Brendoncare Foundation(The)

Brendoncare Chiltern View

Inspection report

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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?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

Brendoncare Chiltern View provides nursing care for up to 30 older people living with dementia. At the time of this inspection 23 people were living at the home.

Brendoncare Chiltern View did not have a registered manager in place. 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.

Management support was being provided by The Brendoncare Foundation senior management team, in addition to the day to day management input of the Senior Nurse Manager for Brendoncare Chiltern View. We were informed recruitment to the registered manager vacancy was being actively pursued.

In September 2012 we found that medicines practice at Brendoncare Chiltern View was not meeting the necessary standard. In October 2012 The Brendoncare Foundation submitted an action plan which set out how they would make the necessary improvements to

Summary of findings

medicines practice. In November 2012 we carried out a responsive review and found those improvements had been made and sustained. In July 2013 we carried out a review of other areas of the service's operation, not including medicines, and found those areas assessed met the required standard.

At the review of 18 June 2015 we found people were not being adequately protected by robust and consistently safe medicines practice and record keeping.

We found identified risks to people had not always been effectively managed or eliminated. Care plans were not always being kept up to date or used to inform the way people's care was received.

The communal activities observed during our visit were imaginative and engaged those people who took part in them. People were not consistently being engaged or involved other than when specific care tasks were being carried out or during activities sessions, which only some of the people were able to access and take part in.

The provider had undertaken a number of recent audits of the service, covering care practice and records amongst other things. These had identified areas which required significant improvement, although these improvements had not yet been fully put into practice or become embedded in the service's routine.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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?

Requires improvement

The service was not consistently safe.

People did not always receive the support with their medicines they required.

Risks to people's well-being, health and safety were not consistently managed effectively.

There were sufficient numbers of staff available to meet people's needs and keep them safe. Effective recruitment of staff meant people were protected from the employment of unsuitable people.

Is the service effective?

Requires improvement

The service was not always effective.

People were not protected by effective and consistent record keeping in respect of the care they received.

Where bed rails were in use to protect people from risk, the appropriate process had not always been undertaken where they were unable to give permission themselves.

Care staff received support and training to help them provide effective care.

Is the service caring?

Requires improvement

The service was not consistently caring.

Staff did not always take opportunities to interact positively with people except when they were undertaking specific tasks.

People or their relatives were not always actively involved in decisions about their wishes at the end of their life.

People benefitted from a positive relationship between the service and the doctors' practice which provided support to the home.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Care plan documentation was not always up to date and staff were not always able to meet people's needs taking into account the latest information about them.

People had the opportunity to engage in well-organised and appropriate activities, appropriately supported by activities and care staff.

People's relatives could participate in meetings about the way the service was run and knew how to make a complaint if they wanted to.

Summary of findings

Is the service well-led?

The service was not consistently well-led.

There was no registered manager in place. The home was being managed under temporary management arrangements which could not realistically provide consistent leadership.

The provider had identified where improvements to the service were required but these had not yet been fully addressed.

People benefitted from the effective partnership working which existed between community health services and the home.

Requires improvement

Brendoncare Chiltern View

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 unannounced inspection took place on the 18 June 2015.

The inspection team consisted of two inspectors.

Prior to our visit we reviewed all of the information we had about the home. This included any concerns raised with us on behalf of people who lived in Brendoncare Chiltern View and any notifications received. Notifications are information about important events which the provider is required to tell us about by law.

We also contacted social care and healthcare professionals with knowledge of the service. This included people who commission care on behalf of the local authority and health or social care professionals responsible for people who lived in Brendoncare Chiltern View.

During the visit we spoke with a G.P and six members of staff including care staff and activity staff. We also spoke with the senior manager from the Brendoncare Foundation who was one of the team members providing management support whilst the home was without a registered manager.

We observed care and support in lounges and dining areas. We observed a medicines administration round and 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 looked at six care records including medicines records. We reviewed one staff recruitment file and summary records of staff training and supervision undertaken by all care and nursing staff. We also looked at quality monitoring processes and reports undertaken by the provider.

