Memory Lane Care Homes Limited

Bryony Lodge Nursing Home

Inspection report

Leechmere Road
Sunderland
Tyne And Wear
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26 February 2018
14 March 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 26 February and 14 March 2018. The first day of inspection was unannounced and the second day announced. This was the first rating inspection for the home. Following this inspection we have rated the home as Good.

Bryony Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Bryony Lodge Care Home accommodates up to 45 people. At the time of our inspection there were 38 people living at the home some of whom were living with dementia.

The provider had recently appointed a registered manager. A new manager had started their employment at the home three weeks prior to our inspection. They had applied to the CQC 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.

People, relatives and staff told us the new registered manager was approachable and supportive. They told us the new manager was making improvements to the home.

People and relatives gave us positive feedback during our inspection. They told us the care they received was good and that staff were kind and caring. People confirmed staff were respectful towards them and their independence was promoted as much as possible.

There were sufficient staff deployed to meet people's needs in a timely way. Staff were visible around the home and available to support and assist people when required.

Staff felt the home was safe. They said they did not have concerns about safety but knew how to raise concerns if required. The provider followed local safeguarding procedures when dealing with safeguarding concerns. Previous concerns had been fully investigated and resolved.

Medicines were managed safely. Records accurately accounted for the medicines staff had given to people. Other records conformed medicines were received, stored and disposed of safely.

Although the provider completed recruitment checks, these were not always done in line with the provider's recruitment policy. In particular, the provider did not always seek to acquire a second employment reference in line with its policy.

Staff completed health and safety checks and risk assessments to maintain a safe environment. Plans had been developed to deal with unforeseen emergency situations.

Incidents and accidents in the home were investigated. Regular monitoring took place to ensure appropriate action had been taken and lessons were learnt.

The home was clean and well maintained. Staff commented the cleanliness of the home had improved significantly since the provider took over.

Management supported staff well and provided training opportunities relevant to each staff member's role. Training, supervisions and appraisals were up to date.

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

People gave positive feedback about the meals provided at the home. Staff supported people with the nutritional needs and to access health care services when needed.

Work was underway to review people's care plans so that they contained current information and reflected their needs.

People had opportunities to participate in a range of activities, such as baking, games and arts and crafts.

Complaints had been fully investigated and resolved in line with the provider's complaint procedure.

The provider carried out a range of quality assurance checks to help ensure people received a good quality of care. Where areas for improvement had been identified, action plans were developed to improve these areas.

There were opportunities for people, relatives and staff to provide feedback about the home. For example, regular meetings, care reviews and formal consultation.

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.

The provider managed medicines safely.

Staffing levels were sufficient to meet people's needs.

The home was clean and well maintained.

Staff completed health and safety checks to maintain a safe environment.

Is the service effective?

Good

The service was effective.

People's needs had been assessed including any religious, cultural or lifestyle needs they had.

Staff confirmed they received good support and completed training relevant to their role.

The provider acted in accordance with the Mental Capacity Act 2005 (MCA), including the Deprivation of Liberty Safeguards (DoLS).

People told us the meals provided at the home were good.

Staff supported people to meet their nutritional and health care needs.

Is the service caring?

Good

The service was caring.

People and relatives gave us positive feedback about the care provided at the home.

People said staff were kind and caring. .

People were treated with dignity and respect and staff promoted

people's independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Further improvements were required to ensure care plans were accurate and updated in a timely way.

People were able to participate in a range of activities.

People gave positive feedback about the care provided. Previous complaints had been fully investigated and resolved.

Is the service well-led?

Good

The service was well led.

People, relatives and staff gave us positive feedback about the improvements the registered manager and provider had made to the home.

The provider had a structured approach to quality assurance.

There were regular opportunities for people, relatives and staff to share their views about the home.

Bryony Lodge Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 26 February and 14 March 2018. The first day was unannounced and the second day announced. One inspector and an expert-by-experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make

Prior to the inspection we contacted the local authority commissioners, the Clinical Commissioning Group (CCG), the local authority safeguarding team and the local Healthwatch. We used their feedback during the planning of this inspection.

During our inspection we spoke with nine people and two relatives. We also spoke with a range of staff including the registered manager, one nurse, one senior care worker and three care workers. We reviewed a range of records including four people's care records, medicine records, five staff files, training records and other records relating to the quality and safety of the home.

Good

Our findings

People and relatives told us they felt safe living at Bryony Lodge Nursing Home. One person said, "Yes, I am definitely safe and well looked after. They have to use a hoist for me to have my bath, very smooth." Another person told us, "There is always someone there if you need them." One relative commented, "[Family member] is definitely more settled here. All doors can be locked, which puts my mind at rest … things are much better since the change of manager." Another relative told us, "They keep an eye on [family member]."

