

Brendoncare Foundation(The) Brendoncare Chiltern View

Inspection report

St Johns Drive
Stone
Aylesbury
Buckinghamshire
HP17 8PP

Tel: 01296747463
Website: www.brendoncare.org.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

Brendoncare Chiltern View provides nursing care for older adults who are living with dementia. It is registered to provide accommodation for 30 people. At the time of our inspection 28 people lived at Brendoncare Chiltern View.

This inspection took place on 11 and 12 July 2017. It was an announced visit to the service.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered 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.

We previously undertook a comprehensive inspection on 23 and 27 May 2016. We found continued breaches of the Health and Social Care Act 2008. We found people who used the service were not protected against the risk of unsafe or inappropriate care in regards to management of medicines. We took enforcement action to ensure people's safety. We served a warning notice to the provider following the inspection. A warning notice gives a date the service must be compliant by. The date the service needed to be compliant by was 31 July 2016. We asked the provider to send us an action plan detailing how they intended to improve. We followed up on the warning notice at a focused inspection carried out on 3 November 2016. We found ongoing breaches of Regulation 12 of the Health and Social Care Act. We imposed conditions on the provider's and registered manager's registration to supply the Care Quality Commission (CQC) with regular information on how they monitored the service to drive improvements.

At this inspection we found significant improvements had been made in the management and administration of medicines. We acknowledge the improvements and the provider and manager had met the condition imposed upon them.

At the last comprehensive inspection we found a breach of the Care Quality Commission (Registration) Regulations 2009, as the provider did not inform us when they made changes to their statement of purpose. At this inspection we found the service had informed us when needed. We were satisfied the provider was no longer in breach of the regulation.

People were supported by staff who were well equipped to provide person centred care. Staff had been recruited, trained and supported to ensure they had the right skills and experience to provide safe care.

People were supported to make decisions in line with the Mental Capacity Act 2005 (MCA). Where required decisions were made in people's best interests and with people who had legal authority to act on their behalf.

People were protected from avoidable harm and were safeguarded from abuse.

People were supported to engage in meaningful activities and had access to individual and group sessions.

There was appropriate monitoring of the service by the registered manager and provider to drive improvements.

The home provided support to people who displayed challenging behaviours and staff had the right skills to ensure people were protected from harm.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

People were supported by staff who provided safe administration of medicine.

People were protected from harm because staff received training to be able to identify and report abuse. There were procedures in place for staff to follow in the event of any abuse happening.

People's likelihood of experiencing injury or harm was reduced because risk assessments had been written to identify areas of potential risk.

Is the service effective?

Good ●

The service was effective.

People were encouraged to make decisions about their care and day to day lives. Decisions made on behalf of people who lacked capacity were made in accordance with the Mental Capacity Act 2005.

People were cared for by staff who were aware of their roles and responsibilities.

People were supported with their nutritional needs.

Is the service caring?

Good ●

The service was caring.

Staff were knowledgeable about the people they were supporting and aware of their personal preferences.

People were treated with dignity and respect.

Is the service responsive?

Good ●

The service was responsive.

People were able to identify someone they could speak with if

they had any concerns. There were procedures for making compliments and complaints about the service.

People were supported to access a range of healthcare and appointments were made promptly when needed.

Is the service well-led?

Good ●

The service was well-led.

People's needs were appropriately met because the service had an experienced and skilled registered manager to provide effective leadership and support.

People could be certain any serious occurrences or incidents were reported to the Care Quality Commission. This meant we could see what action the service had taken in response to these events, to protect people from the risk of harm.

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.

The inspection took place on the 11 and 12 July 2017 and was unannounced; this meant that the staff and provider did not know we were visiting. On the first day of the inspection, the inspection team consisted of one inspector, a specialist advisor within older people's care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of the visit the inspection team consisted of two inspectors, one of whom specialised in the management of medicines.

