Esteem Care Ltd

Brandon House Nursing Home

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 6 December 2016 and was unannounced. At the last inspection we rated the service as requires improvement. The provider was not in breach of regulation, however, we identified there were areas to improve. We also said they required a longer term track record of consistent good practice before we rated the service as good. At this inspection we found they had made improvements and have demonstrated a longer track record of good practice.

Brandon House is a nursing home and provides accommodation for up to 42 older people. The service had a registered manager. 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.

People who used the service and their relatives told us the service was safe. Staff had received training to help them understand how to keep people safe. The home looked well maintained, clean and tidy, and checks were carried out to make sure the premises and equipment was safe.

There were sufficient staff with the right skills and experience; several staff told us the staffing arrangements had improved. Appropriate checks were carried out before staff were employed. Medicines were managed safely.

People who used the service and their relatives told us they were happy with the staff who provided care and support. Staff we spoke with said they felt well supported and received training that made sure they knew how to do their job well. They said they understood their role and responsibilities. The registered manager was going to review the induction arrangements to ensure they met recognised guidance. Staff we spoke with understood their responsibilities around how they should support people with decision making. People had good meal experiences, enjoyed the food, and had plenty to eat and drink. Systems were in place that ensured people accessed healthcare services.

People told us they were well cared for and visiting relatives told us the service was caring. We observed care workers supported people in a calm, compassionate and caring way. Staff were cheerful and friendly. When they walked by people they would say "hello" and checked they were ok. When staff assisted people to move and transfer they explained what was happening and reassured them throughout. Staff knew people well, for example, what people liked to do and their family members. We saw one situation where staff were not responsive to a request for support.
People had access to information which kept them informed.

Staff responded to people's individual needs and delivered personalised care. People's care plans and other records showed their needs had been assessed and care was usually planned, although there was inconsistency with the level of detail and we saw examples where care plans had not been followed. Action

was being taken to improve activities.

The service had developed a 1950's village around the back of the nursing home which people could access. People told us they would talk to staff and management if they had any concerns and complaints had been responded to in a way which resolved the issue where possible to the person's satisfaction. Several written compliments had been received.

We received positive feedback from people about the registered manager. Several relatives described them as "welcoming" and several staff described them as "supportive". Resident and relative meetings and staff meetings were held. We saw from meeting minutes that people had opportunity to discuss the service and were informed of planned events. Where people had made suggestions for improvement the provider had responded. At the inspection we reviewed a wide range of audits which had been completed at the service, which were then used to monitor the quality and safety of service delivery.

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.

Systems were in place to help keep people safe, which included safeguarding them from abuse.

There were enough staff to keep people safe.

Staff managed medicines consistently and safely.

Is the service effective?

Good

The service was effective.

People's needs were met by staff who had the right skills and knowledge.

Staff understood how to support people with decision making including when a person who lacked capacity.

A range of professionals were involved to help make sure people stayed healthy.

Is the service caring?

Good

The service was caring.

People told us they were well cared for and visiting relatives told us the service was caring.

Staff knew the people they were supporting well.

People had access to information which kept them informed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff responded to people's individual needs and delivered personalised care. However, the care planning process was inconsistent which could result in people's needs being overlooked. The registered manager had plans to improve this.

The activity programme was being developed.

Systems were in place to respond to concerns and complaints.

Is the service well-led?

Good

The service was well led.

People told us the home was well led.

Everyone was encouraged to put forward suggestions to help improve the service.

The provider had systems in place to monitor the quality of the service.

Brandon House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 December 2016 and was unannounced. Two adult social care inspectors and an expert-by-experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the service including statutory notifications, and contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider had completed a Provider Information Return (PIR) in August 2016. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

At the time of our inspection there were 34 people using the service. During our visit we spoke with six people who used the service, three visiting relatives, a visiting health professional, seven members of staff and the registered manager. We observed how people were being cared for, and looked around areas of the home, which included some people's bedrooms and communal rooms. We spent time looking at documents and records that related to people's care and the management of the home. We looked at six people's care plans.