Staff also felt the home was safe. One staff member said, "We make it safe, we look after them, we try our best." Another staff member commented, "I think they are safe." A third staff member told us, "I try my best to keep them safe. If [people] are prone to falls we check them regularly."

Staff showed a thorough understanding of safeguarding and the provider's whistle blowing procedure. They also knew how to report concerns. All staff had completed safeguarding training. One staff member told us, "I have never needed to use it", and "Oh yes, I would definitely use it. Staff look after [people] as though they are family." Another staff member said, "I have not used it but I would (if needed)." We viewed the provider's safeguarding log which confirmed four safeguarding related issues had been referred to the local authority safeguarding team and fully investigated.

We observed staff using specialist equipment when transferring people from a wheelchair into a more comfortable chair. We noted they were patient with people and explained what was happening at all stages. Staff involved people and offered encouragement and reassurance. We found this was consistent with people's individual care plans.

People and relatives told us staff were usually busy but were quick to assist if people needed help. One person said, "Staff are excellent. I rang my buzzer last night … they were here in a couple of minutes. I can't fault them." Another person told us about a time when they called staff to assist another person. They told us, "I rang the buzzer and two staff came straight away." A third person commented, "There are always staff available when I need them. They are a bit busy at times but when I ring the bell they come straight away." One relative commented, "Not enough staff in the lounge. Although this is probably because with people in here you always need two staff (to take them to the bathroom)."

Most staff members felt staffing levels were appropriate in the home. One staff member commented, "We manage, we all pick up extra shifts. We are a good team." Another staff member said, "They are good

(staffing levels). The staff know exactly what they are doing. The nurses help out, it is fine." A third staff member told us, "Staffing levels are fine." The provider used a specific tool to check staffing levels in the home. The was completed regularly and used as a guide only as actual staffing numbers deployed were in excess of the numbers the tool recommended.

Pre-employment checks were carried out to check new staff were suitable to work at the home. This included requesting and receiving references. Although all staff had two references, we noted the provider did not strictly follow its own policy when requesting a second reference. The staff recruitment policy dated December 2016 stated 'the second reference must be a previous employer (unless the applicant has only held one job). In which case this may be an educational or character reference.' For four out of five staff files we viewed the second reference was not from a previous employer. We also noted for one person the employment reference was from the current registered manager who was also interviewing for the post. We discussed with the registered manager and the provider who advised they would review their policy. The provider also carried out checks with the disclosure and barring service (DBS). DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with vulnerable people. The registered manager kept a matrix of DBS checks and updated the checks periodically.

The provider managed medicines safely. Staff were trained in the safe handling of medicines and had their competency checked to ensure they retained the required skills and knowledge. Medicines records accurately accounted for all medicines received, administered and disposed of in the home. Medicines were also stored appropriately. One person told us, "I always get my medication on time." We observed a nurse administering medicines to people. We noted they were patient and encouraging so that people received their medicines safely. Some records relating to the application of trans-dermal patches were not immediately available. However, these were located later in the day. The pharmacy supplying medicines to the home had carried out reviews of medicines management. They had made some recommendations about managing 'out of date medicines' and recording fridge temperatures, which had since been implemented.

The provider completed health and safety checks to help maintain a safe environment. This included regular checks of fire safety, water temperatures and the nurse call system. Checks were also completed to help ensure specialist equipment was safe to use, such as hoists used to support some people when mobilising. Records showed external contractors carried out regular servicing of fire alarms and fire-fighting equipment, as well as the gas and electrical supplies to the home. A fire risk assessment had recently been completed. An action plan had been developed which had been signed off as complete.

We found the home was clean and well maintained. Some adaptations had been made to help people living with dementia, such as dementia friendly signage to help people orientate around the home. Picture menus and an activity timetable were used to help people make choices. Staff had completed specific dementia awareness training. One person commented, "Since the change of management, the cleanliness of the place has upped by 25, no 50%." Domestic staff were present during our time at the home carrying out cleaning duties.

Plans were in place describing the measures to deal with unplanned emergency situations. This included the departure of key staff, severe adverse weather conditions and the loss of utility supplies, such as gas, electricity and water.

The provider had systems to monitor and review incidents and accidents in the home to ensure appropriate action had been taken and lessons learnt. Individual incident and accident forms were completed after each incidents and a falls matrix to keep track of accidents in the home. We viewed the minutes form the most

recent meeting which showed falls in the preceding three months were reviewed to look at trends such as the time of day and location where falls had occurred. Other areas discussed included equipment used in the home to prevent falls and a review of people who had regular falls. Actions identified included referring some people to a specialist falls team, reviewing care plans and risk assessments and reviewing another person's medicines.

