Brooklands 1 Limited

The Julie Richardson Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The Julie Richardson is a care home for up to 40 people who require nursing or personal care, some of whom are living with dementia. At the time on our inspection there were 39 people living at the home.

We inspected this service on 18 July 2017. This was an unannounced inspection.

At the last inspection, the service was rated Good.

At this inspection we found the service remained Good. However, they were outstanding in effective

Why the service is rated good:

People received exceptional care from well trained staff. Staff demonstrated high levels of knowledge and understanding required to be able to positively impact on people's wellbeing. People received care from staff that understood the needs of people living with dementia. People felt supported by competent staff that benefitted from regular supervision (one to one meetings with their line manager), appraisals and team meetings to help them meet the needs of the people they cared for.

The provider sought innovative ways to continuously improve the home and better people's well- being. The home was involved in several research projects which had resulted in positive changes for people.

The environment had been creatively adapted to help meet people's needs, in particular people living with dementia. It provided clear dementia friendly pictorial signage and points of interest. The layout and design helped to maintain people's independence and to reduce restrictions of their movements.

People experienced positive outcomes regarding their health care as the service had developed excellent working relations with a number of health care professionals. The service had reduced the use of antipsychotic medicines allowing people more independence.

People's dietary needs and preferences were well met. Meal times were sociable and positive experiences. People were given choices and received their meals in timely manner. People were supported with meals in line with their care plans.

People were supported to express their views and were involved in making decisions about their care and were offered day to day choices. Staff sought people's consent for care and treatment and ensured they were supported to make as many decisions as possible. The registered manager and staff had a good understanding of the Mental Capacity Act 2005. Where people were thought to lack capacity, assessments in relation to their capacity had been completed in line with the principles of MCA. The registered manager and staff understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions.

People supported by the service felt safe. Staff had a clear understanding on how to safeguard people and protect their health and well-being. People received their medicine as prescribed. There were systems in place to manage safe administration and storage of medicines.

People had a range of individualised risk assessments in place to keep them safe and to help them maintain their independence. Where risks to people had been identified risk assessments were in place and action had been taken to reduce the risks. Staff were aware of people's needs and followed guidance to keep them safe.

The Julie Richardson care home had enough suitably qualified and experienced staff to meet people's needs. People told us they were attended to without unnecessary delay. The home had robust recruitment procedures and conducted background checks to ensure staff were suitable for their role.

The Julie Richardson continued to provide support in a caring way. Staff supported people with kindness and compassion. Staff respected people as individuals and treated them with dignity. People were involved in decisions about their care needs and the support they required to meet those needs.

The home continued to be responsive to people's needs and ensured people were supported in a personalised way. People's changing needs were responded to promptly. People had access to a variety of activities that met their individual needs.

The Julie Richardson was led by a registered manager who promoted a service that put people at the centre of what the home did. There was a positive culture that valued people, relatives and staff and promoted caring ethos. People and staff were complimentary of the way the home was managed.

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.

Risks to people were assessed and risk management plans were in place to manage the risks and keep people safe.

There were sufficient numbers of suitably qualified staff to meet people's needs.

People were protected from the risk of abuse as staff had a good understanding of safeguarding procedures.

Medicines were stored and administered safely.

Is the service effective?

Outstanding

The service was extremely effective.

The environment had been adapted to help to meet people's needs, in particular people living with dementia, and promote their independence.

Staff worked exceptionally well with other healthcare professionals to ensure people's healthcare needs were met.

Staff received on-going training which included specialist dementia care training as well development to enable them to deliver the most effective care to people.

People's meal times were sociable and positive experiences.

Staff had good knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards. People who were being deprived of their liberty were being cared for in the least restrictive way.

Is the service caring?

Good

The service remained Good

Is the service responsive?

Good

The service remained Good	
Is the service well-led? The service remained Good	**Good**

The Julie Richardson 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 was carried out by an inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection took place on 18 July 2017 and was unannounced.
Before the inspection we reviewed the information we held about the service and the service provider. The registered 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 looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law.

We spoke with 16 people and 10 relatives. We looked at three people's care records and five medicine administration records (MAR). We spoke with the provider, the registered manager and staff which included nurses, care staff, housekeeping, maintenance and catering staff. We reviewed a range of records relating to the management of the service. These included five staff files, quality assurance audits, minutes of meetings with people and staff, incident reports, complaints and compliments. In addition we reviewed feedback from people who had used the service and their relatives.

Good

Is the service safe?

Our findings

People told us they felt safe living at The Julie Richardson nursing home. Comments included; "Really pleased. Some top class care. I feel safe with them" and "The carers are friendly and of course I feel safe". One person's relative told us, "Since [person] has been here, I have a peace of mind leaving them here".