Good

Is the service safe?

Our findings

People who used the service and their relatives told us the service was safe. People told us they felt safe and visiting relatives told us they did not have any concerns about the safety of their family members. Comments included, "I like it here, it is really nice", "I am settled here; not my own home but I am happy. The room is clean, bedding is clean, and there is food and lighting. What more I can I ask for", "I am a bad tempered old lady but this is my home. They are good with me", "I have no worries here", "Oh yes, we are very happy with the safety here". A health professional who visited at least weekly told us, "I have never witnessed behaviour by staff that has caused me any concern."

Staff told us they had received training to help them understand how to keep people safe; this included safeguarding people from abuse. Staff could identify the types of abuse people may experience and how they should respond if abuse took place or if they had concerns. They were confident the registered manager would respond appropriately and promptly.

We looked around the home, which included some bedrooms, bathrooms and communal living spaces. The home looked well maintained, clean and tidy. We saw maintenance records which showed a range of checks and services were carried out, for example, gas safety, passenger lift, fire safety equipment and electrical installation. We saw a daily environment check was completed which included making sure people's rooms, equipment and wardrobes were tidy and clean. This meant the premises and equipment was safe.

Environmental risk assessments were in place for certain hazards such as 'snow on the ground' and 'use of electrical heaters'. Some assessments clearly identified the level of risk and measures in place to manage the risk; others were not clear and did not contain detail around how the risk should be managed. The registered manager agreed to review these.

Care plans contained a generic risk screening tool. This was a tick-box form which showed which risks which were known to be associated with each person's care and support, and where there was risk, actions taken to minimise these had also been selected. Areas in which risk could be identified included falls, nutrition, pressure ulcers, infection and contractures. Care plans contained information which would alert staff to risk; however, we found there was some inconsistency in how these were completed. The registered manager told us they had identified this as an area for improvement and were working with the nursing staff who were responsible for completing the assessments to make sure the risk assessments fully reflected the level of risk. They agreed to monitor this more closely.

In the PIR the provider told us they had a falls reduction plan which had reduced the number of falls in the home and 'closer observation of higher risk residents reduced the risk for them'. On the day of the inspection we saw staff were visible and ensured people were observed when in communal areas. We saw accident and incidents were clearly recorded and monitored. It was evident from the records that every accident was analysed. There had only been one accident in November 2016.

People who used the service, visiting relatives and staff told us there were enough staff to keep people safe. One person told us night staff were sometimes rushed. Staff we spoke with did not have any concerns and several said the staffing arrangements had improved. A health professional told us, "There is always staff presence." We observed there were enough staff to keep people safe. At peak times, for example at lunchtime, people continued to receive appropriate support and did not have to wait for assistance.

The registered manager said they were confident the staffing arrangements were sufficient and confirmed these had improved. They were also in the process of recruiting a deputy manager to assist with the management of the service. We looked at the staffing rotas which showed the staffing level on the day of the inspection was a reflection of the usual staffing numbers.

Staff told us they had gone through a formal recruitment process, which included completing an application form, providing reference details, attending an interview and applying for a DBS. They said all checks had been carried out before they started work at Brandon House Nursing Home. The DBS is a national agency that holds information about criminal records. We looked at four staff files which confirmed appropriate checks were completed. In one staff file we noted that the employment end date for one positon did not match the date given by a referee. The registered manager said they would follow this up with the member of staff.

We checked the systems in place for managing medicines and found people received their medicines as prescribed. Medication administration records (MAR) sheets were completed correctly and the number of medicines in stock corresponded with the records. Each MAR had a photograph of the person for identification purposes and allergies were noted. Any incidents of non-administration or refusals were noted.

As and when required (PRN) drugs were in place at the home. People had a protocol sheet which indicated the reason why and when they should be given. This meant there was guidance in place for staff to follow.

