The Brendoncare Foundation

Brendoncare Alton

Inspection report

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Date of inspection visit: 2,4, 12 December 2014
Date of publication: 07/04/2015

Ratings

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

Overall summary

The unannounced inspection of Brendoncare Alton took place on 2, 4 and 12 December 2014.

Brendoncare Alton is located in Alton, Hampshire, close to the town centre. It is registered to provide care for up to 80 people who need care and nursing support.

There are five units. Jade, Blue and Pink units care primarily for people who are physically frail and Cedar and Oak units look after people who are living with dementia. We visited all the units during the course of the inspection.

When we inspected the service in January 2014 we found the service was not acting in accordance with the Mental Capacity Act 2005. We also found some care records were not completed properly. We visited again in May 2014 in response to some safeguarding concerns. At that time we found the service did not have suitable arrangements in place to protect people against the risk of control or restraint being unlawful or otherwise excessive. The provider sent an action plan detailing how they were going to address these issues and improvements had been made at the time of this inspection.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People said they felt safe at Brendoncare Alton. However, the service needed to improve the consistency of care to people who could at times be resistant to care to ensure they always met their individual needs. There were times when the service did not provide enough staff to meet people's needs in a timely way.

Improvements had been made to staff awareness and understanding of potential abuse and safeguarding procedures were robust. Risks to people's health and environmental risks were identified and reviewed regularly. Medicines were managed consistently and safely so people could be assured they received their medicines as required.

People received effective care from suitably trained and supported staff. Staff supported people to make decisions and to have as much control over their lives as possible. Staff understood and had a working knowledge of the Deprivation of Liberty safeguards and the key requirements of the Mental Capacity Act 2005. Most people were complimentary about the food and people had a choice both of what they ate and where they had their meals. People's nutritional needs were assessed and staff ensured they had an appropriate diet. People were happy with the health care provided and the service liaised effectively with health care professional when they needed to keep people in the best of health.

People said staff were kind and caring and we saw a lot of positive interactions between staff and people who lived at Brendoncare Alton. Regular staff knew people's interests and preferences and tailored care and support accordingly. People were provided with a range of information and were consulted and involved in their plans of care and support. Their views were also considered in the development of the service.

Visitors were welcomed and relatives were contacted promptly if for example there had been a change in a person's health. There were good links with the local community and people benefitted from a wide range of activities, many of which were provided by volunteers who contributed their skills and experience to enrich the quality of care and support provided. Concerns and complaints were taken seriously, explored thoroughly and responded to in good time.

There was a positive culture at the service and a consistent management structure. The service had clear vision and values and the management team put these into practice by ensuring people and their loved ones were involved and by maintaining good links with the local community. The service worked in partnership with other organisations to make sure they were following good practice and providing a good quality of care. Quality assurance arrangements were used to drive improvement.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which now corresponds to Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Sometimes there were not enough staff employed and staff were not consistently supporting the individual needs of people who at times were resistant to care You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
Some aspects of the service were not safe. Staff did not always support people who could at times be resistant to care appropriately, to ensure they provided support in line with their individual needs.

Staffing numbers needed to be maintained at consistent levels to ensure people received the care they needed in a timely way. Staff recruitment systems were robust.

Risks to people and within the service were recognised and well managed.

Peoples medicines were managed safely

Requires Improvement

Is the service effective?
The service was effective.

Staff were trained and supported in their roles

People were helped to maintain their health and wellbeing and they saw doctors and other health professionals when necessary. People's nutritional needs were assessed and met.

Staff understood the Mental Capacity Act (2005) and the home met the requirements of the Deprivation of Liberty Safeguards.

Good

Is the service caring?
The service was caring.

Staff related well with people and were kind, friendly and supportive.

People were involved in making decisions about their care and staff helped promote their independence. People's privacy and dignity were respected

Good

Is the service responsive?
The service was responsive.

People's individual needs and preferences were assessed and care was provided in line with their support plans. Care was personalised so people spent their time doing the things they enjoyed.

There were good links with the community and a wide range of activities offered.

Complaints were responded to appropriately

Good

Is the service well-led?
The service was well led.

Good

Summary of findings

There was visible leadership within the home, and the manager involved people and staff in developing the service.

The service worked with other organisations to develop the service and to provide a good quality of care.

Systems were in place to monitor the quality of the service and implement improvements

Brendoncare Alton

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 was unannounced and took place on 2, 4 and 12 December 2014.

The inspection team comprised two inspectors, a specialist advisor who was a nurse and two experts by experience. The experts-by-experience had personal experience of caring for someone who uses this type of care service and in dementia care.

