Care Quality Commission

Farrington Care Homes Limited

Brookside House Care Home

Inspection report

35 Wagstaff Lane
Jacksdale
Nottingham
Nottinghamshire
NG16 5JL
Tel: 0115 977 0331
Website: www.farringtoncare.com

Date of inspection visit: 28 October 2015
Date of publication: 14/01/2016

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

Overall summary

This inspection took place on 28 October 2015 and was unannounced.

Accommodation for up to 22 people is provided in the home over two floors. The service is designed to meet the needs of older people. There were 18 people using the service at the time of our inspection.

At the previous inspection on 3 and 4 November 2014, we asked the provider to take action to make improvements to the areas of person-centred care, safe care and treatment, premises and equipment, good governance and fit and proper persons employed. We received an action plan in which the provider told us the actions they had taken to meet the relevant legal requirements. At this inspection we found that improvements had been made in all of these areas, though further work was still required in the area of safe care and treatment, premises and equipment and good governance.

There is a registered manager and she was available during the inspection. A registered manager is a person who has registered with the Care Quality Commission to

Summary of findings

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.

Equipment and the premises were not always managed to keep people safe and medicines management required improvement. However, people felt safe in the home and staff knew how to identify potential signs of abuse. Systems were in place for staff to identify and manage risks and respond to accidents and incidents. Sufficient staff were on duty to meet people's needs and they were recruited through safe recruitment practices. Safe infection control practices were followed.

Consent to care and treatment was not always sought in line with legislation and guidance. However, staff received appropriate induction, training and supervision. People received sufficient to eat and drink. External professionals were involved in people's care as appropriate. People's needs were met by the adaptation, design and decoration of the service.

Staff were caring and treated people with dignity and respect. People and their relatives were involved in decisions about their care.

People received personalised care that was responsive to their needs. A complaints process was in place and staff knew how to respond to complaints.

Systems to monitor and improve the quality of the service provided required further improvement. Notifications were not always made to the CQC where required. However, people and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident raising any concerns with the management and that the registered manager would take action.

Summary of findings

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 not consistently safe.

Equipment and the premises were not always managed to keep people safe and medicines management required improvement.

People felt safe in the home and staff knew how to identify potential signs of abuse. Systems were in place for staff to identify and manage risks and respond to accidents and incidents.

Sufficient staff were on duty to meet people's needs and they were recruited through safe recruitment practices. Safe infection control practices were followed.

Requires improvement

Is the service effective?
The service was not consistently effective.

Consent to care and treatment was not always sought in line with legislation and guidance.

Staff received appropriate induction, training and supervision. People received sufficient to eat and drink.

External professionals were involved in people's care as appropriate. People's needs were met by the adaptation, design and decoration of the service.

Requires improvement

Is the service caring?
The service was caring.

Staff were caring and treated people with dignity and respect. People and their relatives were involved in decisions about their care.

Good

Is the service responsive?
The service was responsive.

People received personalised care that was responsive to their needs. A complaints process was in place and staff knew how to respond to complaints.

Good

Is the service well-led?
The service was not consistently well-led.

Systems to monitor and improve the quality of the service provided required further improvement. Notifications were not always made to the CQC where required.

Requires improvement

Summary of findings

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident raising any concerns with the management and that the registered manager would take action.

Brookside House 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 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 28 October 2015 and was unannounced. The inspection team consisted of two inspectors.

Prior to our inspection we reviewed information we held about the service. This included information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also contacted the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with five people who used the service, two visitors, two care staff and the registered manager.We looked at the relevant parts of the care records of five people, three staff files and other records relating to the management of the home.

Requires improvement

Is the service safe?

Our findings

When we inspected the home in November 2014 we found that people had not been protected against avoidable harm. We found that people were not always supported safely when being transferred by staff. At this inspection we found that improvements had been made in this area.

People did not raise any concerns about how staff supported them when they were being transferred. We did not observe any concerns regarding this.

When we inspected the home in November 2014 we found that premises and equipment were not regularly maintained and the premises were not managed to keep people safe at all times. At this inspection we found that some improvements had been made in this area, however more work was required.

There were plans in place for emergency situations such as an outbreak of fire. However, personal emergency evacuation plans (PEEP) were not in place for all people using the service. These plans provide staff with guidance on how to support people to evacuate the premises in the event of an emergency. The registered manager told us that these plans would be put in place over the next few weeks.