Following our inspection visit we received additional feedback and further information from the service in response to requests we made for clarification or to provide additional evidence where that was needed.

Requires improvement

Is the service safe?

Our findings

We found people were not being provided with consistently safe assistance with their medicines which placed them at risk.

One person had not received their pain control medicine at lunchtime or evening on the 17 June 2015. When we raised this with the relevant member of staff they said they had not given the medicine as they had been busy with another person who had just returned from hospital. The person whose medicine was not given was being nursed in bed due to pressure damage to their skin. This meant they had not received adequate pain relief.

When we looked at their care records we found the same person was receiving their medicines covertly. This had been authorised appropriately originally and updated in April 2015. However the updated authorisation was in the medicines administration record and the out of date authorisation was still in the person's care records.

Another person was prescribed a course of anti-biotic. This had not recorded when received by the service and the date of opening had not been recorded on the bottle. The same person had been prescribed a medicine which had not been given for two days as there was no stock available.

Another person who was being nursed in bed was prescribed pain relief medicine as and when required. We observed during the morning medicines round this was not offered to them. This meant they could have been unnecessarily suffering pain. We drew this to the attention of the nurse who then offered the person pain relief medicine.

We found one person, who had returned to the service on the 17 June following a fall when they had fractured their hip and their wrist. They had returned with pain relief medicines however this had not been written up as given regularly. The only evidence we found for pain relief given was a note on the daily record in the person's care plan. Neither the time of administration or the amount was recorded, simply that it had been given. We were told this was because the appropriate medicines administration record sheets were not available. This was unsafe practice and did not follow the Nursing and Midwifery Council's guidelines for the administration of medicines.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The morning medicines round we observed was still being carried out at 11.30 am. We acknowledge that the presence of an inspector could have extended the round to some extent, however even allowing for that, residents would have been at risk from receiving their medicines too late. This would have had a knock-on effect as lunchtime medicines could not then be given at lunchtime as it would be too soon after the morning administration.

Potential risks to people's safety had been identified in their care plans. This might be, for example from falls or damage to their skin as a result of pressure. Although control measures were put in place to eliminate or manage risks where that was possible, these were not consistently followed.

For example, because of the risk to one person from damage to their skin caused by pressure, they were supposed to be regularly turned to relieve this. We observed the person was on their back at 10 am and was in the same position at midday. However, the turning chart we saw stated the person had been lying on their left side at 10 am. When we raised this with care staff they could not explain why the record was not accurate. The person was at greater risk of pressure damage if regular turns were not being carried out.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw when we arrived during the morning, the door to the laundry, which opened onto the car park was left open with the door from the laundry to the home also open. As there was no member of staff in the laundry at that time, this potentially gave the opportunity for unauthorised or uncontrolled access to the home from the car park, which could have posed a risk to people's security.

In the annual survey carried out in October 2014, all of the relatives who responded thought Brendoncare Chiltern View was safe as did all the staff who responded.

Staff had received training in infection control and we saw they followed good infection control practice throughout our inspection. For example, by wearing appropriate protective clothing when providing care. This helped

Requires improvement

Is the service safe?

protect people from the risks associated with acquired infections. In the provider's infection control audit of May 2015, the home scored 84%. Areas of concern identified in the audit were predominantly around the general environment, including cleaning of some equipment and 'dirty' flooring. It was also identified staff did not have access to or were not familiar with the Department of Health guidance on infection control for care homes. The survey confirmed 96% of staff were up to date with infection control training and that the staff induction included infection control. The service scored 100% in respect of the sluice, uniforms, laundry, waste disposal and the handling of specimens.

There were sufficient staff available to ensure people's needs could be met appropriately.The staff numbers on duty matched the set staffing levels we were given. A significant number of staff had worked at Brendoncare Chiltern View for a number of years and were familiar with the routines of the service and the people who lived there. We confirmed temporary bank staff were used when regular staff were not available and that bank staff were usually familiar with the home and the people who lived there. This helped provide consistency of care for people.

