Norse Care (Services) Limited

Burman House

Inspection report

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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

Burman House is a residential care home for 32 older people. The service also provides short term and respite care. Peoples care and support is provided in purpose built accommodation, over two floors, although only the ground floor was in use for accommodation. At the time of our comprehensive unannounced inspection of 17 April 2018 there were 26 people living at the service.

At the last inspection of 3 May 2016, the service was rated Good. At this inspection, we found the service remained Good.

There was a Registered manager in post, however they had recently applied to cancel this registration. This was because they had recently been appointed to another Registered manager position at one of the providers other registered locations. 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. At the time of our inspection, a registered manager from one of the providers other locations had recently started in the position of manager at Burman House, and had applied to the Care Quality Commission (CQC) to become the Registered manager.

People received support to take their medicines safely. Staff knew how to keep people safe from the risk of harm. Actions had been taken to reduce risks to people's safety. There was enough staff to keep people safe and meet their needs. People's medicines were managed safely.

Staff were competent to carry out their roles effectively and had received training that supported them to do so. People were supported to eat freshly prepared meals, and their individual dietary needs were met. People were able to access and receive healthcare, with support, if needed.

A programme of refurbishment was underway, which included redecoration and replacement of flooring. This had enhanced the environment positively, and improved safety for people with limited mobility.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff were kind and compassionate in the way they delivered support to people. People were treated with dignity and respect. Staff ensured that people were able to have visitors, and enabled people to maintain relationships with relatives and friends who did not live nearby.

People and their relatives were confident that they could raise concerns if they needed to and that these would be addressed. People were able to access a range of activities which they enjoyed.

The manager ensured that the home was well run. Staff were committed to the welfare of people living in the home.

Further information is in the detailed findings below.

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 remains Good	**Good**
Is the service effective? The service remains Good	**Good**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service remains Good	**Good**

Burman House

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 17 April 2018 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. At this inspection, the area of expertise was residential care for older people.

As part of the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events, which the provider is required to send us by law.

Before the inspection, we asked the local authority safeguarding and quality performance teams for their views about the service. We looked at the Provider Information Return (PIR). This is a form we ask the registered provider to complete detailing key information about the service, what the service does well and what improvements they plan to make.

During our inspection visit, we observed how people were being supported and how staff interacted with them. This included a mealtime and some activities.

We spoke with nine people living at the service and two relatives. We also spoke with five members of staff including care workers, a chef, the deputy manager and the newly appointed manager. We checked three people's care and medicines administration records (MARs). We also looked at records and audits relating to how the service is run and monitored, including recruitment, training and health and safety records.

Good

Our findings

The service remains safe.

People told us they felt safe, with one person saying, "I am totally safe here. I generally look after myself, but if I need anything, I only have to ask. I know they check on me at night which gives me piece of mind." Another person said, "They are always looking in on me to see if I am alright, that's really nice."

There were processes in place to protect people from the risk of abuse or harm, and these contributed to people's safety. Staff knew how to protect people from harm and had received relevant training in this subject. Several staff were due to refresh this training shortly after our inspection and this had been arranged. The registered manager knew their responsibility to report issues relating to safeguarding to the local authority and the Care Quality Commission. They were also a member of the local safeguarding adult's board. Staff were able to describe to us the types of abuse people were at risk from, and what they would do if they were concerned.

The risks involved in delivering people's care had been assessed to help keep them safe without impacting their lifestyle. Guidance had been provided to staff on how to manage risks in a consistent manner. Examples of risk assessments relating to personal care included people's mobility, nutrition, hydration, and medicines, these records had been regularly reviewed and updated. We observed a handover meeting between two teams of staff, any changes that had occurred in people's needs during that period, were shared and discussed. This meant staff had up-to-date information about how to manage and minimise risks.

General risk assessments had been carried out in relation to the home environment. These covered areas such as fire safety, the use of equipment, infection control and the management of hazardous substances. The risk assessments had been reviewed on an annual basis unless there was a change of circumstance. This ensured people living in the home were safeguarded from the risks of any unnecessary hazards.

There were enough staff to meet people's needs and people we spoke to confirmed this. One person told us, "There are enough staff but sometimes they can be a bit busy and are rushing around." The registered manager regularly reviewed staffing levels to ensure that people's needs were met in a person centred and timely way. Records we reviewed showed that staff had undergone an interview process and checks to ensure that they were safe to work at the home.

People received their medicines when they needed them from staff who were competent to provide this. Staff completed daily audits of stock and daily checks of records. These records showed that people had received their medicines when they needed them. We saw that staff ensured people had a drink to take their medicines with if required. Staff checked with people before giving them their medicines, to ensure that they were ready and happy to take them.

