Care Quality Commission

Bryden Care Ltd

Bryden House

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 5 and 12 March 2015 and was unannounced.

The provider of Bryden House is registered to provide accommodation and nursing care for up to 30 people who have nursing needs. At the time of this inspection 27 people lived at the home.

In November 2014 the ownership of the home changed. This meant there was a new registered provider and the former deputy manager was now the manager of the home. The manager was in the process of applying to become the 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.

Staff told us they had received training to support them to understand the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). This law sets out to support the rights of people who do not have the capacity to make their own decisions or

Summary of findings

whose activities have been restricted in some way in order to keep them safe. We found there was an inconsistent approach in applying the MCA in order to support people's rights when specific decisions needed to be made so that the right people were involved. This meant the required standards of the law that related to the MCA were not always being met to promote people's best interests.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Where people had been assessed as needing their liberty restricted to keep them safe, referrals had been made to the local authority for their approval. However, practices needed to be strengthened to ensure any urgent DoLS authorisations were reviewed within the required time to do this so that people were not being restricted unlawfully.

All the people we spoke with told us they felt well cared for and felt safe living at the home. People told us staff were respectful and kind towards them and staff were caring to people throughout our inspection. Staff protected people's privacy and dignity when they provided care to people and staff asked people for their consent, before any care was given.

People had their prescribed medicines available to them and these were administered by staff who had received the training to do this.

Staffing levels promoted people's needs appropriately. This included staff responding to people's requests for help and support at times they wanted and needed this.

Arrangements were in place to recruit staff who were suitable to work in the service and to protect people against risks of abuse.

We found people received care and support from staff who had the clinical knowledge and expertise to care for people. However, staff were not aware and did not have all the information they needed about a significant health symptom which could impact upon the person not receiving effective care and treatment when they needed it.

Staff supported people with their meals so that people received nourishing diets and drinks.

People received staff support to follow their individual pastimes and improvements to enhance people's opportunities of social events were going to be progressed further.

People we spoke with told us they knew how to raise any concerns and who they should report any concerns to. Staff knew how to support people to raise any concerns they had. The provider had a complaints procedure displayed so that people accessed this information.

The manager needed to improve their knowledge regarding their responsibilities around submitting statutory notifications to the Care Quality Commission (CQC). The manager had failed to notify the CQC of an incident which the provider is required to do by law.

The provider and manager were committed to making improvements to the service people received. However, the process for monitoring and checking the quality of the service needed to be strengthened further so that actions to drive through improvements were prioritised for the benefit of people who lived there. This included the arrangements in place for care and medicine documentation to ensure these reflected the care people needed and received.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff had a good understanding of what to do if they saw or suspected abuse. Where risks to people's needs had been identified staff had the knowledge to manage these. The provider assessed people's individual needs so that there were sufficient staff with the right skills to meet these. People's medicines were available at the required times so that staff could support people to take their medicines as prescribed to meet their health needs.

Is the service effective?

Requires improvement

The service was not consistently effective. When people did not have the ability to make decisions about their own care, the legal requirements that ensured decisions were made in people's best interests were not being followed. This meant that people's rights were not upheld.

Staff received regular supervision and training to update their skills to help ensure the quality of the care and support provided. People were provided with sufficient amounts of nutritional foods and drink to meet their needs. People had access to health care support.

Is the service caring?

Good

The service was caring. People were treated as individuals and were supported with kindness, respect and dignity. Staff were patient, understanding and attentive to people's individual needs. Staff had a good understanding of people's preferences and how they wanted to spend their time.

Is the service responsive?

Good

The service was responsive. Staff responded to people's individual needs in the right way and at the right time so that people received care that met their needs. People were supported to follow their own individual pastimes. Improvements were in progress to develop further opportunities for all people to be involved in social activities based on their interests. People knew how to make a complaint and the complaints policy was available.

Is the service well-led?

Requires improvement

The service was not consistently well led. The ownership of the home had changed in November 2014 and there was a new manager.The manager and the provider monitored the quality of care provided. However, this needed to be developed further as people could not be certain they would always receive consistently good quality, effective care.

People and their relatives were happy with the quality of the service they received. People said the manager and staff were accessible, friendly and helpful.

Bryden 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.

The inspection took place on 5 and 12 March 2015. This inspection was undertaken by one inspector.

We looked at the information we held about the provider. This included statutory notification's received from the provider about deaths, accidents and safeguarding alerts. A notification is information about important events which the provider is required to send us by law.