Good

Our findings

People's needs had been assessed both before and after admission to the home. This covered areas such as needs relating to personal care, communication, nutrition, personal preferences and religious or cultural needs. This enabled the provider to develop a pre-admission care plan so that people's care needs were documented on admission.

Staff received good support and the training they needed. One staff member commented, "Yes, I am supported. I love my job. If I have problems I can go to the nurse or management. I am working towards the care certificate." Another staff member told us, "I get loads of support, in all areas. One to ones are done and training is no problem." A third staff member said, "I am well supported, we have regular one to ones." Essential training for all staff included fire safety, moving and handling, infection control and equality and diversity. Records confirmed supervision, appraisal, induction and training were up to date.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS authorisations were in place for all relevant people. The registered manager kept a matrix to help ensure DoLS authorisations remained valid. We viewed examples of MCA assessments and best interests decisions in people's care records for decisions such as the use of bedrails and admissions to the home.

Staff had a good understanding of the MCA. They described how they adapted their communication to enable people to make as many of their own decisions as possible. For example, showing people items of clothing to choose from, using visual aids and getting to know people well.

People were supported to make their own decisions and choices. One person told us they were free to make their own choices and decisions as far as possible. One person commented they chose when to go to bed

and when to get up. Other people accessed the local community independently.

People and relatives gave positive feedback about the meals provided at the home. One person commented, "I enjoy all of the meals." Another person said, "I like the food, the food is great. Mince and dumplings is my favourite." One relative told us, "There are always enough drinks, they come in frequently offering drinks."

We observed over lunchtime to help us understand people's experience. Background music was playing to help create a relaxing atmosphere. We observed there was good interaction between staff and residents with lots of laughter. Staff were attentive to people's needs and checked they had what they wanted. For example, we overheard staff asking if "everyone was okay", and "Do you want anymore?" Although people had pre-ordered their lunch, staff still checked they hadn't changed their mind. Where people wanted to change, this was done without any fuss. Staff encouraged people with appropriately positive comments about how well they had done. Where people required assistance, this was provided without delay. Some people made specific requests for certain foods and these were fulfilled without any problem. For example, one person asked for a salad which was provided straight away. We overheard positive comments after people had eaten.

Staff completed a diet notification sheet when people were admitted to the home. This provided details of people's preferences and any special dietary requirements they had. For example, one person required a fortified and mashed diet. They also preferred to drink tea with milk and fruit juices. Kitchen staff had a good understanding of people's individual nutritional needs and were able cater for these.

Staff supported people to access external health care services when needed. Care records showed people had received regular input from professionals in line with the particular needs. This included GPs, community nurses, specialist nurses, dietitians and speech and language therapists.

Good

Our findings

People told us they were well cared for. They also gave positive feedback about the staff team's caring nature. One person told us, "The staff are kind and listen. It's good care." Another person said, "If you are poorly they can't do enough for you, marvellous they are." A third person commented, "They are kind … I can't praise them enough." One relative said, "The staff tell me about any problems and I get daily updates. They are nice to me and lovely to my Dad."

People were treated with dignity and respect. One person said, "They take me for my wash and treat me with dignity." Staff described how they maintained dignity and privacy through effective communication and promoting independence. One staff member commented, "We talk to people all the way through. We reassure them and tell them what we are doing. We encourage them to help if they can."

Where possible, staff spent one to one social time with people. People talked about having good relationships with staff. One person said, "The staff chat to me and hold hands with some of the really poorly people. They chat as much as they can and tell us about their day and ask about our day and if we need anything." Another person told us, "Sometimes the staff are really busy but never too busy to give us what we want." A third person commented, "Staff are always busy but they keep the rooms clean. They are really friendly, they are my friends first and carers second." A relative told us, "They treat them [people] as their own family."

Staff promoted people's independence as much as possible. One person told us, "They help to keep me independent by making me walk but walking with me as my balance is very poor." Another person said, "I'm quite independent and can go shopping by myself."

Staff had access to personalised information about each person to help them gain a better understanding of people's needs. People had a document called 'This is me' which provided a life history for each person living at the home. This included information about their personal qualities, care needs, family links and previous careers. Care records also provided details of people's preferences and particular routines they liked to follow. For example, one person liked to go shopping with family, socialising, going for meals and watching a particular genre of movies. Staff took time to find about any specific cultural, religious or lifestyle preferences people had. These were included in people's care plans to guide staff about how to support people in these areas.

The provider had policies and procedures to guide staff when people needed support from an independent

advocate. When we visited nobody had current input from advocacy services.