The provider completed a Provider Information Return (PIR). 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. We used this information to help us decide what areas to focus on during our inspection.

We also reviewed other information we held about the home, for example any events the provider had notified us of.

During our inspection we visited all of the units. We spoke with 21 residents, six relatives, 14 staff, the registered manager and two senior managers. We looked at how people were supported during their lunch and daily activities. We reviewed 14 people's care records, staff training records and recruitment files for three staff and records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

All people we spoke with said they felt safe at Brendoncare Alton. They said, "Its fine and you never hear a raised voice "and "there are no problems." One person said "I feel safe living here. The staff are very good and kind. I don't know all the staff but I feel well cared for". Visitors all agreed their relative was being safely cared for.

The organisation provided training for staff to support people with behaviours that can challenge. This was mandatory training for all staff with 'Safe holding for Older People training' provided specifically for staff working on Oak and Cedar Dementia Units.

When people resisted personal care staff sought to understand and reduce people's distress and anxiety by providing as much reassurance as they could. As a final resort staff said they used 'gentle restraint' to ensure people received the care they needed, which if not provided, would put people at risk of discomfort or threaten their health. The restraint policy did not include any reference to 'gentle restraint' and staff we spoke with described slightly different methods of how they applied this. One member of staff said "it would be good to have more information and support for staff on how to cope with difficult behaviour." We saw no evidence staff were restraining people in a way which was excessive but the care approach was not always personalised to meet people's individual health and care needs. For example, one person had a shoulder pain which needed to be considered whilst staff were assisting them with their care and it was not clear how staff managed this. When people resisted care this was recorded on a behaviour chart, however these incidents were not evaluated to analyse or identify any possible triggers. This meant there was a risk of people not receiving care that met their individual needs. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living at the home, visitors and care staff varied in their opinion about whether there were enough staff to support people. This also varied between units. Some said Pink, Oak and Cedar units did not always have sufficient staff and commented about a high use of agency staff.

The registered manager used a dependency assessment to calculate the number of staffing hours required on each unit. On Oak and Cedar units staffing levels were below the allocated levels on the morning and twilight shifts on a number of occasions. The registered manager said the shortfalls were due to staff vacancies or staff sickness. She said agency staff were always requested and employed where possible and staff from other units could be moved if required. The registered manager said "If anyone is at risk I will put on (additional) staff, the organisation is generally very supportive to additional needs and I have never been refused". She also confirmed the service was actively recruiting to fill staff vacancies.

Most people felt staff shortfalls inconvenienced people rather than affected their safety. One person said sometimes it meant they had to wait longer for their call bell to be answered but this did not really affect them. One care worker said "We have to juggle things and help each other out, we do the most basic and important things, but we may give a (resident a) strip wash rather than a shower". Another said "Paperwork and tidying up can get missed, I try not to miss anything if we are short staffed and I talk to colleagues and we work together" Another said "sometimes we end up with two care staff because we can't get agency. Things do get done but there is a delay."

At other times shortages of staff had more impact upon people. A visitor commented the lack of staff on Oak unit at times meant some people's food could be quite cold by the time they were assisted to eat it. Staff on Cedar unit said when the correct allocation of staff were on duty in the morning (i.e. three staff) it was good because it gave them more time to spend with people explaining their care. They said "people do listen to you and understand". Staff said time spent talking and explaining to people who were resistant to care was very important as it meant they could provide care in the least restrictive way.

Although measures were in place to address shortfalls, at the time of our visit there were not always sufficient numbers of staff on duty to meet the care needs of people in the service. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood the importance of keeping people safe, from abuse and harassment, and they could describe what

Requires Improvement

Is the service safe?

was meant by abuse. Staff received regular training in recognising and reporting abuse and there were local policies and protocols in place. There was information on display throughout the home to remind staff how to report suspicions of abuse and staff told us they would be prepared to raise concerns if they had any. They were confident any concerns would be listened to. One staff said "If I was concerned about someone I would take it straight to the manager, I know from experience they would respond in the right away." Another said "We are protected by the whistle blowing policy and encouraged to report our concerns – we are here for the residents".

Safeguarding concerns, such as if a person developed an unexplained bruise, were reported under safeguarding protocols to Hampshire County Council and to CQC. This helped to ensure there was a consistent approach to safeguarding and issues were dealt with in an open and objective way. Action plans in response to safeguarding matters were developed, and were reviewed regularly to ensure they were delivered.

Recruitment procedures checked staff suitability, skills and experience. These included checks on whether people had criminal records or were barred from working with vulnerable adults. References were obtained from previous employers including those in health and social care. There was no written explanation of gaps in employment requested in application forms although applicants were interviewed and we were told this was explored at this stage. This meant people were cared for by staff who had demonstrated their suitability for the role. Volunteers had also completed a criminal records check before they assisted at Brendoncare Alton.