Topical medication administration records (TMAR) and body maps were used to record the administration of creams and ointment. These had information about how often a cream should be applied and to which parts of the body.

We looked at medication storage and saw the medication room was well-lit and spacious enough for the amount of medicines required. Medicines were stored securely. Daily temperature records confirmed that medicines were stored within the recommended temperature ranges to ensure their safety and effectiveness. The storage and recording of controlled drug medicines which require extra security was managed safely. Medicines for return to the pharmacy were sent through each month and recorded in a specific book. Any remaining medication and clinical waste was collected and signed for by a specialist contractor.

Staff who were responsible for administering medicines had completed training and assessments to ensure they were competent.

Good

Is the service effective?

Our findings

People who used the service and their relatives told us they were happy with the staff who provided care and support. Comments included, "Oh yes, staff are always around to look after me", "I can speak to anyone, even if I am poorly. They look after me", "I tell them what I want and they listen", "The staff have to put up a lot with me; I am always rude but they still look after me properly", "We have no problems with the staff; they certainly know what they are doing".

Before the inspection we received information of concern that related to problems people had communicating with some care workers due to language barriers. One person told us they were concerned because they sometimes had difficulty communicating with staff, they said, "I cannot understand them. They speak in a different language and they do not understand me. Some of them just look straight through me." The registered manager provided information about how they supported staff when their first language was not English; this included provided additional support within the service and registering staff on English language courses.

Staff we spoke with said they felt well supported and received training that made sure they knew how to do their job well. They said they understood their role and responsibilities.

We looked at the training matrix which showed staff had attended a range of training and training updates, and included communication, first aid, fire safety, infection control, moving and handling, end of life care, challenging behaviour, safeguarding, dementia, skin integrity, fall training and assisted feeding. An overview of supervision showed staff had been supervised between September and December 2016. Supervisions are used to develop and motivate staff and review their practices.

Although staff felt well supported, some were unsure how often they received supervision sessions and the purpose of supervision. The registered manager agreed to clarify supervision with staff so they fully understood what to expect and the benefits.

New staff completed induction training where they spent time with the registered manager, shadowed experienced staff and completed a workbook; this covered many topics relevant to health and social care, however, it did not cover all areas from the 'Care Certificate' which is an identified set of standards that workers adhere to in their daily working life. The registered manager said new care workers had previously done the Care Certificate but recently they had done the 'home's induction' and commenced an NVQ in health and social care. The registered manager said they would recommence the Care Certificate to ensure new staff covered all the standards when they started work.

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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw care plans contained information about making decisions. People's capacity around consenting to live at Brandon House Nursing Home had been checked by external assessors as a part of the DoLS authorisation process, and capacity assessments identified which decision was being considered. For example, it was stated on one person's DoLS assessment that the person lacked capacity in relation to specific decisions and we saw this was referred to throughout their care plan. This meant people were supported to make decisions in the appropriate way.

Six people had an approved DoLS in place. The provider had recognised when an application was required and made applications in a timely way. Records we looked at showed some DoLS had additional conditions; the provider had put measures in place to ensure these were met.

Most care plans contained records which showed how consent for areas of people's support such as administration of medicines and sharing of information had been obtained. People who had capacity had signed documents in their care plans and records of best interests decisions had been made for people who lacked capacity. However, we saw not all were signed; the registered manager agreed to review all consent records and ensure any unsigned records were discussed with the relevant person.

Staff we spoke with said they had received training about the MCA and the training record we reviewed confirmed this. Staff had good knowledge around when they should support people with decision making and when people had the right to make decisions even though these might be unwise.

People we spoke with were overall happy with the meals provided. Comments included, "If I want anything I will ask. They are very good. If the light is on late at night they will come in and ask me if I would like a drink", "I have no problem with the food, when I am hungry I eat. I enjoy the food", "The food is good, not bad at all". Throughout the day, we saw refreshments such as tea, coffee, juice and biscuits were offered to people in the communal area and in their bedrooms.