Requires Improvement

Our findings

Prior to our inspection we received information about concerns from visiting community professionals about poor standards of care records. This included inaccurate assessments and care plans and documents not fully completed. During our inspection we found similar issues. For example, the provider had applied for a DoLS authorisation for one person whose capacity had changed and could no longer consent to their placement at the home. We reviewed the person's care plans which had not been updated following this change. Another person's care records gave conflicting information about how often they preferred a shower. Their pre-admission assessment states three times a week and their care plan stated twice a week. However, the person told us they preferred a shower every day. The registered manager was aware of these concerns and was in the process of reviewing people's care plans with support from the provider. However, this work had not yet been completed.

People and relatives were happy the staff team knew what care was needed. Most people told us they did not feel they needed to be involved in their care planning or reviews. However, they said this was their choice. One person said, "Yes, I have a care plan but I've never bothered to look at it as I don't need to as I'm well looked after." A relative told us, "My wife did the care plan."

Staff completed a range of assessments to help prevent people from potential risks such as falling, skin damage and poor nutrition. Records showed these were reviewed every month. Where a risk was identified, care plans were in place which identified the support people needed in these areas. Where required individual risk assessments were carried out where people had risks relevant to their particular needs.

People had opportunities to take part in activities relevant to their particular interests. One person said "We make scones, we also make pancakes, Chinese lanterns. There is a Bible class. We do snooker and darts. We also go out by taxi which can be expensive, it would be much better if there was a mini bus." Another person commented, "I cook, read avidly, play snooker." One relative added, "[Family member] wouldn't do any activities but now with the pool table and darts [family member] is starting to do other things and is becoming more sociable." They went on to say, "They do try to get [family member] involved with the activities. [Family member] asked for a pool table and a dartboard and they came within a week. So now [family member] doesn't sit in his room all day, he can play darts with me and watch me playing pool. That was very thoughtful of them." Activities were on-going during our visits to the home. Some people and relatives said they would like a minibus for the home to take people on outings. This was something that had been raised with the provider as a suggested improvement.

Although people gave us positive feedback about their care, they also knew how to raise concerns should they need to. One person said, "Of course we have no complaints, what is there to complain about? But if I did I would go to the head person and she would sort it out." Previous complaints had been logged and fully investigated. Action taken to deal with complaints included increased management checks, reviewing care plans and meetings with people and relatives.

Good

Our findings

People and relatives knew who the registered manager was and felt they could approach her if required. One staff member told us, "[Registered manager] is brilliant. Everything is in place, she knows her job. She walks the floor all the time. She asks if you are okay. If there is a problem I feel confident and comfortable to go and see her." Another staff member commented, "[Registered manager] is great, she runs it really well. She makes sure everything is as it should be. She is very approachable, I can go to her with anything. She is a good manager."

People described how they felt valued by the provider and staff at the home. One person said, "Have you seen the sign at the front of the building, as that sums things up here." The sign read 'our residents do not live in our workplace, we work in their home'. Another person commented, "It's really good, they make people feel wanted and loved. [Registered manager] always has time to speak."

People described a positive and welcoming atmosphere in the home. One person said, "It's a nice atmosphere here. I have no complaints; the food is great. Things don't need to improve I'm happy here, everyone is." One relative told us, "Everyone says hello and they give me a cup of tea."

Staff also felt there was a good atmosphere. One staff member commented, "There is a fab atmosphere, lovely. Everybody gets on. It feels more relaxed and everybody looks happy." Another staff member said, "The home has a lovely atmosphere."

There were opportunities for people and staff to share their views about the home. For instance, through attending meetings and completing surveys. People were aware meetings took place and most said they attended the meetings. One person said, "We discuss where we are now and what we will be trying to do in the future." People and relatives were also able to discuss their individual care during care reviews. Records showed people had been involved in discussions and feedback was positive.

We viewed feedback from the most recent consultation carried out in October 2017. Feedback had been received from 12 people, 13 relatives and 19 staff and was mostly positive. For example, over 90% of people and relatives felt privacy was respected and the home was safe. Where areas for improvement had been identified, action plans had been developed to address these areas. Actions included involving people and relatives in menu planning, additional checks to monitor care provision and discussion with people about their preferences. All actions had been signed off as complete.

The provider had a structured approach to quality assurance. This included a range of checks to help ensure people received a good standard of care. For example, checks were carried out relating to medicines management, health and safety and infection control. The quality assurance process had been strengthened following the last commissioning visit. For example, an audit of pressure care had been implemented to ensure people at risk of skin damage were closely monitored. An area manager completed regular quality checks which included gathering the views of people, relatives and staff.