We asked the local authority if they had any information to share with us about the services provided at the home. The local authority are responsible for monitoring the quality and funding for people who live at the home and they informed us that they had no information and or concerns to share with us.

We spoke with five people who lived at the home and five relatives. We also spent time observing people's care in the communal areas of the home. We also 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 spoke with the provider, the manager, eight staff including the staff member responsible for planning and delivering social events and the chef. We looked at the care records related to six people, three staff recruitment records, accidents records, staff rotas and training, menus and quality monitoring and audit information.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at the home and free from harm due to the support that staff provided. People told us if they were worried or unhappy about anything they would feel comfortable in speaking with staff. One person said, "I have no fear being here" and "I know staff are around if I need them which makes me feel safe." Another person told us, "If I did not feel safe I would not stay here."

At different times during our inspection we saw people smiled as different staff approached them and people used gestures such as a wave as staff walked by. From these observations we saw people were comfortable around staff and did not show signs of fear with any of the staff on duty.

All the relatives we spoke with felt sure their family member was safe living at the home. A relative told us, ""I come in everyday and I feel satisfied that [relation's name] is safe here. They (staff) do care you can see that." Another relative said, "[Relation's name] would tell us if she did not feel safe" and "We would be able to tell by her face and what she said if there was anything she was worried about."

The provider had arrangements in place that enabled staff to recognise and report abuse. For example staff told us they had received training in how to identify and report abuse as a priority when they started their employment at the home. Staff were able to share with us the knowledge they gained from their training. They were aware of their responsibilities to identify and report incidents of abuse. This included poor staff practices which could place people at risk of harm. A staff member told us that they, "Always want residents to feel safe and happy."

Staff we spoke with showed that they knew the people who lived at the home. Staff were able to tell us how they assessed and managed any risks to people's wellbeing so that people's needs and safety were met. For example, staff were able to tell us about people who were at risk of falling and people who needed support so that their skin did not become sore. We saw people had walking aids to support and assist so that people's needs were met. We also saw pressure relieving equipment in place so that risks of sore skin were minimised.

People who lived at the home and relatives we spoke with told us they felt there were enough staff to keep people safe. Staff told us that most of the time there was adequate staff and if staff were away the manager always tried to cover shifts. A staff member told us, "People are safe here we are offered extra shifts when staff are off sick." The provider told us that they had a system in place for determining staffing levels and this was based on people's individual needs. Our observations on the day showed staff were busy, yet staff supported people and cared for people at the pace they required. There was a call bell system at the home and we saw that people who could not easily move from their bed or chair had call bells within their reach. Throughout the inspection we saw that staff responded to call bells promptly when they were activated. One person told us, "The staff usually turn up quickly when I use the call bell. I always have it by my side." Another person said, "I always have my call bell with me even at night. When I use the call bell they (staff) get here pretty quickly." This showed that people who need staff urgently were not left at risk of not receiving the care and attention they required at the time they needed it.

Arrangements were in place so that medicines were available for people when they needed them. One person told us, "I prefer staff to do my tablets now." Another person said, "The staff always make sure I have my tablets on time and I know what I am having by the colour of them." Medicine records we looked at showed people had received their medicines as prescribed by their doctor. We observed a medicine round. The staff member checked each individual medicine and checked people had taken it prior to signing the records. Staff we spoke with confirmed they had appropriate training to do this so that risks to people's health and wellbeing were reduced.

We saw that safety precautions were in place so that medicine errors could be identified and action taken to reduce risks to people. For example, staff wore a tabard while they administered medicines as a reminder that they must not be disturbed. However, there were avoidable interruptions and distractions to the staff member who administered medicines. When we spoke with the member of staff they knew that there was a risk of medicine errors if they were distracted and they confirmed this would not happen again.

We saw in the staff records that staff were only employed after essential checks to ensure that they were fit to carry out their roles effectively and safely were made. We found new staff had a Disclosure and Barring Service (DBS),

Good

Is the service safe?

references and records of employment history. These checks helped the provider make sure that suitable people were employed and people who lived at the home were not placed at risk through their recruitment practices.

Requires improvement

Is the service effective?

Our findings

We spoke with the manager about the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. This protects people who do not have the mental capacity to make specific decisions about some aspects of their care. The manager confirmed that some people who lived at the home were unable to consent to the use of bedrails and a locked front door as they did not have the mental capacity to be able to do this. We looked at some people's care records with the manager and saw that people's mental capacity had not been assessed or considered and action taken when they lacked capacity to consent. The manager confirmed that best interest decision making pathways for people who did not have the capacity to consent to the use of equipment had not been followed through. We also saw that one person had their medicine administered to them by disguising this in food but there was no documented best interest decision in their care records. The manager confirmed this was the case.