Regular maintenance schedules were in place for equipment to ensure it remained safe to use. There was a system in place for the reporting and recording of incidents and accidents. The provider had plans in place to maintain people's health, safety and welfare in the event of a major incident affecting the safe operation of the service. For example, care plans included 'personal emergency evacuation plans'.

People were protected from abuse. Staff told us they had received safeguarding adults training both during their induction and updated regularly thereafter. This was confirmed from training records. Staff were able to explain what might constitute abuse, how they might recognise it and what they would do if they saw or suspected it. There were safeguarding information and contact details readily available to staff and others to refer to.

Staff told us they were aware of the provider's whistle-blowing policy and would not hesitate to share any concerns they had with them as they were confident they would be addressed. CQC had received whistle-blowing concerns from previously employed members of staff.

There were effective staff recruitment processes in place to protect people from the employment of unsuitable staff to provide their care and support.

Requires improvement

Is the service effective?

Our findings

Care plans included evidence of assessments carried out before admission. These identified individuals' care needs and any equipment required to help staff meet them. This meant, for example, any specific equipment could be put in place before they moved in so that people's care needs were met from the outset.

People's care plans listed their nutritional needs which included the use of a recognised screening tool to assess where people were at risk of weight loss or malnutrition. People had fluid and food record charts within their personal files, however fluids were not always listed as being given. We found this had already been identified as an issue and had been discussed with staff at a meeting held on the 4 June 2015. An internal audit carried out on the 11 June 2015 identified a significant number of individual monitoring records which had not been completed at all or were only partially completed or with entries in the wrong part of the record. For example, in respect of the application of creams, body charts and re-positioning records. The care plan for one person identified they were an insulin dependent diabetic. Whilst the person's diabetes was being managed flexibly under guidance this was not clear in all of the care plan documentation seen.

This made it impossible to accurately assess what care people had received at what time and by whom. These issues were being followed up by the provider's quality standards nurse.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they sometimes found it hard to keep routine records up to date. They gave as examples hourly check records where these were in place. We observed during one of our observations that two staff were completing a pile of red folders in each of the two lounges. This was whilst people were sitting in the lounges and could mean staff would either have to break off completing the records to provide any assistance required, or if they concentrated on completing the records, not respond immediately to any non-urgent calls for assistance.

In the annual survey carried out in October 2014, all of the relatives who responded thought Brendoncare Chiltern View was effective whilst 80% of staff thought so.

People received care and support from staff that had the necessary support and training required for them to meet people's needs effectively and safely. We looked at training records and talked with staff about their training to confirm this. New staff had received an appropriate induction which meant they knew what was expected of them and gave them the knowledge, skills and support required to carry out their role. For example, domestic staff received training in infection control and in the use and storage of chemical cleaning products which could be hazardous to people's health. We saw staff training and supervision were monitored to identify where updates were required.

People received care from staff who overall felt supported. This was despite the temporary disruption to the day to day management of the service following the recent resignation of the registered manager. Information provided to the CQC prior to this inspection setting out one person's assessment of staff morale and teamwork had also been given to the home's management. We saw minutes of meetings held to discuss and address those concerns where they were considered valid.

Staff told us there was a mixture of formal and informal supervision, together with an annual appraisal and we saw staff supervision records to support this.

The staff we spoke with understood the implications for them and the service of the Mental Capacity Act (2005) (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make specific decisions at a given time. When people are assessed as not having the capacity to make a decision themselves, a decision is taken by relevant professionals and people who know the person concerned. This decision must be in the 'best interest' of the person and must be recorded.

The Care Quality Commission (CQC) monitors the operation of the DoLS as they apply to care services. DoLS provides a process by which a person can be lawfully deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after them safely.

Those care plans we saw included best interest decisions and assessments of people's capacity for specific decisions.

Requires improvement

Is the service effective?

