Regal Care Trading Ltd

Brenalwood Care Home

Inspection report

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Essex
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Date of inspection visit:
17 February 2016

Date of publication:
16 September 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 16 February 2016 and was unannounced.

Brenalwood provides accommodation and personal care for up to 38 older people and people who may be living with dementia. The service does not provide nursing care. At the time of our inspection there were 28 people using the service, four of whom were receiving respite care.

There was a registered manager in post at the service. 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 were safe because the manager and staff understood their responsibilities in managing risk and identifying abuse. People received safe care that met their assessed needs.

There were sufficient staff who had been recruited safely and who had the skills and knowledge to provide care and support in ways that people preferred.

The provider had systems in place to manage medicines and people were supported to take their prescribed medicines safely.

People's health and social needs were managed effectively with input from relevant health care professionals and people had sufficient food and drink that met their individual needs.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) which apply to care homes. We found the provider was following the MCA code of practice.

People were treated with kindness and respect by staff who understood their needs.

Staff respected people's choices and took their preferences into account when providing support. People were encouraged to enjoy pastimes and interests of their choice and were supported to maintain relationships with friends and family so that they were not socially isolated.

There was an open culture and the registered manager encouraged staff to provide care that met people's needs.

The provider had systems in place to check the quality of the service and take the views and concerns of people and their relatives into account to make improvements to the service.

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

There were sufficient staff who had been recruited appropriately and who had the skills to manage risks and care for people safely.

Staff understood how to protect people from abuse or poor practice. There were processes in place to listen to and address people's concerns.

Systems and procedures for supporting people with their medicines were followed, so people received their medicines safely and as prescribed.

Is the service effective?

Good

The service was effective.

Staff received the support and training they needed to provide them with the information to support people effectively.

People's health, social and nutritional needs were met by staff who understood their individual needs and preferences.

Where a person lacked the capacity to make decisions, there were correct processes in place to make a decision in a person's best interests. The Deprivation of Liberty Safeguards (DoLS) were understood and appropriately implemented.

Is the service caring?

Good

The service was caring.

Staff treated people well and were kind and caring in the way they provided care and support.

Staff treated people with respect, were attentive to their needs and provided care in a dignified manner.

Staff understood how to relieve distress in a caring manner.

People were encouraged to be involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People's choices were respected and their preferences were taken into account when staff provided care and support.

Staff understood people's interests and encouraged them to take part in pastimes and activities that they enjoyed. People were supported to maintain family and social relationships with people who were important to them.

There were processes in place to deal with people's concerns or complaints and to use the information to improve the service.

Is the service well-led?

Good

The service was well led.

The service was run by a capable manager who demonstrated a willingness to provide a service that put people at the centre of what they do.

Staff were valued and they received the support they needed to provide people with good care and support.

There were systems in place to obtain people's views and to use their feedback to make improvements to the service.

Brenalwood Care 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 16 February 2016 and was unannounced. The inspection team consisted of two inspectors.

We reviewed all the information we had available about the service including notifications sent to us by the provider. This is information about important events which the provider is required to send us by law. We also looked at information we received from others, including the local authority. We used this information to plan what areas we were going to focus on during our inspection.

During the inspection we spoke with seven people who used the service, three visitors, one social care professional and one health professional about their views of the care provided. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also used informal observations to evaluate people's experiences and help us assess how their needs were being met and we observed how staff interacted with people. We spoke with the registered manager, one senior care staff, two care staff and one catering staff. We also spoke with one health care professional and one social care professional.

We looked at six people's care records and examined information relating to the management of the service such as health and safety records, recruitment and personnel records, staff rotas, quality monitoring audits and information about complaints. We also examined questionnaires that had been completed by relatives and visitors as part of the provider's quality assurance processes.

Good

Is the service safe?

Our findings

One person told us, "I feel safe here there's no trouble."

Staff were able to demonstrate that they understood how to keep people safe and they understood safeguarding processes. They confirmed that safeguarding training was up to date and were able to explain different types of abuse and the signs to look out for that would indicate someone was being abused. One member of staff said, "My safeguarding and mandatory training is up to date. I would report safeguarding concerns to my manager or head office if nothing was done." Another member of staff said they would approach management or head office first and if necessary they would contact the local authority. There was a poster about abuse of older people clearly displayed on the wall and staff knew that they could contact the local authority for advice.