The manager and staff had received specific training on the MCA and the Deprivation of Liberty Safeguards (DoLS).The manager showed us a recent urgent DoLS application for one person that had been authorised for seven days but we saw that the application had expired. When we spoke with the manager about this application they told us the restrictions continued to be in place. They acknowledged that they should have reviewed this application and extended the time limit. This showed that although the manager had knowledge about DoLS this was not consistently applied to ensure people were not unlawfully restricted of their freedom or liberty.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People that we spoke with told us that they were happy with the service provided and what the staff did for them. One person told us, "I can assure you the staff do know what they are doing and they understand my needs very well." A relative told us, "[Relations name] improved when she came here. It was due to the good care and good food. Yes, I would say they (staff) are well trained."

Staff spoken with told us they had received training in a range of areas to be able to do their job effectively and received an induction when they started work at the home. Discussions with the manager and training records showed there was a programme of training for staff. The manager was aware of any gaps in staff training and refresher courses and was addressing these. One member of staff said, "I get all the training I need. If I need any more training I would speak with the manager in supervision." Staff told us they received regular supervision where they could discuss their practice and identify any training needs.

Staff spoken with told us they also received training in more specialised aspects of care so that they had the knowledge to meet people's specific needs, such as, pressure care management and dementia care. We saw staff put their training and knowledge into practice while they met people's needs. For example, staff supported people to move safely and knew how to use any equipment or aids which were needed to effectively meet people's health and physical needs. Staff also told us they looked at people's body language and facial expressions to help decide if people who could not tell them due to their dementia were in pain. Staff told us they would then consult the nurse and people's care plans to ensure people received the support they needed to effectively meet their needs. Staff we spoke with were able to tell us about the individual needs of the people we asked about, as well as any health conditions that affected their care.

People's health care needs were met. This included calling the doctor promptly as required and also having access to chiropody, opticians, dentists and district nurses. During our inspection we saw people had their eyes tested by the visiting optician service and a community nurse visited. One person said, "If I need a doctor I would get one. Staff are on the ball here." Another person told us they had their eyes tested on the day of our inspection as they had some difficulties in reading at times.

Staff told us that people at risk of weight loss had been reviewed by their doctor and had access to food supplements. Records showed that people had an assessment to identify what food and drink they needed to keep them well.

All the people we spoke with were positive about the food served and felt the food had improved. One person told us, "The food is good." Another person said, "The meals are lovely, they are very filling." The chef knew about people's

Requires improvement

Is the service effective?

food requirements. For example, they were aware of how many people had diabetes, what food allergies people had, and how many people required their food to be pureed due to swallowing difficulties. Where people required their meals to be pureed this information was recorded in their care plans. Staff we spoke with told us that there were currently no people who required food to meet their cultural needs and or who preferred vegetarian food. This reduced the risk that people would be given food that was inappropriate to their needs.

Good

Is the service caring?

Our findings

People told us that they were treated with kindness and that positive, caring relationships had been developed. One person said, “They have a happy demeanour and sing a lot” and another said, “They (staff) are down to earth I’m quite happy here”. A relative said, “They are very caring and she likes them because she chats about them fondly.”

During our inspection we saw people and staff chatted and laughed together as they provided support to people. Staff were friendly and respectful and people appeared relaxed with staff. Staff supported people at their preferred pace and helped people who had limited mobility move around the home. We saw staff were caring and compassionate towards people, engaged them in conversations and addressed people by their preferred names.

Some of the staff had worked at the home for a long time. This helped build positive relationships with people. Staff were able to explain the individual needs of people and people’s personal preferences. They told us that they got to know people by spending time and talking with them. One person told us they were very touched that a staff member had thought about them. They told us, “It was just a little thing, my clock stopped and they (staff) sorted this.” The person told us this meant a lot to them. We heard other examples where staff treated people as individuals and knew what was important to them.

People’s privacy and dignity was maintained. We saw that people’s care records were stored in a room when not in use. Staff were aware of the need for confidentiality and we saw them speak quietly with people about the support they needed. We observed staff took their time and gave people encouragement whilst supporting them. People told us that staff treated them with respect and dignity when providing personal care. When people needed assistance with personal care we observed that staff did this behind closed doors in bedrooms and bathrooms. We also saw when the staff member was supporting people with their medicines during the morning round they closed people’s doors when administering injections and applying cream.