Before the inspection the provider completed a Provider Information Return (PIR). The PIR is a form that the provider submits to the Commission which gives us key information about the service, what it does well and what improvements they plan to make. We reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We spoke with three people living at the home who were receiving care and support, 10 relatives; the registered manager, head of care and seven staff. We reviewed four staff recruitment and training files and seven care plans within the service and cross referenced practice against the provider's own policies and procedures. We looked at medicine records and checked medicine stock against records held.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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 the home.

Is the service safe?

Our findings

We previously undertook a comprehensive inspection on 23 and 27 May 2016. We found continued breaches of the Health and Social Care Act 2008. We found people who used the service were not protected against the risk of unsafe or inappropriate care in regards to medicine management. We took enforcement action to ensure people's safety and ensure improvement occurred at the service. We served a warning notice to the provider following the inspection. A warning notice gives a date the service must be compliant by. The date the service needed to be compliant was 31 July 2016. We asked the provider to send us an action plan detailing how they intended to improve. We followed up on the warning notice at a focused inspection carried out on 3 November 2016. We found ongoing breaches of Regulation 12 of the Health and Social Care Act. To help support the service to improve we imposed conditions on the provider's and registered manager's registration. We asked the provider to supply the Care Quality Commission (CQC) with regular information on how they monitored the service to drive improvements. At this inspection we have found significant improvements in the way the service stored and managed medicine administration.

During our inspection we looked at the arrangements for managing medicines (including obtaining, recording, handling, storing, security and disposal) and found that processes kept people safe. Staff followed the home's medicines policy and we were told that managers actively sought feedback from staff when changes to any processes were made to ensure that they were working. Staff recorded medicines administered to people on an electronic medicines administration record system (EMAR). Medicines were administered by registered nurses in a caring and supportive manner. Staff told us that they had completed medicines training, including training to use the EMAR system. The home had four EMAR 'super-users' that were skilled to train others. New staff felt supported through their induction to the home and all staff involved in the administration of medicines were assessed to ensure they were competent to do so.

We were shown how managers used the EMAR system to check that medicines were administered at the correct times. The EMAR system sent an email alerting managers if staff had not recorded that they had administered a dose and we saw evidence in minutes of staff meetings that the EMAR system had helped to reduce medicines errors. Staff carried out daily stock checks of all medicines. This had been introduced following discrepancies between physical quantities and paper records before introduction of the EMAR system. However, managers were reviewing this as the EMAR system had led to a reduction in errors.

Some medicines were prescribed to people on a 'when required' basis. Although staff were aware of people's needs and there was guidance in place for when and why the medicine should be given, the guidance lacked some details. For example we saw that two medicines were prescribed as 'one or two to be taken when required' but there was no instructions about how to decide how many to give. This meant that people may not receive the best outcome from their medicine.

We recommend- the home ensures that guidance for 'when required' medicines includes details for deciding on doses when prescribed as a variable dose.

Some people were administered their medicines covertly (disguised in food or drink). We saw that appropriate mental capacity assessments were completed. However, advice had not always been sought from the pharmacist to ensure medicines were compatible with food or drink. For example, we saw evidence that this had been identified and discussed at a meeting in March 2017, but action to contact the pharmacist had not been completed.

People's medicines were stored safely and securely. The area was clean and tidy and each person's medicines were stored separately. Medicine fridge temperatures were monitored effectively. All medicines were within their expiry dates and there was a process in place for disposing of unwanted and expired medicines appropriately.

The home held a stock of medicines that could be bought over the counter to treat common ailments such as a headache or indigestion. We saw that the GP had authorised that these were safe for people to have when required.

Controlled drugs (CDs – medicines with potential for misuse, requiring special storage and closer monitoring) were stored and recorded in line with legislation. Nurses carried out regular balance checks of CDs and we found these to be correct.

Medicine safety alerts (national alerts regarding faulty products) were received by the manager and action was taken if required. Staff used a communication book to leave messages for staff about medicines. For example, medicines that had been ordered from the pharmacy. We saw that these were followed through. Nurses also used a daily checklist to ensure that all tasks relating to medicines documentation were completed.