The manager explained that a dependency tool was used to calculate the number of staff required to meet the needs of people currently living at the service. We examined staff rotas for a period of four weeks and saw that staffing levels were consistent. One person told us that they could not go out safely on their own and needed the support of staff when they wanted to go out. They explained that they were not much bothered about going out a lot but if they wanted to it was not a problem, staff would take them out. They said, "There are enough staff on shift. If I wanted to I could ask the staff and they would come with me." We saw that staffing levels were sufficient for most of the time, people's needs were being met, staff had time to chat to people and they did not have to wait a long time for support. However we did note that care staff were busier at certain times of the day such as in the morning and at mealtimes. A health care professional told us that the care was in place but they felt that staff sometimes appeared quite busy. They gave an example relating to the person that they came to visit saying that often when they visited the person's bed was unmade. We followed this up and saw that the person frequently preferred to have a lie in and staff did not prioritise making the person's bed so that they would not feel they were being rushed. A social care professional also commented, "Sometimes they could do with some more staff, it is very busy." From our observations we noted that the times when care staff were busy did not have a negative impact on people.

We saw from people's care records that their risk assessments had been reviewed monthly. There was a range of risk assessments in place according to the person's individual needs. For example, a nutritional risk assessment was carried out using a nationally recognised tool, the malnutrition universal assessment tool (MUST). Where the MUST assessment identified a risk a care plan was developed and, where appropriate, relevant health professionals were consulted such as the speech and language therapy team. Other risk assessments were in place relating to use of a hoist, walking frames, use of sensor mats, mobility, manual handling, falls and oral health.

We examined the provider's system for recruiting staff and found safe recruitment processes in place. We saw that records of applicant's interview were kept in their personnel files. The processes included taking up two or more relevant references, eligibility to work in the UK where appropriate and Disclosure and Barring Service (DBS) checks to confirm that people are not prohibited to work with vulnerable people who require care and support. Newly appointed staff received a three day company induction that related to

practical aspects of their role and established staff had also received an induction based on the skills for care guidelines.

A senior care staff told us, "I have recently had a medication competency assessment completed. I have had medication training including level 2. I feel competent in my role." We examined the systems in place to support people with their medicines and found they were clear. We observed a member of staff administering medicines to people. This was carried out safely and good practices were followed. For example the member of staff explained what the person's medicine was for and offered them a drink. At lunchtime we noted the member of staff administering medicines dropped a tablet on the floor. We observed that correct procedures were followed to dispose of the tablet and complete the record.

There were processes in place to keep people safe from environmental risks and risks associated with infection control. The service had received an inspection from environmental services and had a food hygiene certificate that displayed a rating of five, which is the highest rating awarded. There were lockable cabinets in people's individual rooms to store personal creams and toiletries safely. We saw that the cupboard containing cleaning materials was kept locked so that people did not have access to substances that would be hazardous to their health. Staff had access to personal protective equipment such as gloves and aprons and we saw that these were used correctly. Notices were displayed throughout the service reminding staff and visitors to wash their hands and there was also antibacterial gel available in places throughout the building. We observed staff followed correct procedures.

Good

Is the service effective?

Our findings

The manager, senior staff and other staff spoken with were all able to demonstrate a good knowledge and understanding of people's care and support needs. This included describing people's background and personal history as well as their preferences, likes and dislikes. Staff understood their roles and responsibilities. The service operated a keyworker system in which members of staff were responsible for monitoring the care and support for specific individuals. Staff were able to describe their roles and were clear about their responsibilities.

We noted that staff training was in the main up to date. Where some individual members of staff were due updates the manager had made arrangements for these to be completed.

A member of staff told us, "I can raise concerns with my manager. I have regular supervision. "I've had mandatory training including NVQ level 2 in food hygiene. I have had safeguarding training and I have been reminded that I must do my refresher."

Staff told us that they felt well supported and received support through the supervision process. One member of staff said, "I can request supervision if I need this I can bring issues up and they are addressed." Another member of staff said, "I have monthly supervision." The system for staff supervisions in place could be more robust so that staff received regular supervisions and appraisals of their performance. Records confirmed that supervisions had taken place but the registered manager advised that formal one-to-one supervisions had not been as regular as they would like for some staff. The registered manager was revising the system of supervisions and introducing a new way of using observations of competency to assess how staff were progressing. These observations would also link to the new appraisal system. The registered manager and senior staff also worked hands on alongside staff and provided support as and when required.