People felt that staff knew them well and that they exercised a degree of choice throughout the day regarding the time they got up, went to bed, whether they stayed in their rooms, where they ate and what they ate. We asked some people about whether they liked their bedroom doors open or closed. All people told us they chose to have their door open but if they wanted it closed they could at any time. People felt they could always ask any staff for help if they needed it.

We saw that a member of staff who administered people’s medicines did this with sensitivity and knew each person’s individual needs. For example, the member of staff was seen to have everyday conversations with people and made eye contact with people before giving people their tablets. Throughout the process the member of staff explained what they were doing and some people who liked to count each of their tablets first were given the time to do this. This enabled people to maintain their levels of independence and control over their care and treatment.

Good

Is the service responsive?

Our findings

People told us that they were happy at the home and that staff "always tried" to meet their needs. They told us that the staff knew them well and cared for them in the ways they wanted. One person told us, "I am very independent and the staff only helps me with certain things and I can discuss with them what I want". Another person told us that they admired the way staff made sure everyone had their meals when the lift broke.

Relatives we spoke with told us they were kept informed by the staff of any changes in their relations needs and or if they became unwell. A relative told us, "The important thing is that the staff know what [relation's name] needs and they provide it, and I've seen the staff do that."

We spent time observing the care and support people received. We saw people were supported appropriately at different times and by different staff. Staff gave people their full attention and responded to each person in a caring way. We saw staff provided support and care that responded to people's needs as assessed and planned for at lunchtime. We saw people who needed assistance with meals; staff were on hand to assist them although they were seen to be busy. We saw that people had been given a choice of food and drinks and noted that throughout the day people were offered and supported with drinks and snacks.

Staff we spoke with described how people received care personalised to them. One staff member said, "I always ask people what they want." Another staff member said, "I read the care plan before I provide any care, especially if it is someone new." We saw staff had handovers that took place at the end of each shift and staff told us they were able to refer to the notes during the shift. This showed us there were processes in place to share information to support staff so that people received care personalised to them.

We saw staff consulted health professionals so that people's needs could be reviewed. This showed staff sought professional's advice so that they could respond to people's changing needs. For example, one person's medical condition placed them at risk of choking; their care plan included detailed information about the medical devise they used to aid their eating and how their food should be prepared and presented. Staff were fully aware of the devise so that the person received the care and support they needed.

We saw one person's medical condition meant they were at risk of other symptoms but staff we spoke with were unaware that the person could experience these specific symptoms. We looked at this person's care records with the manager and could not find a care plan with guidance for staff in the event of this person displaying these symptoms. This meant there was a risk that the person would not receive effective care and treatment from staff in the event of the symptoms occurring. The manager was responsive to our concerns and told us they would ensure staff had information about the person's specific symptoms and a written plan to enable staff to have this knowledge to refer to.

People we spoke with us gave us various examples of their individual passions and interests they followed and did not feel socially isolated. For example, people told us they read certain newspapers, liked to paint and follow certain sporting events on the television. One person said staff spent time in their room with them just passing the time of day with a chat and a laugh. The person's facial expression lit up when they spoke about the jokes they shared with staff which showed they clearly enjoyed these opportunities. This person said they liked to spend time in their room following their own interests as opposed to being in large groups of people. Another person we spoke with told us they sometimes went into the lounge area to join in social events and at other times liked to be in their room to spend some time alone. They told us they missed a particular range of exercises that were facilitated by a person who came in to the home to do these and the manager told us they were aware of this. A further person told us they liked to go out with staff support.

We spoke with staff about the arrangements for people to participate in leisure interests and hobbies. We received various comments about the range of social events for people to participate in at the home. For example, one member of staff told us, "We have activities here, there's games and people can join in a group to do knitting. We do try to encourage people to join in activities." Another staff member told us, "I think activities could be improved upon but most people like to have a chat and have visits from their families." A further member of staff told us social

Good

Is the service responsive?

events and community outings needed to be improved. All staff who we spoke with told us people were encouraged to take part in more group events but a lot of people liked to remain in their rooms. During our inspection we saw a small group of people having fun exercising with a ball.

The manager was aware that the activities offered did not always match with the activities planner which was displayed. The manager told us that they were already aware of this and that the planning and arranging of social events needed to be improved. They were working towards using people's personal histories to base people's social activities designed around their needs and interests. This showed that improvements were being looked at so that people's specific needs and interests of people were responded to.