Staff were able to describe the process for reporting and managing medicine errors or near misses. We saw examples of incidents that had been reported and evidence that investigations and learning had taken place.

People were supported by staff with the appropriate experience and character to work with people. The service operated robust recruitment processes. Pre-employment checks were completed for staff. These included employment history, references, and Disclosure and Barring Service checks (DBS). A DBS is a criminal record check. Where qualified staff were appointed appropriate checks were in place to ensure that they were able to practice as a nurse.

We received mixed feedback about the deployment of staff. We observed that although there were enough staff to carry out the care as identified in the care plans, there was not always staff available to observe that people were kept safe at all times. For instance, we found staff could have been deployed better at lunch times, as some people needed support with a meal in their own rooms. We noted staff juggled supporting people with their meal and managing challenging behaviours in others. We spoke with the registered manager about this. They were able to give us an explanation as to why people were supported in that way, as they tried to promote choice and inclusion for all at the home. We also noted there was not always a staff presence in the lounge at all times, at one point during day two we observed there were five people in one lounge with no staff present. We fed this back to the registered manager at the time.

Relatives gave us feedback about staffing levels at weekends. Comments included "There are less staff at weekends. There is more visibility of staff during the week. There has been an improvement here in the last 6-9 months," and "They could always do with more staff." We checked the rotas for the weekends and found the same staffing numbers were allocated for weekends and weekdays. Other relatives told us they were

happy with staffing levels. Comments included "Generally there are enough staff here but of course there is sickness and annual leave. Sometimes agency staff are used. I think there are two members of staff on long term sickness. The agency staff have become regular ones. There is a good bunch of staff." Another relative told us "Always enough staff on duty to meet her needs" and "She is checked every 15 minutes if she is in her room."

People were protected from the risk of abuse. The service had a safeguarding procedure in place. Staff received training on safeguarding people. Staff had knowledge on recognising abuse and how to respond to safeguarding concerns. Staff had access to the local safeguarding team contact details. Where concerns were raised about people's safety or potential abuse, the service was aware of the need to report concerns to the local authority and also their requirement to report this to CQC.

Risks posed to people as a result of their medical or physical condition were identified by staff and appropriate measures were in place to minimise those risks. For instance, people were protected from the risk of developing pressure ulcers. Appropriate mattresses were used and these were checked regularly. People's records specified that they should be supported to turn over in bed to relieve pressure. For example, one person's care plan indicated that they should be repositioned every three hours during the day and every four hours at night. Records viewed confirmed this was undertaken and staff had taken responsibility for this. The person had been a high risk of pressure damage and did have a previous wound which had been successfully healed by the staff. Another person was admitted to the home with pressure damage. The home had worked under the direction of the tissue viability nurse (TVN) and again the staff had successfully healed the wound. Staff we spoke with knew how to get advice about the prevention and management of pressure ulcers from the TVN and told us they would not hesitate to make contact with them. This meant the staff took a proactive role in the prevention of pressure damage and reduced the likelihood of harm to people.

Other risks to people were recorded and actions put in place to minimise harm to people. For instance, one person had been identified as of high risk from falling. It had been identified they were at risk of hurting themselves and others. The person had been awarded funding to increase staffing levels to provide continuous supervision to them. Since the person received the continuous support there had not been any further reports of falls or injury.

One person had been identified as high risk of falls. The level of mobility they had was variable. The person would often place themselves on the floor. This occurred twice when we were at the service, we checked what guidance the staff had. We noted the falls risk assessment or care plan did not provide direct instructions for staff to follow in the event of the person being on the floor. We discussed this with the registered manager at the time. They advised us the person's needs were changing a lot and they were due to be re-assessed. On the second day of the inspection we were provided with an updated care plan which provided clearer guidance for staff.

Incidents and accidents were recorded and were signed off by the registered manager. The registered manager had to report any trends to the provider.