Relatives and people living at the service were satisfied with the care and support provided by staff. A relative told us, "Staff are friendly. I keep my eyes open and I watch how they are and they are really good with other people who live here as well as my [family member]. Staff have learned how to cope with really difficult behaviour." The relative went on to describe some of the challenges staff had to deal with and said, "They have been really patient with [my family member]. They have to keep going back and encouraging them."

People's health needs were met and referrals were made to health professionals such as community nursing services and doctors according to people's individual needs. A relative told us, "The carers called the doctor really quickly when my [family member] needed them."

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. Care records confirmed that MCA assessments were carried out to assess people's ability to make

day-to-day decisions. The registered manager demonstrated an understanding of processes to be followed to assess people's capacity.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found that they were. We noted that, where people did not have capacity applications had been submitted to the local authority for consideration and two DoLS authorisations were currently in place.

People told us they were happy with the food and choices available to them. A person said, "I have a choice of the food I want to eat." Relatives also made positive comments about the food. One told us, "I have eaten food here and there are always healthy options." People received the support they needed with their meals. A relative told us that when care staff supported people to eat they never hurried them.

We observed a member of staff supporting a person with breakfast. The person had recently moved in and the member of staff spent time gently explaining choices and checking if the person could manage or if they would prefer someone to help. The person chose to eat independently and the member of staff checked that the adjustable table was at the correct height to be comfortable. They continued to check on the person to see if they were managing and to offer encouragement.

The lounge area had jugs of different flavoured squashes available at all times and we noted throughout the course of the day that people were frequently offered choice from a variety of hot and cold drinks. Staff were able to explain the importance of encouraging people to drink more so they did not become dehydrated.

Our observations in the dining room showed that people appeared to enjoy their meal. Two people told us they enjoyed their lunch and a social care professional said, "The food is fantastic." A relative told us that they usually brought some lunch for themselves when they visited. They said, "I left my lunch today so they offered me lunch. They do this every time I come but I rarely have it. I just had lasagne today and it's lovely."

We noted at the lunchtime meal that the food was well presented and the portion sizes were ample. There was a photographic menu on display so that people could see the choices available. Care staff checked with people whether they were happy with their meal. We observed a member of staff say to someone, "Does the food taste okay?" and the person replied that they did not like the batter [on the fish]. The member of staff asked whether the person would like to have the batter removed or whether they would prefer an alternative meal and assisted them with their choice. We observed another member of staff encouraging a person to eat. They said, "Shall I get you a spoon as it may be easier for you to eat it? What about your chips? You can use your fingers if you want to."

The design of the premises met people's needs; there was sufficient communal space for people to choose whether they wanted to socialise or if they preferred to be somewhere quiet. As part of the providers on going improvements further work could be considered to make the environment more dementia friendly, including areas that are tactile for sensory stimulation.

Good

Is the service caring?

Our findings

Relatives commented on the caring, family ethos of the service. A relative said, "They celebrate birthdays like this is a family." and "This home has given such amazing and wonderful support. Staff are superb and they love people."

We saw kind and caring interactions between staff and people in the service and during our inspection staff were cheerful and friendly. A visitor told us, "It's homely here and staff are friendly." One person told us, "Staff are patient and attentive. This is a friendly home."

Feedback from relatives who completed surveys was positive and they were satisfied with the service their family member received. One relative recorded that their family member received, "loving care" and another said, "Staff are always patient and cheerful."

People's spiritual needs were respected and arrangements were in place for anyone who followed a particular faith. Some people, who were able, visited their chosen place of worship; in addition a faith leader visited the service for someone who was unable to go out.

A senior member of staff knew people well and told us how some people who were living with dementia could become distressed and gave examples of how people could behave if they were confused. One person could be very vocal and shout out, another person would refuse care. The member of staff demonstrated that they understood how to support individuals when they were anxious and they gave us examples of the different techniques they could use to help reduce people's anxieties.

Staff promoted people's independence and care staff gave an example of a named person for whom being independent was very important. The person could not always manage some tasks such as doing up buttons. We saw that they had refused assistance with this but had not been able to do it. Staff explained they did not intervene because the person would usually come and ask for support when they were ready or staff could return later when the person was more amenable to the suggestion of assistance. The manager explained that the person had recently had a change to their prescribed medicines which appeared to be working quite well as the person was less anxious. Staff explained that the person was calmer when they got up in their own time and did not have to rush for any reason, such as an appointment.