People living at the service and their relatives told us the home was clean and tidy. We saw the home was very clean throughout. Domestic staff had the required equipment to clean the home effectively. We saw staff use gloves and aprons were appropriate to help reduce the risk of cross infection. The registered manager had procedures and checks in place to maintain infection control. Most of the flooring within the home had been recently replaced with a product that was much easier to keep clean and odour free. Several people we spoke with told us that this had been a welcome improvement.

The registered manager showed us how they had a system in place to learn from any accidents or incidents, to minimise the risk of reoccurrence. This meant the feedback and analysis of where things went wrong was used to make improvements to people's care.

Good

Our findings

The service remains effective.

People told us their needs were assessed and this was confirmed by relatives we spoke with when they begun to use the service. Staff told us they received guidance and information about people's needs including from community professionals. This information was used to inform their care plans.

The manager ensured that the provider's policies concerning people's human rights were followed at the service. These included policies on equality and diversity. Staff celebrated people's ethnicity and cultural identity and supported them to follow their faith. People were supported with those aspects of their lives by staff who were understood their responsibilities and people's rights.

Staff told us they had completed the provider's mandatory training and were supported to identify their own training needs. Records we reviewed showed that some staff were in need of refreshing some of this training, and this had been arranged to take place in the near future. Training was a mixture of on line training and practical, face-to-face training depending on the subject matter.

Staff told us supervision sessions to support them in improving their performance were regular and they felt well supported. This support consisted of an annual appraisal of their performance, an interim review of this, and direct observations of their practice.

Most people told us that the food was of a good standard generally. One person said, "The food is quite nice, I think there is plenty of choice and they tell you what is for lunch in advance." However, some people did not like recent changes to the menu. The chef told us that they were aware from feedback that a recent seasonal planned changed had some unpopular aspects to it. They told us that the provider was reviewing these recent changes and making some interim amendments. All the food was fresh and as far as possible home cooked. There was a four-week seasonal menu operated. Catering staff knew people well and had a sheet updated daily about people's needs including any weight loss or specific dietary requirements. Staff knew if there was anyone at risk of choking, and if a soft foods diet was required. There was also a list of people's allergies.

People told us how staff organised for them to have their health care needs met and arranged health care appointments for them. A relative told us, "If [family member] isn't feeling well, the staff will phone me and keep me up to date……It gives me confidence that they know what they are doing and that they are keeping

a close eye." The manager told us the GP visited routinely and as required. Staff spoken with were able to tell us about people's individual health care needs and how they were addressed.

The premises were easy to navigate around. Toilets and bathrooms had signs on them and people's bedrooms had names and pictures outside to help people familiarise themselves. New flooring had been installed and many people we spoke with commented that this made them feel safer when walking as it was non-slip. They also told us that it made the environment brighter, which also gave them confidence when moving around the home.

Space was ample and enabled people to socialise with other people, spend time by themselves or private time with family if they wished. The gardens were accessible and all people had a bedroom with a view. The manager told us that the activity co-ordinator was planning a redevelopment of the garden area using funds that had been raised. They were planning this in conjunction with people living in the home.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

All of the staff we spoke with demonstrated they had an understanding of the MCA and worked within its principles when providing people with care. Consent to care and treatment was sought in line with legislation and guidance. People had been assessed for their capacity to consent to specific aspects of their care. When people lacked capacity to consent, best interest decisions were made in consultation with relevant others, such as relatives or GP's.

Good

Our findings

The service remains caring.

People and their relatives told us that all staff at the home were kind and caring. One person said, "I am really happy here. The staff are so nice and caring; they can't do enough for you." We observed staff as they supported people. They were friendly and communicative taking time to stop and chat with people, checking they had everything they needed. We saw humorous exchanges between people and staff who were clearly comfortable with each other, laughing and smiling as they talked.

Staff spoken with understood their role in providing people with compassionate care and support, which included promoting people's dignity. Some people chose to spend time alone in their bedroom and staff respected this choice. One person told us, "[Staff] are really sweet; they make me feel like I am their Nan. If you feel upset, they will come and comfort you.

We asked people how they were involved with the running of the service and they told us they were consulted daily about activities, food, and their personal care needs. We saw there were regular resident meetings and these also involved relatives and staff. Regular agenda items included activities menus and changes within the service.

People were consulted about the care they needed and how they wished to receive it. The staff were knowledgeable about people's individual needs, backgrounds and personalities and were familiar with the content of people's care records. People were able to request preferences about how their care was delivered, including the times at which they received their support. One person told us, "I usually go for breakfast between 8 and 10, when I feel like it. The [staff] put me to bed about 11pm, which is when I want to go." Another person told us, "If I want to have a lie in, I can."

Staff respected people's privacy and ensured their conversations could not be overheard. They told us it was important to uphold people's confidentiality and showed sensitivity towards people's needs. We observed staff knocking on doors and waiting to enter during the inspection, which demonstrated respectful practice.