The service had procedures in place to deal with emergencies. Personal emergency evacuation plans were in place for each person. These detailed the support people required in the event of an emergency. The registered manager informed us the provider had commissioned a full health and safety audit which was due to be undertaken in the near future. The provider had also identified a new fire risk assessment was required. This had been booked for 7 August 2017.

Maintenance and remedial action was undertaken on a regular basis to ensure the home and equipment used was safe. We noted where water temperatures posed a risk of Legionella growth this was reported and acted upon to reduce the likelihood of harm.

Is the service effective?

Our findings

Relatives told us they felt staff were knowledgeable and had received training to provide effective care. This was supported by what staff told us. One staff member told us "I had training in moving and handling. I also had training from the physiotherapist about the use of hoists and sliding sheets. When I first started I shadowed an experienced staff and observed them transferring using the hoists and gradually I learned about the safe methods of lifting and transferring using different type of hoists."

The registered manager had a system in place to monitor what training staff had received. We noted there was information available for staff on forthcoming training sessions.

New staff were supported through an induction period. One new staff member told us, "I have felt so supported, they have been great here." Another member of staff told us "Staff are not allowed to use the hoists and slings, unless they have had training. New staff are paired with an experienced staff to help them to learn and gain confidence."

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.

The care records showed that the serviced complied with the legal requirements of the MCA. This included appropriate assessments of people's capacity to make decisions. Communication plans were in place which explained how staff supported people to participate in decision making. For example, one person's care plan stated that staff should explain things clearly and slowly and then check to ensure that the person had understood. Care records showed that people had been involved in making decisions by participating in meetings and reviews.

Where people had been assessed as not having the mental capacity to make certain decisions about their care and support appropriate action was taken. Records showed that family members, and other people who knew the person well were involved when 'best interest' decisions were made on their behalf about their care and support.

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 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 and whether any conditions on authorisations to deprive a person of their liberty were being met. The records showed that the home submitted applications DoLS applications when people were subject to restrictions to their freedom. The registered manager kept a record of any applications to the local authority and what decisions had been made.

People at risk of malnutrition had the Malnutrition Universal Assessment Tool (MUST) in place. People's weight were monitored according to their MUST score. Most of the scores indicated that people were weighed monthly. A person who had lost weight regularly was referred to the dietitian. Records showed that staff had incorporated the recommendations from the dietitian into the care plans. The person was on food nutrients, regular snacks, food was fortified by the chef, and their daily fluid intake was calculated. Staff were very knowledgeable about the person's care. One staff member told us "We try to encourage [name of person] to drink at all times of the day by giving her tea, her favourite drink, but lately she has lost her appetite and is not drinking her target amount of fluid." During lunch her meal was served hot and was presented in an appetising manner. The food was the right texture. Staff positioned her in bed to make sure that she was comfortable and also not at risk of choking. The staff involved her throughout lunch, giving explanation throughout the support and taking time to not rush the meal. After the meal when asked by the staff about how the meal was she replied "Very nice, thank you" with a smile on her face.

A person with swallowing difficulties was referred to the speech and language therapist who made recommendations to the staff. These were incorporated within the care plans. There was also guidelines for staff. At lunch time we observed the person being provided with the appropriate puréed diet. There was a swallowing assessment in place and a care plan for staff to prevent choking and to deal with it should it happen. There were pictures in the care notes illustrating the different steps to deal with choking.

Relatives gave us positive feedback about the food. Comments included "Mum eats food now that she never would before - such as spaghetti bolognaise. Before mum came here she would have red wine, gin and tonic and Pringles and take away fish and chips. Now she eats a lot more," "Food is pretty good. Generally there is a three course meal," "There is no problem with food here, more than enough choice" and "The food here is very good. It's proper cooked food; They even provided us all with a lovely Christmas dinner."

Is the service caring?