However, we found in a least three cases there were no assessments in place in respect of the use of bed rails and no consent recorded for their use. At the time of our visit two people had a DoLS approved, although one had just expired and a further application had been made. We confirmed that appropriate applications had been made to protect people. Where DoLS were not in place, this was due to applications not yet being processed by the relevant authority due to the significant increase in the volume of applications made to them following a recent Supreme Court judgement.

People had regular access to the home's GP practice. This was through routine visits to the home and at other times when required. People's care plans demonstrated they had access to community health services; for example opticians and dentists and also to hospital services for routine appointments or emergency treatment.

Requires improvement

Is the service caring?

Our findings

We carried out and recorded two observations. We also walked around the service during our visit, observing staff interactions with people they provided care and support for. In the majority, though not all cases, the interactions we saw were confined to the times tasks were being undertaken, for example provision of food or during medicines rounds. We found people in bed for significant periods of the day with little obvious social stimulation, accepting we were not able to observe every person all of the time.

During our observation between 09.23 am and 10.25 am we saw that domestic staff came in and out of the lounge without engaging or acknowledging any of the people sitting there. When it was time for activities, one person was not asked if they wanted to participate, whilst two other people were and were taken out of the lounge by staff to do so. At another time, staff interacted with one lady present in the lounge, but ignored another. There is no suggestion this was intentional, it was not however an example of taking every opportunity to positively interact and engage with people who lived with dementia.

We received feedback from the home's general practice. Overall they provided quite positive views of their interaction with the service and the quality of care and support they observed. They confirmed staff followed advice and recommendations, however they found sometimes communication between staff about recommended care was variable. They also found the availability and completion of some care records, for example nutritional information, wasn't always clear. They told us they were called for additional visits only when appropriate to do so.

Care staff told us they provided people's support in the way they wanted them to. They told us they referred to care plans to find out things that were familiar and important to the person concerned. They said they always asked before providing care and treated them with respect.

Care plans included details about the action to be taken in the event someone died. We saw there were do not attempt cardio-pulmonary resuscitation (DNACPR) documents in place. These were not always fully completed or shown to have involved either the person concerned or their representative. For example, in one case the reason for not involving the person was given as Alzheimer's/dementia and that the person; "lacks capacity". This was signed by the GP and a nurse. Where the form recorded who had been informed, it only gave the GP and the home and did not record the involvement of the person's next of kin, although they were said to have a legally valid power of attorney for welfare matters. The same person had an advanced care plan for personal preferences and wishes in the event of their death; however this had not been completed.

In the annual survey carried out in October 2014, all of the relatives who responded thought Brendoncare Chiltern View was caring, whilst 93% of staff thought so.

Interactions we observed between staff and people living in the home were polite, respectful and friendly. People's dignity was upheld.

People's spiritual needs were addressed through contacts with caring and religious organisations within the community.

There were relatives' and residents' meetings from time to time where people could say what they thought about various areas of the home's operation. For example, we saw minutes of a relatives' meeting in March 2015.

The senior nurse manager present confirmed that contact details for advocacy services were readily available for those people who might want support to express their views.

Requires improvement

Is the service responsive?

Our findings

Care plans included assessments of people's needs prior to them moving into the home. They included details of the support people required including with their mobility, medicines and any specific health conditions, for example dementia. There were details of their medical history together with details of their preferences as to daily routines and care, including their end of life wishes, although these were not always fully completed. Care plans included background histories of the person concerned where it had been possible to get the details from the person or their families. Staff confirmed they had access to care records; however it was not always clear how care staff made use of the information in these documents. One person, who was on their own for some time with popular music playing, was said in their care plan to particularly like steel bands. We asked the activities organiser if this could not have been used to engage and stimulate them during the time we observed them and they noted it was something they might do in the future.

An audit of care plans had identified these had not been consistently updated. They were supposed to be reviewed monthly to note any significant changes. This was being addressed by the service, monitored by the provider's management team who were supporting them.