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff had attended training in safeguarding vulnerable people and had good knowledge of the home's safeguarding procedures. Staff were aware of types and signs of possible abuse and their responsibility to report and record any concerns promptly. One member of staff said, "We report any abuse to the nurse or manager. I know we can also whistle blow to safeguarding, police or CQC (Care Quality Commission)".

Risks to people were identified and risk management plans were in place to minimise and manage the risks and keep people safe. These protected people and supported them to maintain their freedom. Some people had restricted mobility and information was provided to staff about how to support them when moving them around the home. Risk assessments included areas such as falls, fire and moving and handling. Risk assessments were reviewed and updated promptly when people's needs changed. For example, one person was at risk of falling fell and was referred to the care home support service (CHSS). Staff were advised to use a sensor mat which could alert staff when this person fell. The person's risk assessment and risk management plans were reviewed to reflect the changes.

On the day of our inspection we saw people were supported by sufficient numbers of staff. Records showed the number of staff were sufficient to meet people's needs. Staff told us, "We have enough staff" and "I wish the provider could employ more staff. I don't mind doing more hours to cover sickness". People told us they were attended to without delays. One person told us, "They have fair number of staff but could do with more".

The provider followed safe recruitment practices. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable people. Staff holding professional qualifications had their registration checked regularly to ensure they remained appropriately registered and legally entitled to practice. For example, registered nurses were checked against the register held by the Nursing and Midwifery Council (NMC).

People received their medicine as prescribed and the home had safe medicine administration systems in place. The provider had a medicine policy in place which guided staff on how to give and manage medicines safely. We observed staff administering medicines to people in line with their prescription. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given or, if not taken the reason why. People understood the reason and purpose of the medicines they were given.

The equipment used to support people's care, for example, weight scales, wheelchairs, hoists and standing aids were clean and had been serviced in line with national recommendations. We observed staff using mobility equipment correctly to keep people safe. People's bedrooms and communal areas were clean. Staff were aware of the providers infection control polices and
adhered to them.

The provider had a business continuity plan and an emergency plan. These plans outlined the actions to be taken to ensure the safety of people using the service in an emergency situation.

Outstanding ☆

Is the service effective?

Our findings

People living at The Julie Richardson received excellent care from staff who were highly knowledgeable, skilled, confident and well trained in their practice. Records showed and staff told us they had the right competencies, qualifications and experience to enable them to provide support and meet people's needs effectively.
Staff undertook core training in areas such as health and safety, moving and handling; infection control, fire safety, first aid, medicines management and safeguarding adults. Some staff had completed more specialised training in order to meet the specific needs of the people using the service. This included dealing with challenging behaviour, dementia awareness, person centre care, and end of life care.

We observed positive staff attitudes, behaviours and interactions with people and noticed they were in line with people's support and care plans. Staff took time to meaningfully engage with people even during very simple tasks. For example, when staff offered people drinks they would often engage them in conversations, sitting down with them and enjoying positive interactions. This had a positive effect on the people's wellbeing. People smiled and appeared content. Staff had received training and guidance which allowed them to understand the individual needs of people living with dementia and this was reflected in such excellent day to day practices.

New staff completed an induction to ensure they had appropriate skills and were confident to support people effectively. The induction training was informed by the 'Skills for Care Framework' which is a nationally recognised program for the care sector. It ensures all staff have the same induction and learn the same skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. This included training for their role and shadowing an experienced member of staff. Staff felt well supported during their induction period. One staff member said, "When I came here I had not done caring and I got a lot of training". Staff skills and attitudes were also assessed during probationary period to ensure good standards of practice.

The provider was very aware of the challenge that all care homes faced with a shortage of nursing staff. The provider also supported overseas nurses with registration with the nursing and midwifery (NMC) board. In addition the provider was in the process of working closely with the local NHS and the Open University so that they would be able to offer distance learning nursing degrees to staff working in the service.

Staff told us and records showed all staff had received dementia training. This training focused on understanding people's communication and validating their feelings and emotions. People's feelings and beliefs at any stage of their dementia journey were acknowledged by staff. For example, staff used people's life stories to have a better understanding of current behaviours. This meant people were less anxious and constantly reassured by staff who were able to understand and anticipate their needs.