Our findings

We observed and we received positive feedback about how caring and thoughtful the staff were. Comments from relatives included "All staff are great and very kind. I am on first name terms, which is lovely," "The staff are very good, caring and respectful of the needs of my mother. I come here twice a week. I can visit at any time. At first I used to come at different times to check on my mum's care, but very soon I stopped because I know that my mum was in good hands." Another relative told us "There is not anybody who is not caring or helpful here."

We observed that positive relationships had developed between people and staff. One person was looking for her spectacles. This was spotted by the staff who asked the person "Are you looking for your glasses? Would you like me to get them for you?" A few minutes later the staff member arrived with the person's glasses, cleaned them and then handed them over to the person. This brought a smile to the person's face. The person thanked the staff. We observed many more positive interactions between staff and people. One relative told us "The staff are all lovely."

Relatives told us they felt supported by the staff as well as their family member. One relative told us "They even look after me as well. It's not easy and the staff understand it's hard for me and they suggested that I can take a day off for visiting." Another relative told us "The staff had the patience of a saint. It's very hard for me as we have been married 64 years."

Staff treated people with dignity and respect. Staff addressed people by their preferred name, and spoke with them appropriately. We observed many positive interactions and laughter between people and the staff. For instance one person complained of cramp in their hand. A staff member responded by providing gentle massage to the person's hand. The person responded well to the interaction and they had a smile on their face.

People were encouraged to be actively involved in decisions about their care. When people required support with this, the service ensured an advocacy service was available. Advocacy gives a person independent support to express their views and represent their interests. One person was being supported by an advocate at the time of our inspection. Other people had family members who were involved in decision making. One family member told us "I have been to her reviews about 5 or 6 months ago - with [name of staff] the nurse" and "I go to the user group - but I have chosen not to get the emails. But my sister does. I am happy with the home and mum likes the staff."

People's privacy was respected. People were taken to their room or bathrooms when personal support was required. We observed staff routinely knocked on the door and asked permission before going in the room. Relatives were able to visit the home at any time, and many did do so during our inspection.

Is the service responsive?

Our findings

People received a personalised service. Staff understood people's likes and dislikes. Pre-admission assessments were undertaken prior to people moving into the service. Important information was gathered about people's previous life history, as well as important relationships. People received individualised care that met their needs. The service undertook person centred care planning and we saw a wide variety of person centred information.

Relatives told us their family members received care that met their needs. For example one relative told us "I believe that my mum receives all the care she needs. Obviously her level of involvement has changed as she has deteriorated and she is more dependent now. But the standard of care has remained the same, if any it has improved." Another relative told us "They [staff] do cater for challenging behaviour... Her challenging needs are met here...I wish there were more places like this that can deal with challenging behaviour."

We observed all staff worked together well to help people receive a personal and responsive service. We observed staff responded well to any change in people's needs. For instance, one person who walked a lot during the day was supported to maintain their hydration levels at ad hoc moments, we observed them being supported to drink whilst they were still and standing next to staff in the kitchen area. Staff responded well when people presented with challenging behaviour. We observed staff responded prompting and appropriately when a person became abusive when their family member was trying to leave the home. The staff intervened to ensure the person and the relative were safe and supported the relative to leave the service.

Relatives we spoke with were contacted by the service when important events took place. For instance, one relative informed us that they were always contacted when their family member was unwell and the GP had been called. One relative told us "They call me when there is any change. My mother is always clean and nicely dressed and comfortable in bed. I feel that I can bring up anything if I need to, things are improving. She also has her favourite radio station on to listen to her music."

People had access to a wide range of activities. The service employed an activities co-ordinator. The staff member responsible for activities was knowledgeable about people, their life history and their interests. This meant they could start conversations with people. We observed staff talking to a person who had worked in the Rain Forest. The person was engaged and animated when talking to the staff about their work.

People had easy access to outside, we observed many people walking outside. When the weather was less favourable staff encouraged people to be suitably dressed so they could still enjoy the open air.