We saw that the premises were well maintained and safe. Checks of the equipment and premises were taking place and action was taken promptly when issues were identified. However, we saw that hoists were only being maintained once a year instead of twice a year as required. The registered manager contacted the provider during our inspection to ensure that this would now take place twice a year as required.

When we inspected the home in November 2014 we found that staff were not recruited safely. At this inspection we found that improvements had been made in this area.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work. We also saw that the service followed clear staff disciplinary procedures when necessary.

When we inspected the home in November 2014 we found that medicines were not managed safely. At this inspection we found that some improvements had been made in this area, however more work was required.

People we talked with told us they received their medicines regularly and they did not recall any occasions when their medicines could not be given because they had run out. Staff told us they had completed medicines administration training and they undertook a refresher course annually. They had their competency checked by the deputy manager regularly and this was discussed at supervision.

Processes were in place for the timely ordering and supply of people's medicines and we were told checks were made when new medicines were delivered to ensure medicines were available when they were required. We checked the medicines administration record (MAR) for 10 people using the service and did not find any evidence of medicines being missed due to a lack of availability. We checked the storage of medicines and they were stored in line with requirements in locked rooms and locked trolleys and cupboards. Temperature checks were recorded daily and were within acceptable limits.

We observed the administration of medicines and saw checks were made against the MAR and staff stayed with people until they had taken their medicines. The MAR had a photograph of the person on the front but there was no information about the person's allergies or the way they liked to take their medicines. We found there was some information about each person's medicines within their care plan, but there were no PRN protocols with the MARs to provide information on the reasons for administration of medicines which had been prescribed to be given only as required. We found necessary checks had been carried out to ensure people were receiving the correct dose of drugs which affected blood clotting. Some people had needed to have their medicines handwritten on the MAR. These should have been checked and signed by two people to ensure accuracy, however we saw some of these had only been signed by one person.

Topical creams and ointments and liquid medicines were not labelled with the date of opening and there was a note against the topical creams on MAR charts to indicate they were kept in the person's room, but we found there was no record of application of the creams.

Requires improvement

Is the service safe?

When we inspected the home in November 2014 we found that safe infection control processes were not followed at all times. At this inspection we found that improvements had been made in this area.

People raised no issues about the cleanliness of the home. Staff were able to clearly explain their responsibilities to keep the home clean and minimise the risk of infection.

During our inspection we looked at some bedrooms, the laundry, all toilets and shower rooms and communal areas. These were all clean. We observed staff following safe infection control practices.

People told us they felt safe in the home. One person said, "All the staff are very good. I have nothing to grumble about." They said staff looked after their belongings and staff were always nearby if they needed them. Another person said, "Yes I feel safe, else I'd be gone. I wouldn't stay here." Staff told us the home was secure and staff were able to chat with people and listen to them so if there were any issues they would feel able to discuss them.

Staff were able to identify the signs of abuse and told us if they identified a concern they would report it to the registered manager or deputy manager. Senior staff said that if the registered manager or their deputy was not available they would report it themselves and identified that the telephone number was displayed in several locations in the home. A safeguarding policy was in place and staff had attended safeguarding adults training. Information on safeguarding was displayed in the home to give guidance to people and their relatives if they had concerns about their safety.

Risks were managed so that people were protected and their freedom supported. Risk assessments were documented in the care records for each person to identify their level of risk for aspects of their daily living such as the risk of malnutrition, development of pressure ulcers and risk of choking. There was also a risk assessment for the use of bed rails when these had been considered necessary. Interventions were identified to reduce the risks to the person. However, risk assessments had not been reviewed as frequently as would be expected. For example, one person's risk assessments had not been updated for five months. However, we saw documentation relating to accidents and incidents and actions taken to minimise the risk of re-occurrence.

People we talked with said they felt there were normally enough staff on duty to care for them. They said staff responded to their requests and call bells promptly. One person said, "Yes they come quickly I have had no trouble." They also told us that if staff were busy with another person they would come and tell them and check they didn't need immediate attention. They said that if they wanted to go to the toilet they did not have to wait for lengthy periods.