Risk management procedures were in place to minimise people experiencing harm in the home. Risks were considered effectively to balance people's freedom so they were cared for with the minimum of restrictions. People who were, for example, at risk of falling, or at risk of developing pressure ulcers had regular assessments and action was taken to reduce the risk as far as possible. For example, alarm pads were provided to reduce the risk of falling and pressure relieving equipment was provided to protect skin integrity.

Environmental risk assessments were in place and these were regularly reviewed. There was a fire safety risk assessment which included an emergency evacuation plan for all people likely to be in the premises, and information about how that plan would be implemented.

There was a safe process for managing medicines including medicines controlled under the Misuse of Drugs legislation. One person managed their own medicines and they had secure storage in their bedroom. Other people's medicines were stored safely, in locked cupboards with secure key management. They were kept at the right temperature. Most medicines were supplied in a medicine dispensing system which made them easier for staff to administer. Staff recorded when people had their medicines on the medicines recording reports. There were policies and procedures for medicines management and only staff assessed as competent were allowed to administer medication. There was guidance in place for when to administer drugs, such as pain killers, needed only 'as required'.

Good

Is the service effective?

Our findings

Visitors said staff had the skills and knowledge to care for their relative effectively. Staff said the training provided was good. New staff completed an induction period which included training in key health and safety areas and familiarisation with the home's aims, objectives, policies and procedures. They then completed a range of mandatory training and more in-depth training in subjects such as safeguarding and moving and handling. Training was available to staff in how to respond to specific conditions, such how to support people who demonstrated behaviours which could challenge them or others. A few staff had also completed training in specific medical conditions such as caring for people who had had a stroke or who had arthritis. Nearly three quarters of staff had completed a National Vocational Qualification (NVQ) in Health and Social Care. Training was monitored and staff were prompted to keep their competency levels up to date. Volunteers were supported for the role they undertook and each volunteer had an induction and basic training in key areas such as fire safety and safeguarding adults.

Staff said they felt supported and had regular supervisions. Staff supervisions followed a set agenda and enabled staff to share their experiences, make suggestions and review their progress. Training needs and development opportunities were discussed during supervision. Some staff had completed appraisals and the registered manager had identified the staff appraisal programme needed to continue over the next twelve months.

People's ability to make decisions about their life in the home was assessed in line with the principles of the Mental Capacity Act 2005 (MCA). Procedures were in place to complete mental capacity assessments involving family members, health or social care professionals and advocates as appropriate. Staff understood that decisions made for people who lacked capacity must be made in their best interests, and outlined examples of how they supported people to carry out personal care. They also explained how they assisted people in making decisions. For example if people did not wish to have personal care at a particular time, staff said they would offer it again later. Where staff acted in people's best interests they did so in the least restrictive way they could. We saw a range of examples of mental capacity assessments that had been carried out, for example in relation to medicine administration and resuscitation. Staff received training in the MCA.

The registered manager had completed Deprivation of Liberty Safeguards (DoLS) applications for some people living at the home. These safeguards protect the rights of people by ensuring that any restrictions to their freedom and liberty have been authorised by the local authority, to protect the person from harm. Care practices were in place which supported people's rights to freedom.

Most people were complimentary about the food and people had the choice to take their meals in the restaurant or in their unit. People had a choice of food and a daily menu was completed with people by care staff. This helped to ensure people had the meal they wanted. Each person met with a member of the catering team to discuss their individual needs and preferences. A brochure was available for people to choose snacks in between meals.

Staff understood people's dietary preferences and needs and they supported people to have a suitable diet. For example, people who wanted a vegetarian diet and people who needed pureed food were provided with this. Fluids were provided at routine times spaced throughout the day. A staff member said "people who can ask are given drinks when requested in addition to the routine times; other people are supported at routine times to drink." We observed staff encouraging people to drink. Staff were aware of people who were at risk of malnutrition as they had completed a nutritional risk assessment. People's food and fluid intake was monitored where necessary. Staff said "We can see if someone is losing weight and not eating well. We can see if we can assist them in eating to help them". Records showed that people's weight was monitored.

People were supported to maintain their health and people we spoke with were happy with the health care provided. There was a nurse on duty on each unit and people said they had easy access to a doctor. A GP visited every Wednesday. People had health care plans to address their specific healthcare needs. Records included information about people's medical history, health needs and the care and treatment they required. Staff regularly reviewed people with specific healthcare needs. For example, one person had been supported to make improvements in their health in respect of a pressure sore. The person's care plan

Good

Is the service effective?

included a risk assessment and tissue viability care plan, which was regularly reviewed, photographs and a description of the pressure area. As a result the pressure sore, which the person had on admission, had improved.