We observed lunch and found people had a pleasant meal experience. It was relaxed and staff gave people time and checked they had enough to eat. People were served a variety of fresh food and enjoyed the food. There was plenty of staff to assist people to eat and drink, and provide general support with the meal. We saw staff encouraged people to eat and ensured they were happy with the food provided.

We looked at the menus and saw people had a choice of a hot meal at breakfast, lunch and teatime. The main meal was served at lunch and choices included chicken casserole, lasagne, beef casserole, steak dinner, and all were served with vegetables. Fish and chips or mash were on the menu and served on Fridays; one person said they didn't get the choice of chips only mash. A member of staff said, "I go to see each and every service user every day to check what they would like to eat. This is recorded on the resident daily choice menu list. The menu is set but if a service user wants an alternative we try to get this." We saw staff checked the menu list when serving meals.

Most staff we spoke with, including the chef, had a good understanding around people's specific dietary requirements, for example, different textured meals. One relative told us they thought the presentation of food was not satisfactory. The registered manager said they had recently purchased moulds that replicated types of food to help improve the appearance of blended food, and would be using these very shortly. We saw from one person's record there was conflicting information about their food preferences, and staff we spoke with were not sure if the person had an allergy or a dislike of two specific foods. The registered

manager said they would ensure this was addressed.

Visits by health and social care professionals were recorded in people's care plans, together with notes relating to advice or instructions given. We saw people had access to a range of visiting professionals including GPs, opticians, psychiatric services, memory teams, safeguarding teams and dieticians.

An advanced nurse practitioner and prescriber attended the home at least once a week. We spoke with this person about their experience and they told us, "They are quite diligent, notice issues and flag these up. They have access to a direct therapy team are quite good at direct referrals, for example to the dietician, physios and speech and language therapists. Where we put plans in place they have a good awareness. Relatives have shared with me the care is good. People who are here for nursing care are well looked after."

Good

Is the service caring?

Our findings

People told us they were well cared for. Comments included, "They are excellent, I could not fault them", "They are not rude at all. If I ask they will do it", "Yes, yes, yes to everything, they listen, respect and are very good to me", "I like it here and I can speak to anyone. They listen to me", "I am really happy here". One person told us they did not always feel staff were caring. They told us, "Some are good; others are not."

Visiting relatives told us the service was caring. Comments included, "Excellent service. We cannot fault the staff", "It is great to see when support staff come in to see our relative. He has a massive smile on his face and this gives us full assurance that our relative is happy", "We had seen a lot of care homes. [Name of registered manager] was so welcoming and open. We chose this place even though it is quite a distance to travel to. We had seen care homes nearer but this home was so welcoming."

We observed during the day that care workers were clearly visible and supported people in a calm, compassionate and caring way. Times for people to get up were flexible. Staff were cheerful and friendly. When they walked by people they would say "hello" and checked they were ok. When staff assisted people to move and transfer they explained what was happening and reassured them throughout. Staff knew people well, for example, what people liked to do and their family members. People looked well cared for and consideration had been given to people's dress, their clothing was clean and footwear was appropriate.

Although we saw some very good interactions, we saw one example, where a person used their call bell but staff didn't respond. We discussed this with the registered manager who explained it was an unusual situation and there had been some tensions around relationships with the person. They said, however, under no circumstances should a call bell be ignored and agreed to follow this up and monitor closely any future requests for assistance.

Care plans had information relating to aspects of people's lives including their likes, dislikes, hobbies and interests. This information helped staff form relationships with the people they supported, and promoted person centred care. We saw the registered manager had begun to gather more information from people and their families in order to develop a better understanding around people's history and what was important to them.