People appeared to be able to vary their daily routine, for example what time they got up and had breakfast. We heard staff offering people choice, for example when we observed mealtimes. People were able to change their previous choices about food without any obvious trouble and could choose what they wanted to drink. One person, when asked, told staff they had eaten three breakfasts so far that morning. Staff indicated the person often had three modest portions rather than one large one.

We observed two very effective and engaging activities sessions. Both were tailored for people who lived with dementia and appeared to be well-received by those who participated in them.

We spoke with the activities organiser and looked at some of the past activities and those planned for the future. Each person in the home had an activity record. They were assisted by two care staff for each of the two weekday sessions. We saw this was the case when we observed the activity sessions during our inspection. They told us staff were in general very supportive of new ways to approach activities, although initially some staff had reservations about the use of dolls. We saw, however, one person sitting very happily with a doll, watching what was going on around them. The activity organiser had an appropriate activity qualification and had access to advice and support from other activities staff within The Brendoncare Foundation. They received a monthly budget and hoped to be able to resume more trips out of the home in the coming months. We saw minutes of an activities meeting held in May 2015 at which future events were planned and facilitated by the whole staff team, for example catering staff.

People were encouraged and assisted, where required, to access the garden. There was also a 'realistic' pub bar, although this was not being used during our visit.

Relatives had noted an improvement in communication with the home. One person reported in a relative's meeting they had not been informed of a fall involving their relative and in the annual survey carried out in October 2014, 86% of the relatives who responded thought Brendoncare Chiltern View was responsive.

People knew how to make a complaint and had the information they needed if they wanted to. They said they would raise any concerns they had with care staff or the management and felt it would be sorted out.

Requires improvement

Is the service well-led?

Our findings

Concerns had been raised with CQC and the management of the service about what was described as a culture of resistance to change on the part of some staff that had been with the service for a number of years. People who received care benefitted from a settled staff team, who had a good knowledge of them over time and provided consistency. However one person noted; "It is the new staff that leave". This could potentially make it harder to introduce new ways of working to enable care to reflect current best practice. A heads of department meeting had been held in May 2015 to address the concerns raised.

We saw records of a very comprehensive series of audits carried out on specific areas of the home's operation. These had identified areas where the service was not performing as well as it should. Action plans were in place to address these shortcomings. These were shared with us as part of the inspection. It was positive these audits took place and had identified the failures in record keeping, in particular medicines, care plans, fluid and food charts identified within this report. It was less positive these failures persisted.

It was positive the provider had requested assistance to assess and improve current care practice from the local authority 'Quality in care' team. We spoke with them following the inspection visit and confirmed their involvement.

The staff who spoke with us during our inspection said they had the opportunity to discuss any issues with their line manager or the temporary senior management team currently overseeing the service following the resignation of the previous registered manager.

We saw minutes of staff meetings held to discuss issues and share information. Staff told us they were aware of the provider's whistle-blowing policy and would not hesitate to share any concerns they had with them as they were confident they would be addressed. CQC had received whistle-blowing concerns from previously employed members of staff.

We saw the analysis carried out following an annual survey of relatives and staff in October 2014 These compared the performance of Brendoncare Chiltern View with other Brendoncare Foundation homes. These identified where the service was performing better than the average and where it was performing less well. The analysis included a; "You said – we will do" response to areas of less good performance.

People benefitted from the effective partnership working which existed between community health services and the home. One particularly positive feature of the inspection was how the activities staff were supported by the Brendoncare Foundation and the home's management to resource and encourage meaningful activities for people who lived with dementia.

There was a system in place for the reporting and recording of incidents and accidents. The CQC had been informed of any reportable incidents as required under the Health and Social Care Act 2008, with the exception of two approvals of a deprivation of liberty for people who lived in the service. It was agreed this would be done in future.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There were not always sufficient quantities of medicines to meet people's needs. Regulation 12 (2) (f) People were not consistently protected by proper and safe management of their medicines. Regulation 12 (2) (g) People were not always protected because the service had not done all that was reasonably practicable to mitigate identified risks to them. Regulation 12 (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2) (c). Records of care and treatment provided to people were not consistently accurate or complete.