It was evident during our inspection that staff were knowledgeable of how to support people with the most complex forms of dementia. Staff received distress reactions training to support people effectively when dealing with complex behaviours. During our inspection we observed staff easily noticed signs of distress

and successfully used distraction techniques. The distraction technique redirects a person's attention away from a negative mood to something entirely different and positive. For example, one person got agitated and started calling out for their family. A member of staff sat next to them and spoke to them clearly, holding their hand. This interaction provided therapeutic touch and had a positive effect on the person. The member of staff supported this person patiently and took time to listen to them and responded in a non-patronising way. The end result was that the person was happy and not distressed. The person's care plan gave staff clear guidance on how to communicate with the person without causing distress. Staff told us they knew this person well enough to interpret what they communicated.

The provider emphasised continually striving to improve and the management team promoted and regularly implemented innovative systems in order to improve the effectiveness of the service. For example, they promoted good practice by participating in research. The home had been involved with the University of Oxford in a research project aimed at improving environments for those living with dementia. This had resulted in the publishing of a national guidance on provision of positive environment for people living with dementia. The provider had adopted the King's Fund Dementia Environment audit tool to make changes and design the main floor of the home. As a result of this, 'destination areas' were created on the home main floor. The destination areas had themes which included the nurses' station is in the shape of a Banbury Barge, a street scene along on corridor and a kitchenette area resembling a 1950's diner. These areas gave people with dementia a purpose to move with the aim of reaching the destinations. Another sitting area had a post office theme and seats which people used throughout our inspection. Staff told us they also used these destination areas as talking points. We saw people and staff engaging in stimulating conversations in these areas.

The interior of the home was dementia-friendly and was designed according to the research on dementia carried out by University of Stirling. Colour coordination was used to enable people to find their way in the home and to promote their independence and reduce feelings of confusion and anxiety. For example, toilet doors had contrasting colours and had a visible coloured picture on them. People's bedrooms were personalised and contained photographs, pictures and the personal belongings each person wanted in their bedroom. We saw people easily and freely navigating around the home independently.

People could move around freely in the communal areas of The Julie Richardson. There were several sitting rooms, conservatory, musical theme lounge and a patio garden with sensory effect where residents grew herbs and plants. This gave people a choice of where to spend their time. Most of the home's areas were decorated in a way that followed guidance for helping people with dementia to be stimulated and orientated.

The provider was also involved in a research study with the University of Bradford to assess if Dementia Care Mapping (DCM) could make a difference to the care provided. DCM is an established approach to achieving and embedding person-centred care for people with dementia, recognised by the National Institute for Health and Clinical Excellence (NICE). Senior management staff attended the DCM training and fed back to the team at The Julie Richardson. A dignity and dementia group was formed following this initiative. It included activity coordinators, nurses and carers aiming to change practice in dementia care. The provider further introduced a Banbury Interaction Observation tool (BIO). This allowed the management team to observe staff practices so as to promote and improve positive behaviours through better communication.

People were supported to maintain good health and benefited from the excellent links the home had made with health and social care professionals. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included the GP, care home support service (CHSS) and speech and language therapist (SALT). Visits by healthcare professionals, assessments and referrals were all

recorded in people's care plans. Records showed people's health care needs had been identified and were monitored. For example, people's weight was monitored and action was taken if they were losing weight, for example consulting with their GP and dieticians.

The home worked effectively with the GP and CHSS mental health team to reduce the use of anti-psychotic medicines in people with challenging behaviours. Staff invested enough time to know people's behaviours and understand any possible triggers. Staff were trained to use psychosocial interventions to support people with challenging behaviours. Psychosocial interventions are informational activities, techniques, or strategies that target biological, behavioural, cognitive, emotional, interpersonal, social, or environmental factors with the aim of improving health functioning and well-being. The GP completed three monthly reviews for all people on antipsychotic medicines in line with the NICE guidelines. As a result, many people had significantly reduced or stopped the use for antipsychotic medicines. People were more involved in activities and their general well-being had improved. One person's relative commented, "[Person] looks so much better than when they first came here".

People were complimentary of the food. One person told us, "Diet all round is very good" and "Not very exciting but a balanced diet". People enjoyed the food and were supported to meet their nutritional needs. We saw that people were given choices and had a pleasant dining experience. Mealtimes were truly sociable events and staff and people greeted each other with smiles. The atmosphere was pleasant. There was conversation and chattering throughout the dining room. People chose where they wanted to sit and did not wait long for food to be served. Picture menus were available to enable people to make informed choices around their meals.

Where people had specific dietary requirements, these were met. These included special diets such as kosher, vegan or halal. Finger foods were available and these aided dietary intake in people living with dementia. The chef was very keen to support healthy and alternative diets to promote good health. Where people had been identified as having a swallowing problem and required a soft or pureed meal, these were attractively presented. The provider operated protected meal times. This allowed people concentrate on eating without distractions. Menus were reviewed regularly following people's feedback.