When we looked around the service we saw there was information displayed in communal areas to help people understand procedures and keep them informed. There was a notice board near the entrance of the home which had resident and relative meetings minutes, and the provider survey results. The provider had displayed how they improved the service following the last CQC inspection. We saw a dignity tree which outlined what dignity and respect should look like. Information around advocacy and safeguarding people from abuse which informed people about what action they should take when they had any concerns.

Requires Improvement

Is the service responsive?

Our findings

People who used the service had a range of needs; some people had complex needs and were dependent on staff support for many aspects of personal care; others managed some aspects of their care, for example, they ate independently. We observed that staff responded to people's individual needs and delivered personalised care.

Before people moved into the service an assessment of people's care and support needs was carried out. This meant the provider had checked to make sure they could meet people's needs. From this assessment risk was assessed, and a series of care plans were written.

People's care plans and other records showed their needs had been assessed and care was usually planned. Everyone had a care plan although we saw there was inconsistency with the level of detail. Some people had care plans that clearly outlined how staff should deliver care, but others were less specific. For example, we saw from one person's risk screening tool they displayed behaviours which meant staff and people could be at risk. This section of their care plan highlighted the risk but there was insufficient guidance for staff to follow when behaviours that challenged were displayed.

Staff completed a range of charts to help ensure people were receiving appropriate care. For example, weight records, repositioning, and food and fluid and charts. These were well completed and showed care was being delivered to meet people's needs. A senior member of staff monitored these regularly to make sure they were filled in correctly. We saw two examples where the care plan was not followed. One person should have been weighed weekly, however, they were only weighed every two or sometimes three weeks. Another person had not had their blood pressure taken for three months even though their care plan stated it should be done monthly. Staff had recorded that they had refused each time but had not shown what action had been taken to address this. We also saw one example where a person had returned from hospital. Two body maps had been completed on the same day but contained different information.

Care plans were reviewed monthly, with notes to explain what if anything had changed or why the care plan should remain unchanged; there was no information to show how people had been involved in this process. An annual review was carried out with people, their families or representatives and details were recorded of any concerns raised and changes to the care plan.
People who used the service could not recall if they had been involved in the care planning process. We received the following comments from visiting relatives, "We were involved with our family members care plan. If they have any concerns they contact us immediately", "Anything major the home will let us know", "We do feel there are teething problems. To date we have not been consulted or no one has discussed our family member's care plan". We discussed the issues relating to care planning and delivery with the registered manager. They said they had identified there was room for improvement and continued to work with staff to make sure everything was appropriately recorded. We saw care planning and care recording had been discussed at staff meetings. The registered manager agreed to increase the level of monitoring around care planning and said the new deputy manager would focus on this.

During the inspection we saw people actively getting involved in a painting, and art and craft session. The hairdresser visited and several people had their hair done in the allocated hairdressing room or their bedroom. Staff recorded activities on a daily activity sheet. One person said, "I like painting and they paint here." Some people told us they liked to spend time on their own and this was respected. One person said, "I like to sit on my backside reading a book. I do not like to join in with others, the TV is my company."

In the PIR the provider told us, 'We have created a 1950's village around the back of the nursing home, this includes a sweet shop, a post office, a pub, and a green grocers. There is also signage around the village advertising items familiar to our residents, and an old mangle and bike etc. The village was created to bring as much of the outside world into the lives of the residents that are not able to visit those places they once enjoyed'. We saw the village which was as the provider described. One person told us, "When the weather is nice. I go for a walk in the village."

An activity plan dated December 2016 was displayed and had events taking place every week up to Christmas. They included a musical film day and Christmas card making. Some events were planned and family and friends were invited to attend. The service had an activity trolley which had activities such as painting, reading, baking and music. The registered manager said generally activities were not offered on a morning because people got up at different times and usually didn't want to participate.