Staff told us they felt there were enough staff on duty to provide the care and support people needed and to keep them safe. One member of staff said that when the dependency of people living at the home increased the registered manager would schedule an additional carer on duty to provide additional assistance. They said that in the case of sickness or absence they were usually able to cover with their own staff working flexibly. We were told the home did not use agency staff.

We observed that people received care promptly when requesting assistance in the lounge areas and in bedrooms. Staff were visible in communal areas and spent time chatting with people who used the service.

Systems were in place to ensure there were enough qualified, skilled and experienced staff to meet people's needs safely. The registered manager told us that staffing levels were based on dependency levels and any changes in dependency were considered to decide whether staffing levels needed to be increased. We looked at records which confirmed that the provider's identified staffing levels were being met.

Requires improvement

Is the service effective?

Our findings

When we inspected the home in November 2014 we found that staff did not always ensure that they were providing care and treatment for people with their consent. At this inspection we found that some improvements had been made in this area, however more work was required.

We saw that staff clearly explained what care they were going to provide to people before they provided it. Where people expressed a preference staff respected them.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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.

The requirements of the Mental Capacity Act (2005) were not always adhered to in that when a person lacked the capacity to make some decisions for themselves; a mental capacity assessment had not always been completed. In two care records, we saw MCA assessments were decision-specific and linked to a care plan which was clearly identified as having been developed in the person's best interest. However in another care record we saw that it contained a best interest decision in relation to the person's nutrition, but not for other aspects of their care and support such as the use of bed rails.

We also saw that consent for the use of bed rails were not recorded for a person with bed rails in place. There was also some confusion amongst staff as to the ability of relatives to consent for a person who lacked the capacity to make some decisions for themselves when there was no formal arrangements in place for the relative to make decisions on behalf of their family member.

Staff told us they had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. They were able to discuss issues in relation to this and the requirement to act in the person's best interests. Where a DOLS application had been made copies of this were kept in the person's care records.

We saw the care records for people who had a decision not to attempt resuscitation order (DNACPR) in place. There were DNACPR forms in place and they had been completed within the last few months. One person had had a mental capacity assessment completed in relation to the decision, but the other person had not. The DNACPR for this person indicated a Lasting Power of Attorney (LPA)/court appointed deputy was in place for this person, but we did not see evidence of this in the care record and other parts of the care record stated there was no LPA or court appointed deputy for the person.

A person using the service mentioned that some people became confused and agitated sometimes and they said, "If [staff] can't settle them down they stop, give them time and let it subside." Staff told us they never restrained people. They said people often became agitated and upset in a noisy environment and they encouraged them to move to a quieter area of the home and provided reassurance. They said that by speaking to people softly and quietly and listening to them they were able to calm and reassure them.

When we inspected the home in November 2014 we found that people were not effectively supported to eat and drink. At this inspection we found that improvements had been made in this area.

People we talked with told us they were very happy with the meals provided. One person said, "The food is nice. We like everything we get." "I'm a funny eater, but I can eat it here." A relative told us staff catered to their relatives needs and provided salads instead of sandwiches at tea time as they didn't eat bread. They went on to say on an occasion when their relative had not felt like eating they had been provided with scrambled egg as they felt they could manage that. Another person said, "The food is good and there is good choice, but if you fancy something different they would do it for you."

We observed the lunchtime meal in the dining room. Tables were set with tablecloths and cutlery, and people were provided with drinks prior to the meal being served.

Requires improvement

Is the service effective?

However, no condiments were provided on the tables. People were served in a timely way and staff checked whether they need assistance in cutting up their food. When people needed assistance staff sat with them and helped them without hurrying the person. Staff checked whether people had enjoyed their food and whether they had finished before removing their plates.

The cook was knowledgeable about people's dietary needs and preferences. They told us they did not have a set menu but would plan meals according to people's preferences and ensured variety by looking back at the previous meals. There was normally a choice of two main meals but they said they offered people different options if they didn't want the main dishes.

Records were kept of the amounts people ate and drank when they were at risk nutritionally and we found that these were completed consistently and although the volumes of fluids people drank were not totalled daily the records indicated they had a good fluid intake. People's care records contained care plans for eating and drinking and there were records of their preferences and the support they required. People were weighed monthly and the care records examined indicated that people had maintained or increased their weight over the previous six months.

We saw there were snacks such as packets of crisps and readily available on a table in the communal areas throughout the day. A person said they were always available and people could help themselves as they wished.

