they were happy to raise any concerns they had. One person said, "I go and see (manager) if I have any problems." A relative told us, "I just go to the office with any issues." The provider had received one complaint since our last inspection. We saw that this had been investigated and dealt with in line with the provider's complaints policy.

Good

Is the service well-led?

Our findings

There was a registered manager for the home, however, they were in the process of handing over to a new manager. The new manager had submitted their application to register with the Care Quality Commission. Both the registered manager and new manager were positive about the home and were dedicated to providing good care for people. This was reflected in the staff team. At all times staff used people's preferred names and went about their jobs in a pleasant manner.

The new manager was approachable and willing to make themselves available to people living in the home, relatives and staff. They told us, "My door is always open." They said they were happy to be available to relatives when needed. For example, they visited one person's relatives over the weekend as this was the only time the relatives would be available. One member of staff told us, "It's a very happy place to work. If something is bothering them [other members of staff] I would support them and encourage them to raise concerns with the provider."

We noted that the registered persons had taken a number of steps to ensure the service's ability to comply with regulatory requirements. There was a registered manager in post. . In addition, the registered manager had notified us about all the incidents they were required to tell us about by law. However, the rating for the home was not displayed. We raised this with the registered manager who apologised as it had not been moved when the new entrance was opened. They told us they would ensure this it was displayed. In addition the

We found that a number of systems were in place to help care staff to be clear about their responsibilities. For example, staff meetings looked at how staff worked as a team and areas where improvements were needed. At the last staff meeting they had discussed the importance of communicating so that staff were able to speak knowledgably about people when their relatives asked how they were doing. In addition, incidents and accidents were discussed along with the changes in care needed to keep people safe from similar accidents occurring. Staff were also supported with supervisions where they were given the opportunity to discuss any concerns they had.

The provider and registered manager had audits in place to assess and monitor the quality of care provided to people. In addition, they also engaged with external organisations to get expert advice on the care provided. For example, a pharmacist had recently audited the medicines. Where any concerns were identified the registered manager and provider took action to improve the care people received.

We found that people who lived in the service and their relatives had been engaged and involved in making improvements. Residents' meetings had been held to discuss the care and changes in the home. Records showed that at the last meeting they had discussed the upcoming Christmas party and the local primary school who would be visiting to sing to people. People requested that they would like a different singer to come in and entertain them as the one they had been using sang the same songs all the time. In addition, changes people wanted to see to the menu were discussed. The provider had also requested people complete a survey on the care provided. Action had been taken about any concerns people had raised.

We found that the registered persons had made a number of arrangements that were designed to enable the service to learn and innovate. This included members of care staff being provided with written policies and procedures that were designed to give them up to date guidance about their respective roles.

The registered manager was continually looking for ways to improve the care provided to people. They spoke about changes that they had planned to improve people's wellbeing. For example, they were planning on offering people a yoghurt drink with their medicines as they felt this would strengthen the friendly bacteria in people's stomach and may help prevent digestive disorders such as diarrhoea and constipation while helping to build immunity and reduce risk of infections.

We found that the home worked in partnership with other agencies to enable people to receive 'joined-up' care. There were systems in place to ensure information was passed over when people moved between services and the registered manager worked collaboratively with specialist nurses to meet people's needs.