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. Staff had received training about the MCA and understood how to support people in line with the principles of the Act. One staff member said, "We accept residents have capacity until we can prove otherwise. If they can't make certain decisions, it doesn't mean they can't make all decisions".

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had a clear understanding of the DoLS. However, we found where the best interest process had been completed, the involvement of other people had not always been recorded in line with the MCA Code of Practice. The provider took immediate action to ensure this would be recorded. At the time of our inspection several people at the service were subject to DoLS authorisation and were supported in line with the authorisations.

Good

Is the service caring?

Our findings

The home continued to provide a caring service to people. People benefitted from caring relationships with staff. People told us, "Nice carers, I have no moans", "I been here five years, excellent, really pleased, top class care" and "Nothing too much trouble for the staff".

People were involved in their care. Care plans contained documents stating people had been involved in the creation of their support plans. Throughout our inspection we observed staff involving people in their care. One staff member said, "We try to do our best with the residents for their well being".

People told us staff respected their dignity and privacy. One person told us, "The carers are always polite and respectful". When staff spoke about people to us or amongst themselves they were respectful and they displayed genuine affection. Language used in care plans was respectful. People were addressed by their preferred names and staff knocked on people's doors before entering. One member of staff said, "We respect people's decisions, do not tolerate abuse and we do not force people to do anything they don't want to".

People were supported to be independent. Throughout our inspection we saw staff encouraging people to be independent. One staff member said, "We offer choices and allow enough time for people to do things they still can".

People were confident their personal information was kept safe and they told us staff did not discuss other people with them. People's personal files were kept secured, locked in provider's office. Staff received training about handling information and confidentiality. One member of staff said, "We don't discuss residents in front of other residents or visitors".

The provider's equal opportunities policy was displayed in the home. This stated the provider's commitment to equal opportunities and diversity. This included cultural and religious backgrounds as well as people's gender and sexual orientation.

Good

Is the service responsive?

Our findings

The Julie Richardson continued to be responsive. People's needs were assessed prior to admission to the service to ensure their needs could be met. These assessments informed the plan of care. Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs.

People's care plans reflected how each person wished to receive their care and support. For example, people's preferences about where they wanted to spent their time or when to go to bed. People and their relatives confirmed they were involved in planning and review of their care.

Care plans and risk assessments were reviewed monthly to reflect people's changing needs. Where a person's needs had changed, the care plan had been updated to reflect these changes and the service sought appropriate specialist advice. For example, one person's behaviour became more challenging and the person was referred to the mental health team. A personalised mental health plan was put in place and the person's care plans and risk assessments were reviewed to reflect the changes.

People had access to a range of activities. The provider employed two activity coordinators. There was emphasis on providing personalised activities. These included breath of fresh air which encouraged people to go out and 'sun downing' (evening) hours to allow people engagement in the evenings. Throughout our visit we saw staff engaging with people on a personal level, playing games, reading with them or supporting them with activities where ever people chose to spend their time.

People's views and feedback was sought through residents and relatives meetings, yearly surveys as well as through quality monitoring questionnaires. Records of family meetings showed that some of the discussions were around what changes people wanted, people's opinions were sought and action was taken to respond to issues raised.

People and their relatives knew how to make a complaint and the provider had a complaints policy in place. This was given to people and clearly displayed on notice boards. People and relatives spoke about an open culture and felt that the home was responsive to any concerns raised. There were many compliments and positive feedback received about the staff and the care people had received.

Good

Is the service well-led?

Our findings

The Julie Richardson continued to be well led. There was a registered manager in place. 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. The registered manager had a clear vision to develop and improve the quality of the service. There was a clear leadership structure which aided in the smooth running of the service.

People told us they felt the service was well managed and they complimented the registered manager. Comments included: "It is a well run home and well managed" and "If made aware, the owners always deal with anything".

Staff were complimentary of the support they received from the management team and they told us the service was well run. Staff comments included; "Manager is approachable and supportive", "Manager is a good listener. I can discuss anything with her" and "The providers listen to us".

The registered manager promoted and honest, open and inclusive culture which put people at the centre of care. The registered manager spent time interacting with and supporting people; demonstrating a kind and caring manner.

The provider had effective quality assurance systems in place to assess and monitor the quality of service provision. For example, quality audits included medicine safety, care plans and accidents and incidents. Quality assurance systems were operated effectively and used to drive improvement in the home.

The registered manager also monitored accidents and incidents and analysed information to look for patterns and trends. For example, where people suffered falls they were referred to the care home support service who's guidance was implemented into people's care. The registered manager was supported by the provider who facilitated external checks and audits to improve the service.