When we inspected the home in November 2014 we found that people were not always effectively supported to maintain good physical health. At this inspection we found that improvements had been made in this area.

People told us staff would contact their GP promptly if they became unwell. We saw people's care records contained evidence of visits from the community nurse, GP, chiropodist, and optician. Staff told us they contacted the person's family doctor if they had any concerns about a person and the local GPs were very good and attended when asked.

We saw that pressure relieving equipment was in place when required and there was a record of position changes one to two hourly during the night along with checks for incontinence. Staff told us of a person who had had a number of injuries due to the way they moved their legs when sitting in their wheelchair and they said they had discussed this with community specialists and had obtained a specialised chair for the person.

People we talked with said they had confidence in the knowledge and skills of staff caring for them. We observed that staff competently supported people.

Staff told us they had annual mandatory training and they felt they had had the training they needed to meet the needs of the people who used the service. Staff told us they were up to date with their mandatory training. One staff member said they had monthly supervision sessions but another said they did not receive supervision. However, when we checked the second staff member's staff file there was a record of regular supervision sessions.

Training records showed that staff attended a wide range of training which included equality and diversity training. Annual appraisals had not taken place for a number of staff; however, supervisions had regularly taken place of staff.

Adaptations had been made to the design of the home to support people living with dementia. Bathrooms and toilets were clearly identified, people's individual bedrooms were easily identifiable and there was directional signage to support people to move independently around the home.

Good

Is the service caring?

Our findings

When we inspected the home in November 2014 we found that staff did not always respond promptly to people showing distress. At this inspection we found that improvements had been made in this area.

One person said, “They all help us. They are very kind.” “We get on well with [the staff]. They talk with us and you can enjoy yourself.” A relative said, “There is a good atmosphere, it is caring and homely. [My family member] is happy to be here.” They went on to say, “We are 110% satisfied with the home.”

Relatives told us staff welcomed them when they came to visit and offered support to them as well as their relative. They said they could visit at any time and staff always offered them refreshments and the opportunity to stay for lunch with their relative. They said staff knew their family member’s needs and preferences. Staff were able to describe people’s care needs and their preferences.

People clearly felt comfortable with staff and interacted with them in a relaxed manner. Staff greeted people when they walked into a room or passed them in the corridor. They checked they were all right and whether they needed anything. Staff were kind and caring in their interactions with people who used the service.

We saw staff responded to people when they showed distress or discomfort. They provided reassurance and support to people who became anxious or who were confused. Staff told us about the action they were taking to calm and gain the cooperation of a person living with dementia who had recently come to the home and who had short term memory problems. They repeatedly explained to the person where they were and who the staff were. They explained what they were going to do by ensuring they maintained eye contact with the person and explained slowly and clearly what they were going to do and why it needed to be done.

When we inspected the home in November 2014 we found that staff used some terms which did not respect people’s dignity. At this inspection we found that improvements had been made in this area.

People told us they were treated with dignity and respect. We saw staff take people to private areas to support them with their personal care. One person we talked with said staff did not bother to knock before they came into their room but they closed the curtains and doors when providing personal care. A member of staff told us the person usually had their door open anyway but admitted that they did not always knock on people’s doors before entering.

The home had a number of areas where people could have privacy if they wanted it. Staff had been identified as dignity champions. A dignity champion is a person who promotes the importance of people being treated with dignity at all times.

We saw one person’s care record contained a care plan for maintaining their privacy and dignity, identifying providing them with choice, and ensuring they were covered as much as possible when assisting the person with their personal hygiene.

A person said they were able to be as independent as possible. A relative told us their relative was not walking at all when they first came to the home but staff had encouraged the person to stand and walk and they were now able to walk with a frame. Staff told us they encouraged people to do as much as possible for themselves to maintain their independence.

People were actively involved in making decisions about their care. People felt they were given choices. One person said, “We go to bed when we feel ready. They don’t tell us what to do and what not to do.”

People we talked with did not recall being involved in their care plans, but they said staff had discussed their care with them. There was evidence within people’s care plans that they had been involved in recent monthly reviews of the plans.

Care plans were person-centered and contained information regarding people’s life history and their preferences. Where people could not communicate their views verbally their care plan identified how staff should identify their preferences. Advocacy information was also available for people if they required support or advice from an independent person.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. One person said, "If you want something, you say so and you get it if they can." We observed that staff responded quickly to people when they requested support.