People were encouraged to maintain their independence, and staff were clear about what level of support people needed. One person told us, "I am so used to looking after myself, and I can get washed and dressed myself, but if I do need help there is no bother in getting this. All the staff are lovely and willing to help."

Good

Our findings

The service remains responsive.

Staff had a good knowledge of people's needs and could clearly explain how they provided support that was important to each person. People told us that staff understood their needs and knew how to meet them. One person told us, "It is up to you to say what you want to do and what help you want. They just fall in with you, which is all you can ask really. I feel like they treat me as an individual and they will always help you."

We looked at three people's support plans and other associated documentation. These showed that a comprehensive assessment of people's needs had been conducted. The plans were split into sections according to people's needs and were easy to follow and read. All files contained details about people's life history and their likes and dislikes. The profile set out what was important to people and how staff should support them.

We saw the support plans were reviewed if new areas of support were identified, or changes had occurred. The plans were sufficiently detailed to guide staffs' care practice. Staff recorded the advice and input of other care professionals, within the support plans, so their guidance could be incorporated. Daily records provided evidence to show people had received care and support in line with their individual needs.

Staff told us how changes in people's needs were communicated and how they used handovers to ensure all staff were up to speed with what needed to be done. In the handover we observed, we saw that detailed information was shared between the changeover in staff teams. The staff member leading the meeting ensured that a staff member who was returning from a period of annual leave was updated with essential information from that time.

People were complimentary about the activities that were provided. One person said, "I sometimes go to the craft activities, and they put some of the things we make on display." Another person told us they enjoyed the entertainers that came in, and a recent visit from a companion dog. We observed people had access to reading materials and newspapers. There were puzzles and games in the communal lounges that people could use. Special occasions were celebrated such as birthdays, Valentine's day and Easter.

We looked at how the service managed complaints. People and their relatives told us they would feel confident talking to a member of staff, or the registered manager, if they had a concern or wished to raise a complaint. People told us that action had been taken when they had raised a concern or complaint. Staff

confirmed they knew what action to take should someone in their care want to make a complaint and were confident the manager would deal with any given situation in an appropriate manner.

We spoke with the manager about how they supported people with planning for end of life care. Staff could describe to us how plans were put in place when people were at the end of their life. Staff told us and the manager confirmed these plans would include how the person should be supported with their hydration and nutrition, how their pain would be managed, what other services and health professionals would be involved and guidance for staff on how to offer reassurance and any special wishes would be recorded. This meant the service had a system and plans in place to ensure people could have a dignified and comfortable death in line with their wishes.

Good

Our findings

The service remains well-led.

People told us that the home was run well. Although there had been a recent change in manager, staff told us that they had already stared to build a rapport with them, and that they were looking forward to working with them. Staff told us that the previous manager was approachable and proactive with any concerns they had.

The service had a registered manager who recently registered with the Care Quality Commission. 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. However, they were in the process of changing their registration to manage another of the provider's services. The current manager had applied to become the registered manager of Burman House. There had been a detailed handover between the two managers, and they were in regular contact with each other through this transition.

Staff were aware of the lines of accountability and who to contact in the event of an emergency or with concerns. If the manager was not present, there was always a senior member of staff on duty with designated responsibilities. We saw that the rating of the last inspection was on display and could be accessed by people and visitors to the home. Notifications were received promptly of incidents that occurred at the service, which is required by law. These may include incidents such as alleged abuse and serious injuries.

The manager was visible throughout the home and accessible to staff. The staff members spoken with said communication with the manager was good and they felt supported to carry out their roles in caring for people. Staff told us they were part of a strong team, who supported each other. We found there to be a culture of good teamwork and morale amongst staff was positive.

We saw there were policies and procedures, which set out what was expected of staff when caring for people. Staff had access to these and they were knowledgeable about key policies. The provider's whistleblowing policy supported staff to question practice. It also assured protection for individual members of staff should they need to raise concerns regarding the practice of others. Staff confirmed they would report any concerns and felt confident the registered manager would take appropriate action.

The provider and manager used various ways to monitor the quality of the service. For example, they checked on people's care plans and daily records to ensure they were completed accurately. They also checked people's weights monthly to look for any signs of weight loss and enable immediate action. This meant they could be assured people were receiving the care they needed. The manager completed monthly checks on a range of areas within the home. These included monthly infection control audits, checks on the kitchen and health and safety. We saw these audits were identifying areas for actions and these were taken promptly.

We found the manager and staff team had systems in place to provide consistent care and work collaboratively with other agencies. This included engaging with a range of health professionals such as doctors, nurses, physiotherapists and hospital departments. The staff team had regular opportunities to discuss people's care and they had handover meetings at the start of each shift. This meant staff provided consistent care and had support from other professionals to improve outcomes for people.