We asked people and their relatives how they would complain about the care if they needed to. People who lived at the home were aware they could tell staff if they were unhappy. A relative of a person at the home told us, "The manager is approachable and I'd just talk to them if there was a problem. The staff tell me what's going on."

The home's complaints procedure was displayed at prominent points throughout the building in order that people could refer to this if needed. At the entrance of the home, we saw that there was information displayed regarding the fees, service user guides and contact details for the care Quality Commission so that people could make contact if they wished to share information about the service they received. There was also a suggestions box that people could use to raise issues anonymously if they wished.

We asked staff how they would know if people who had mental health needs were unhappy with their care and were not always able to verbally express their feelings. A staff member told us, "We would see they were unhappy by their facial expressions and body language, such as, people may stop eating or drinking."

Requires improvement

Is the service well-led?

Our findings

The provider had a clear leadership structure which staff understood. The provider was at the home during both days of our inspection. We saw the provider was developing the procedures and practices at the home while providing support to the manager in their new role. People we spoke with knew who the manager was and felt that they could approach her if they wanted or needed to. One person said, "The manager is approachable". A relative said, "The manager is usually around when we come and visit. When she is not the nurses are in charge. So we know who we can go to if we need to."

The provider was developing opportunities to enable people who lived at the home and relatives to share any issues or concerns. For example, questionnaires had been sent to people who lived at the home, relatives and visitors. The provider told us the responses in the questionnaires were currently being analysed and then the findings would be acted upon and shared. The feedback from the questionnaires would be used to make improvements at the home. The manager told us that they were frequently visible to people should people wish to raise anything with them. We saw the manager spend time with people and visitors during our inspection. These practices enabled the manager to monitor people's satisfaction with the service provided and ensure any changes made were in line with people's preferences and individual needs.

Staff said that the manager was approachable and open to suggestions. Staff meetings took place where staff could raise issues and discuss service provision. One staff member said, "Yes I feel able to be open and staff meetings are useful and the manger attends." Another staff member said, "The manager is approachable and I can say what I think to them." A further staff member told us, "We are all involved in discussions at staff meetings. We do our job well. We try to improve their lives, we try our best to make residents happy." We saw some minutes of recent staff meetings where staff had discussions around staff practices. For example, using people's personal histories to plan and develop social activities and interests for people.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC) of important events that happen in the home. The manager showed us evidence that a recent incident had been reported to the relevant authorities so that people were protected from harm. However, the provider and manager had failed to report this incident to the CQC which they are required to do by law. When we spoke with the manager about this they were unsure about what should be reported to the CQC. This showed that they not fully aware of their responsibility to notify us so we could check that appropriate action had been taken. The manager told us they would refer to the information on the CQC website. This is so that the manager could improve their knowledge about how, when and what they needed to report to the CQC to ensure their legal responsibilities are always met in the future.

We were able to see from the evidence the provider and manager showed us that they had identified areas which needed to be improved upon since the change in ownership at the home. There had been a number of actions taken to help improve standards within the service. We saw the reception area of the home had been redecorated as the provider wanted it to be more welcoming for people and visitors to the home. Also the redecoration of some rooms had taken place and this work would be on-going.

The manager told us that one of the key challenges at the home was care planning. The manager showed us they were in the process of introducing a new care planning system with greater emphasis on people's involvement in their care plans. The manager also told us that they wanted to ensure care plans had been consistently reviewed as this was an area that required further improvement. We also found care plans were not always reviewed on a monthly basis so that they were not reflective of people's current needs. There was also no evidence people had previously been involved in the review of their care and support needs. This suggested people did not receive care and support in the way they liked. The manager showed us they were committed to making improvements to the quality of the service people received. For example, they showed us some people's care records had been developed using the new care planning system but agreed certain aspects of people's care planning needed to be prioritised, such as, mental capacity assessments.

Some people had medicine prescribed to them on a 'when required' basis. We saw people did not have written protocols or plans in place for such medicines for staff to refer to so that people could always be assured they had their medicines in the right way. However, staff were able to

Requires improvement

Is the service well-led?

tell us how people were supported with these type of medicines. On the second day of our inspection the manager took prompt action in starting to complete the protocols for people who were prescribed when required medicines as these were not previously in place. As a result of the feedback we gave to the manager they told us they would be prioritising improvement actions based on risks going forward. The manager was also aware their own quality audits needed to be more effective in identifying the areas that required improving. This would enable people to be assured of living in a home that was well managed where their care and safety were promoted.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not taken appropriate steps to ensure that people who lacked capacity to give their consent to their care had decisions made in their best interest in line with the Mental Capacity Act 2005.