People told us they were asked if they would like to join in activities within the home, but they were able to choose whether they wanted to participate or not. One relative said their family member enjoyed the exercise sessions which were held in the home and told us that a large group of people participated in them. They also talked about trips into the village to attend a coffee morning which helped their family member maintain the links with the people they knew in the village.

On the day of the inspection, a game of dominoes was in progress when we arrived, involving four people and the activities coordinator. We saw small group activities being coordinated during the day. People told us they enjoyed games in the home. One person said, "We enjoy ourselves, the staff are friendly and we do all sorts of things."

People told us that their families and friends could visit whenever they wanted to. We observed that there were visitors in the home throughout our inspection. People were supported to maintain and develop relationships with other people using the service and to maintain relationships with family and friends.

People's care records contained an initial assessment when the person first came to the home and this included information about their preferences. Each care records contained an Alzheimer's Society "This is me" document in place which had been completed in detail to provide information on the person's life history, interests and preferences. The care plans included a good level of detail regarding people's individual preferences and daily routines. For example, "[Person] likes to get up quite early and will use her buzzer to let staff know she is ready…" It then went on to describe the person's preferences in relation to personal hygiene.

Monthly care plan updates had only been completed up to July 2015 and these were stored in a separate part of the folder where it was difficult to extract the information about the person's current needs. We also saw that two people's care records contained inconsistent information regarding the people's current needs, however, when we spoke with staff they knew what care should be provided.

Care records contained information regarding people's diverse needs and provided support for how staff on how they could meet those needs.

We asked people if they knew how to make a complaint about the service. People told us they were happy to raise any concerns with staff. Staff were clear about how they would manage concerns or complaints.

We saw that complaints had been responded to appropriately. Guidance on how to make a complaint was displayed in the main corridor of the home. There was a clear procedure for staff to follow should a concern be raised.

Requires improvement

Is the service well-led?

Our findings

When we inspected the home in November 2014 we found that quality assurance systems were not fully effective. At this inspection we found that some improvements had been made in this area, however more work was required.

The registered manager carried out a monthly audit which covered safety and cleanliness of the premises, care records, medicines, staff records and complaints. However this audit had not been effective in identifying and responding to the issues that we found during the inspection. We also found that the registered provider was still not carrying out any formal written audits of the home to assess the quality of the care being provided. This meant that fully robust quality assurance processes were not in place to ensure that people received good care.

People were involved in developing the service. People did not recall any meetings or being asked their opinions on life in the home or their care. Visitors were also not aware of a questionnaire or survey to get their views. However, we saw that surveys were completed by people who used the service and their families. Meetings for people who used the service and their relatives also took place and actions had been taken to address any comments made.

A whistleblowing policy was in place and contained appropriate details. Staff told us they would be comfortable raising issues using the processes set out in this policy. The provider's values were in the guide provided for people who used the service and we saw that staff acted in line with them.

Staff and people who used the service said there was a good atmosphere within the home and that staff worked well together. Staff were proud to work at the home and told us they always tried to ensure they provided a good standard of care.

Some people knew who the registered manager was and said that they could ask one of the staff and the registered manager would come to see them if they wanted to talk to her about something. One person said, "The [registered manager] is always walking about and comes to talk to us." Other people did not know who the registered manager was but said if they were unhappy about something they would talk to any of the staff and they felt they would be listened to.

Staff told us the registered manager had told them they could come to her if they had an issue or concern. They said she was available within the home on a daily basis and they could ring her at home if necessary. They said when the registered manager was away on leave the deputy manager would be available. One member of staff said, "[The registered manager] is very easy to talk to and has also told us we can go to her if we have any issues or concerns."

Staff told us they had staff meetings every few months. They said they received feedback from the registered manager on the things they needed to change as a result of complaints and when new people were admitted the registered manager ensured they had information about the person and their care and support needs.

A registered manager was in post and was available during the inspection. She clearly explained her responsibilities and how other staff supported her to deliver good care in the home. She felt well supported by the provider. We saw that all conditions of registration with the CQC were being met however, we saw one incident had taken place where a notification had not been sent to the CQC when required. We saw that regular staff meetings took place and the registered manager had clearly set out their expectations of staff.