People had access to activities which were tailored to meet their individual needs. People had access to individual sessions and group sessions of activities. Relatives told us they were happy with the level of activities on offer. One relative told us "There are lots of activities going on [name of staff] does one to one with him and will read to him and tell me what has happened."

The registered manager told us how successful a recent sixties themed activity had been. Relatives had commented how much they enjoyed the get together. Other activities included music sessions, gardening and coffee mornings.

The service's display of activities was in an easy read and understandable format with pictures and words. It had been complemented by the local Healthwatch team (Healthwatch is the national consumer champion in health and care) as the activities available provided to be meaningful and promoted dignity. In the annual report for Healthwatch it referred to the activity planner as "A great example of activity planning in one of the care homes we visited."

The service had a complaints procedure and information on how to make a complaint was available. We saw that the service responded to complaints. People and relatives we spoke with were aware of how to raise concerns if needed.

Is the service well-led?

Our findings

We previously undertook a comprehensive inspection on 23 and 27 May 2016. We found continued breaches of the Health and Social Care Act 2008. The service had not informed CQC of any changes made to the statement of purpose. This was a breach of regulation 12 of the Care Quality Commission (Registration) Regulation 2009. At this inspection we checked if the service had informed us of any changes. Our records showed the provider had made us aware of changes to their statement of purpose. We were satisfied the provider was no longer in breach.

Following the focused inspection completed on 3 November 2016 we imposed a condition of the registered manager's and provider's registration. We asked them to provide us with monthly evidence of how they were monitoring the management of medicine. We have received the information we required. At this inspection we checked the management of medicine to evidence if the condition needed to remain. We found significant improvements had been made to the management of medicine. We were satisfied the registered manager and provider has met the conditions imposed on their registration.

There was a registered manager in post. Since they had been in post we had received positive feedback from staff about the stability of the service. One new member of staff told us "I did shadowing for two weeks and [name of manager] said I could have more. It was really good, I love it here, it's a really good team." We observed good team work among the staff throughout the course of the inspection.

The provider had a clear vision to provide a home for life. The service supported people with complex and challenging behaviours. They accepted people who had been given notice by other homes. We found staff were fully committed to supporting people and made appropriate referrals to external agencies in order to support people to remain living in the home. For instance the home worked alongside consultant psychogeriatricians.

We received mixed feedback from relatives about the availability of the registered manager. Comments included "My [family member] is in another care home. When I visit there the manager is always present and will welcome people in. That's not the case here" and "The manager is not particularly interactive. She is absent as far as the home is concerned." Another relative told us "I don't see much of the manager - she is always in her office. If I need to see her I could always go to her office." We discussed the feedback with the registered manager and their manager. The registered manager often works early and leaves the home early so is not always present at the end of the day. The registered manager advised they would make their diary available to relatives. We noted this had been discussed at the next relatives meeting after the inspection.

The service worked well with external agencies. The home had supported an external pharmacy audit and contract monitoring by the local clinical commissioning group (CCG) and local authority.

The provider and registered manager had good oversight of the service. This was because quality assurance processes were in place to monitor the service. For instance, we noted the provider held quarterly health and safety meetings and held regular support meetings for managers to attend. These were an opportunity

for managers to share good news stories and improve the service they provided.

There was an annual programme of audits which the registered manager was expected to undertake. These were sent to the provider. The provider undertook regular visits to the service to monitor how effective the service was.

The registered manager held regular head of department meetings, staff meetings and relatives' meetings. Information from these meetings was used to drive improvement. We noted at the last relatives' meetings an update on staffing was provided.

There is a legal requirement for providers to be open and transparent. We call this duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, states when certain events happen, providers have to undertake a number of actions. We checked if the service was meeting the requirements of this regulation

Providers and registered managers are required to notify us of certain incidents or events which have occurred during, or as a result of, the provision of care and support to people. One notifiable event is when a decision made had been made about a DoLS application. We checked our records and we had been notified about events when required.