Appropriate referrals were made to other healthcare services. People who needed specialist healthcare had been referred to for example a continence team, physiotherapists, chiropodists and orthotics where needed.

Good

Is the service caring?

Our findings

People spoke highly of the staff saying they were kind and caring. A resident said "It's nice in here; I'm comfy and they are all kind." A Visitor said staff were "lovely." Another said "The permanent staff are very caring and interested in the clients" and said they acted quickly upon any suggestions made by relatives.

We observed staff speaking with people respectfully, kindly and cheerfully. For example asking if they had slept well, checking people were OK during lunch or if they wanted more and asking if they had enjoyed lunch. People were spoken to by name and appeared comfortable with staff. One resident said of staff "They have a lot of patience." We observed one staff sitting next to a person who was distressed. They were calm and spoke quietly to the person, reassuring them and not leaving them until they were calmer.

The staff were attentive to people and knew what their preferences were. For example, when they asked people if they wanted a drink they knew what they liked and offered them this. They described people's diets and how their food should be prepared and described how people liked to receive their personal care. Staff said one person, for example, disliked being washed with a very wet flannel.

Staff also knew about people's life history and spoke with them on these topics. Staff said they had received training in caring for people with dementia and it helped them to understand different problems people had. For example, staff described how one person became more agitated the more they talked to them and so they were careful not to do this. Another staff explained the importance of giving people, who sometimes had behaviour which challenged others, enough time to help them to demonstrate what they needed support with. They said "I listen till the end of their talking. We need to fit in to where they are in terms of communication".

People were provided with information about the service in the form of a service user guide. This comprehensive pack included information about how to make a complaint, the most recent inspection report and statement of purpose. There was also an advance care plan which people were encouraged to complete. Advance Care planning enables people to plan their provision of care, to help them live and die in the place and the manner of their choosing.

People were asked for views about their care during resident meetings and during reviews of their care. Relatives were fully involved in people's care and helped inform people's care plans by sharing what they knew people liked and disliked and how they liked to live their lives. Records reflected peoples preferred daily routines and the manager reminded staff to ensure they recorded any new information about a person's wishes and preferences to enhance the quality of their experience. People were able to bring possessions which were important to them to personalise their rooms. Advocacy services were also used where appropriate, to help people with making decisions.

People were cared for with dignity and respect. Staff ensured doors were closed when they provided personal care and always knocked before they entered people's bedrooms. People's independence was supported. For example, we saw staff provided encouragement to a person who was trying to eat their lunch without assistance, and did not appear to want any intervention.

Good

Is the service responsive?

Our findings

Relatives said people were treated as individuals and they were consulted in their care. One visitor said "We review and discuss mum's care plan. Since being here; she is calmer and happier, and much less agitated (she "used to shout out a lot")". They were very happy with her care, said they were always consulted about her, and felt completely involved in her care. Visitors were welcomed. One said "[The staff] are very good and friendly – make me feel at home".

Care plans were clearly laid out and described people's needs, choices and preferences. People's changing care needs were regularly reviewed. Care plans included 'Hospital Passports' which recorded important information that would be needed should they be admitted to hospital in an emergency. This included their dietary preferences and mobility needs. People were also encouraged to complete advance care plans which considered their personal preferences and choices for end of life care. This included their worries, decisions and who to talk to about their care.

Staff confirmed they read the care plans and also read the daily handover log to ensure they were aware of any change in people's needs. People's health plans were up to date, and reflected their specific needs. Staff were prompt to raise issues about people's health and people were referred to health professionals when needed. Specific guidance about supporting people's health was documented, such as body maps for injuries. There were specialist care plans in place for those who had specific conditions such as diabetes and staff followed the guidance they contained.

We asked staff how they delivered person-centred care. They said "We ask people what they want." They went on to explain people were given choices when they could express them, and where they could not they referred to the care plan and information from the family. They described a person who could not verbally express their needs and said "If she doesn't want something to eat she will not open her mouth, if she likes it then her mouth is wide open". They also said "We show people clothes and they can say yes or no and we always explain what we are doing or going to do". People also had a choice of where to eat their meals, with the option of eating in the downstairs restaurant, the communal dining room on their unit or in their bedroom.

People were supported to follow their own interests. People were encouraged to complete a life map and a "This is me document." a simple and practical tool that people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests. Where people were unable to complete this themselves they were filled in by a family member.