Staff understood that supporting people with their mobility needs, especially when using equipment such as hoists could make people anxious and they used good practices to help reduce the anxiety for people. We observed staff supporting a person to transfer from an armchair to their wheelchair. Staff explained what they were about to do before they moved the person and continued to offer reassurance throughout the procedure, speaking gently and kindly. We saw that, when a person was being supported to transfer by members of staff using a hoist, they used a screen to maintain the person's dignity and privacy. We saw two care staff working together to assist a person to mobilise. They spoke patiently to the person explaining what they were doing, "I'm just turning you round, can you just put your knees in for me?" A social care professional told us, "People are always treated with respect and I've never seen any lack of dignity."

We saw caring and supportive interactions between staff and the people when they became agitated. We observed some people became slightly agitated when one person was going around collecting plastic glasses that were on people's tables. Care staff noticed this and intervened by approaching the person, speaking with them calmly and diverting them.

During our observations one person came and stood close to one of the inspectors. A member of the care team intervened and explained that the person could be aggressive. This was done discreetly so that no-one else could overhear the conversation.

Staff knew people well and understood how to communicate with them. We observed that care staff crouched down so that they were on a level with the person they were speaking with. They touched the person's arm whilst speaking calmly to them. The person appeared calm and reassured by the member of staff's approach.

We saw a person having some friendly banter with a member of staff. They asked the care staff for a bottle of scotch, the care staff made some light-hearted jokes then went to get the person a drink and returned with a drink in a pint glass.

Care staff tried to promote and support people's independence as much as possible. For example we saw someone attempting to get up from the armchair and holding on to their walking frame. The member of staff spoke quietly to the person and asked if they would like some assistance. The person said they wanted to try to do it themselves. The member of staff stayed nearby, giving the person time and encouragement.

The manager explained about how they approached end of life care and they had a member of staff who was an 'end of life champion'. The role of the end of life champion was clear. They told us, "I am the end of life champion and have completed NCFE [National Council for Further Education]level three End of Life care. I am passionate about end of life care and family involvement. I make sure that the paperwork is up to date or in place if required. I am the main point of contact for the family." There were appropriately completed DNAR [Do Not Attempt Resuscitation] records in place to confirm the person's wishes around cardio pulmonary resuscitation. Where people were on end of life care there were records confirming that the person and their family's wishes had been taken into account. These were recorded in a preferred place of care [PPC] document which clearly set out whether the person wished to stay at the location or if they wished to be taken to hospital or a hospice.

Relatives told us about the end of life care for their family members. They said that staff sat with them all night and they had contacted the doctor to get a syringe driver to administer pain relief medicines so that their family member was not in pain and "The staff showed great love and friendliness. The night staff called me promptly and gave me updates at every point." and "Staff came in when they were not on shift when my [family member] was passing." A member of staff told us, "As keyworker I am responsible for talking to the person and their family about their end of life wishes. This is important for me to get it right, it's important that people have a good end."

Good

Is the service responsive?

Our findings

Relatives told us they were satisfied with the care. One said, "I know people who want to transfer their family here because of the care."

We saw from people's care records that their needs were assessed before they moved to the service. The care plan for a person who had recently moved in contained a pre-admission assessment that identified their health needs and the information was used to put a plan of care in place. The person's needs and abilities were identified and staff explained they had received information about their likes and dislikes and they were getting to know the person better every day. We observed that staff checked on this person throughout the day and spent time speaking with them, checking if there was anything they wanted and chatting to them about what they would prefer.

People were consulted about their care and where possible input was also sought from relatives. One person told us their circumstances and explained they did not have much contact with family. They said, "The staff here are good, anything I want or need they get me." A relative told us that their family member's care plan was reviewed. They said, "They took my views into account as well as [my family member's]." There was evidence in people's care records that relatives had been consulted about their care and support.

A relative who completed a questionnaire as part of the provider's quality assurance processes stated, "They want families to get involved." Staff were able to give specific examples of input from relatives and how the information they provided helped in the planning of care. Staff told us that they got information from relatives about people's personal history and we saw people's preferences recorded in a "This is me" document that gave details of what was important to the individual. For example, we noted that details in one of the care plans examined instructed staff that the person preferred to receive personal care and support from a member of staff of the same gender and this was respected.

A senior member of staff demonstrated a detailed understanding of people's likes, dislikes and preferences. Staff told us about a person who liked to sing and we saw that this person presented as being happy. Staff explained that the person had complex behaviours and their mood could change very quickly. We saw that the person's individual care records reflected this information and there was information to guide staff on how they should respond in situations where the person was anxious or chose not to co-operate.