We saw from survey results that concerns had been shared around the level of activity; out of 13 relatives, 11 had expressed concern. An activities worker had started the day before the inspection and was being employed five days per week, which included one day on a weekend. We spoke with the activity worker who told us they were enthusiastic and had already had initial discussions with the registered manager about the activity programme. The registered manager said it was very positive they had appointed the activity worker, but also acknowledged there had been issues with activities and the recruitment had taken longer than anticipated.

People told us they would talk to staff and management if they had any concerns. Comments included, "If I want to complain I tell any of the nurses", "I know I have the form but never thought about it. I've never had need to complain. No one has ever done any wrong to me. These are nice people", "No complaints but I know what to do". Staff we spoke with generally knew how to respond to complaints and concerns although one relatively new senior member of staff was unsure.

We looked at the complaints file and saw complaints were investigated and responded to in a way which resolved the issue where possible to the person's satisfaction, and minimised the risk of the same issue arising in the future. The registered manager had written outcome letters and where appropriate had apologised and identified where lessons had been learnt. The complaints procedure was available in each person's room and informed people they could contact the provider or CQC if they were unhappy with the outcome. There was no reference to the local ombudsman who will also take up people's complaints. The registered manager agreed to add this and also include the information in response letters. The local authority contracting department told us the service had reviewed some concerns raised and they were happy with their response.

We saw the home had received some written compliments which included the following comments: 'During my mums stay there was nothing but kindness, courtesy and willingness to offer extra help', 'Thank you to everyone who has looked after [relative] and for the care you have taken of her' and 'Thank you from the bottom of our hearts for all the care you have given'.

Good

Is the service well-led?

Our findings

The service had a registered manager who was registered with the CQC. We received positive feedback about the registered manager. Comments from relatives included, "[Name of the registered manager] is brilliant, always welcoming and always takes time to speak to us. We have brought our family member here because of this manager. We would definitely recommend this home.", "The place does not smell, it's clean. They are very welcoming. We are very happy with management", "[Name of the registered manager] is welcoming and always approachable", "[Name of the registered manager] is the best lady we have seen and instantly put us as relatives at ease". A health professional said, "[Name of registered manager] is a strong leader. Staff have gained confidence under her; she supports them well." One member of staff said, "The service has really improved. [Name of registered manager is very good. I can speak to her about anything." Another member of staff said, "The manager is very approachable and coaches us. She gives us opportunities to develop." Throughout the inspection the registered manager was receptive when areas for improvement were identified; they said they were keen to develop the service and wanted to make continual improvement.

The provider asked for the views of people using the service and others to help drive improvement. Resident and relative meetings and staff meetings were held. We saw from meeting minutes that people had opportunity to discuss the service and were informed of planned events. At a resident and relative meeting they had discussed management improvements, staff changes, nursing and how to raise concerns. Dates for future meetings were displayed. At staff meetings they had discussed included care plans, use of mobile phones, safeguarding and pressure area care. We looked at the provider's survey results which captured people's responses and comments. Where people had made suggestions for improvement the provider had responded.

At the inspection we reviewed audits which had been completed at the service, which were then used to monitor the quality and safety of service delivery. We found a wide range of audits were carried out by a range of staff and the registered manager. These included checks of mattresses, slings and sensor mats. We saw they carried out resident and well-being audits where they visibly checked if the person was expressing a good standard of wellbeing and looked at, for example, if people's footwear was suitable and their nails were trimmed. At the front of the service record file, they had a list of all dates that certificates expired which helped make sure auditing and monitoring was clear and picked up any areas that needed addressing.

In the PIR the provider told us, 'We operate an open door policy and encourage staff, residents and relatives to come and express any concerns they have with regards the care delivery. The home operates a very in depth quality assurance process, which covers all areas of the service, the building is maintained to a high standard, and services are regularly maintained. We spot check the home regularly to ensure the correct standard of care is being delivered. We operate a very transparent service and encourage relatives to ask questions about the running of the home and how we monitor its safety, and care standard.' We saw evidence at the inspection to support the statements from the PIR.