The service employed two activity coordinators who led the twenty two volunteers who helped to provide a wide range of activities. For example, volunteers provided sensory massages,

Pat dog activities and staffed the shop. The service had good links with the local community and worked with local colleges to offer students work experience opportunities.

There was a programme of activities each week. Each resident had a copy of the activity programme and there were regular church services. Activities ranged from those which took place in a large group to 1-1 activities for people who preferred these or who were nursed in bed. There was a sensory room on one of the units and this was used for massages and for people to relax in. We observed one person, who had used this facility to have a massage, returned to their unit appearing much calmer and content than they had been previously.

There was open visiting for relatives and friends, who were welcome to stay for meals and snacks, and outings were encouraged with relatives when possible. Staff took phone messages for residents and passed them on straight away and visitors said they were always contacted promptly if there was ever a change in their relative's condition. One resident who had recently been admitted said "They are charming here" and said they had been made very welcome.

Guidance on how to make a complaint or raise a concern was on display. People knew how to make a complaint if they needed to and said that if they had any concerns the registered manager took them seriously and issues were resolved. A record was kept of complaints and this showed the service had responded quickly and had recorded actions taken as a result. This was in line with the homes complaints procedure.

Good

Is the service well-led?

Our findings

People told us the service was well led. People were mostly complementary about the service and said they would recommend it to others. Staff said the home was a good with effective leadership. One staff said for example, “The managers know what is going on with residents and with staff, you always see them around and I have confidence in them to run the home well”. Staff said they could approach senior staff with any concerns and were confident they would be acted upon. One agency staff said “I get to choose where I work and I come back here.” The registered manager said she regularly walked around the service and she demonstrated a good knowledge of people needs and wishes on different units.

The home’s philosophy of care stressed the importance of the involvement of relatives’ friends and the local community, to create an environment where residents can live in the style of their choosing. They also aimed to provide care towards a peaceful death, with personal wishes met where possible, and to provide a resource and teaching centre for the care of older people. These values were put into practice and there was an open culture at the home which placed the needs of people at the centre of the organisation.

Staff had access to training, supervisions and professional development. They were encouraged to gain further qualifications and extend their knowledge. The organisation had its own annual awards and one member of staff from Brendoncare Alton had received an award for her leadership on end of life care. A volunteer had also received an award for their contribution to activities. This helped staff and volunteers feel involved in improving people’s care and recognised for the quality of their work.

The provider was committed to providing a high quality of care for people The provider was accredited for the Gold Standard framework in end of life care. To qualify for accreditation, care homes must have undertaken a training programme over nine months, embedded this into their homes for at least six months and then undertaken an accreditation process 'Going for Gold'. The home also had accreditation with Hospitality Assured, which is the quality standard created by the Institute of Hospitality. Staff had regular links with The Alzheimer's Society and used their resources in developing the activity programme for people with dementia. The service worked in partnership with other organisations such as adult social services and NHS commissioners to make sure they were following current practice and providing good quality care. for example the Head of Care had regular meetings with the Specialist Nurse for Care Homes in the Hampshire Area.

Staff had received training in the new CQC methodology and the five key questions we inspect and report upon. This helped to ensure staff were aware of the regulatory process and how they could demonstrate the quality and safety of the care they provided.

The approach to quality assurance was robust, with systems for regularly checking that people were cared for safely. A care and clinical governance committee oversaw quality assurance processes. A clinical delivery and performance group monitored compliance, education and research to promote best practice. These committees regularly reported to the board of governors to enable the board to comment on and challenge performance.

The provider had worked to a detailed action plan following a serious safeguarding incident in early 2014 to raise staff awareness of how to keep people safe. There were processes in place to enable managers to account for actions, behaviours and the performance of staff. Lessons learned were discussed at individual and staff meetings. Safeguarding and other incidents were reported and logged at the provider’s central office to ensure appropriate actions were monitored, to reduce the risk of reoccurrence.

There was a planned programme for audits to monitor standards of care. These included checks on medicines, records and safety checks of the staff, premises and equipment. At the time of our visit there was a care plan audit underway and improvements included how care plans were worded to ensure staff all understood guidance in the same way.

People using the service and relatives were asked for their feedback on the quality of the home, through for example reviews of care and through group meetings and their opinions and suggestions were taken forward.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 9 HSCA (RA) Regulations 2014 Person-centred care We found that the registered provider had not taken proper steps to ensure the planning and delivery of care met the service user's individual needs. Regulation 9 (3) (b)- (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered provider had not ensured that there were at all times sufficient numbers of suitably qualified skilled and experienced persons employed. Regulation 18 (1)