People felt that they were treated as individuals and that they had choice over their care and support. One person said, "If I want a shower I can have one when I want. Staff are at my beck and call. I can have beer if I want it. There is a social club here and I can go on a Friday, but it's not my scene." We observed that staff knew people well and understood their preferences. During busy periods some care focused on tasks but staff still spoke with and treated people as individuals whilst they were carrying out tasks. We observed how care staff supported three different people with their moving and handling needs. The equipment used was well maintained and we saw the slings were in good condition and fitted the individuals well. We saw that care staff spoke clearly and explained what was going to happen, speaking with a calm voice and using touch such as holding the person's hand to provide them with reassurance. We also saw that when one

person tried to stand up from the chair they were sitting in care staff immediately went to offer assistance. They guided the person to place their hands in a better position so that they could mobilise more easily.

The service operated a keyworker system so that there was an individual member of staff who took responsibility for overseeing the person's needs and wishes were known. A member of staff said, "As a keyworker I am responsible for ensuring that the person's cultural and spiritual needs are met correctly." They also told us, "I take the person shopping we go out, I make sure [their] cat is okay, by taking her to the vet and getting food."

People could choose what they wanted to do for example, what time they got up or went to bed. We saw the cook speaking with one person who had just got up. It was after 11:00am. The cook asked the person what they would like for breakfast. They said, "I know you don't like prunes, but would you like some cereal?" The person agreed and when they were almost finished the cook returned to see if they would like some toast and discussed what kind of preserves they could choose from.

People were able to take part in organised activities and events or could spend their time doing things that they wanted. A social care professional told us that activities at the service were well organised. They said, "The activities person is brilliant and gets everyone involved. There is also a drama person who comes in and they do things like keep fit." During our visit a visitor arrived and accompanied someone on a trip to a local garden centre.

Relatives gave positive feedback about the type of activities available at the service. A relative said, "They hold events [and bring in] animals and children, they have BBQ's in the summer and they have even had a 60's night with everyone dancing." Other relatives said, "There are always a lot of activities. Events are put on that include everyone, even the local school children and animals from the farm." and "They make families and pets feel very welcome, they really try."

We saw that a small communal area had be decorated with a bar area and staff explained that they used it to have 'Pub evenings' where people could socialise and have refreshments of their choice.

People knew how to make a complaint. One person told us, "In my opinion this home is still the best. If I needed to complain I would speak to a senior. They would all do anything for you." A relative said, "I know how to complain and they listened to me when I did." A person living at the service said, "I would speak to the manager if I needed to complain. I am not afraid to complain and I would if I needed to."

Good

Is the service well-led?

Our findings

A social care professional was complimentary about how the service was managed. They said, "[The manager] does a good job. Best manager I've seen." A relative told us, "The manager is accessible and approachable."

The provider had systems in place for checking and monitoring the quality of the service. The manager and senior staff carried out checks and audits on processes around medicines and monitoring care records. In addition to these ongoing checks the regional manager carried out checks on medicines. The provider visited the service on a regular basis to talk to people and to staff and they also carried out audits on people's care plans.

Part of the provider's quality assurance process was sending out questionnaires to relatives and visitors. Responses from relatives in the most recent survey carried out were positive about the quality of care and support their family member received. One relative stated, "Everyone on the staff and management are very caring and my [family member] is treated very well."

Staff told us that team meetings were held so that staff could raise issues relating to people's care or procedures that were in place. We saw records of a team meeting that showed discussions took place about areas within the service that needed to be improved and staff were able to have input into decisions about making improvements.

The manager carried out a 'walk round' of the premises every week, specifically looking for any areas for improvement such as repairs to be carried out. They explained that woodwork was easily damaged by moving equipment about such as hoists and wheelchairs. Where repairs were identified these were carried out promptly. We noted that some areas of the environment had been redecorated but other areas looked tired and in need of decoration. The manager explained that the provider was very supportive about providing resources for environmental improvements. There was a comprehensive environmental improvement plan in place. Some work had already been completed and we saw that there was new flooring in the corridors and there were plans for improvements in other areas.

There were systems in place for managing records. People's care records were well maintained and contained relevant information. All records examined including people's care records, personnel records and health and safety documents were up to date. All documents relating to people's care, to staff and to the running of the service were kept securely when not in use. People could be confident that information held by the service about them was confidential.