Cumbria County Council

Brackenthwaite

Inspection report

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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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This was an unannounced comprehensive inspection which we carried out on 18 September 2017.

We last inspected Brackenthwaite on the 17 April 2013. At that inspection we found the service was meeting the legal requirements in force at the time. We found the legal entity for the provider was not correct and the provider was registered under the entity of Cumbria County Council in November 2015. This is the first inspection since this change in registration was made.

Brackenthwaite is a care home registered to provide accommodation for up to 30 people requiring personal care. The property is a three storey building with a passenger lift to assist people to access the accommodation on the upper floors. People live in small units, each with a sitting and dining area. One unit specialises in providing care for people living with a dementia. At the time of our inspection there were 18 people living in the home.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

People's rights were protected and staff obtained people's consent before providing care. The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA). People made informed choices and were enabled to be involved in decisions. Some of the records in people's care plans were not clear on the support they needed to make decisions.

We made a recommendation about how people's capacity was recorded.

People were supported with care and compassion and there was an ethos of care which was person-centred: valuing people as individuals. People told us they felt safe and well cared for. They appeared content and relaxed with the staff who supported them and told us that staff were very kind and caring. Activities and entertainment was available for people that met their diverse needs.

Relatives reported a "warm and welcoming atmosphere" and being updated with any concern about their relative's well-being.

The home was suitably staffed to provide care and support to people when they needed it. Staff were supervised and well supported. Staff in the home had completed training to give them the skills and knowledge to carry out their roles and to ensure people in the home were safe.

People were protected as staff had received training about safeguarding and knew how to respond to any allegations of abuse. Staff were aware of the whistle blowing procedure and knew how to report bad

practice. When new staff were appointed thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

People were safe because risks had been identified and managed. Records had been updated and they were regularly reviewed to reflect people's care and support requirements. People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. People received their medicines in a safe and timely way.

People were supported to eat a well-balanced diet and those who were at risk of malnutrition and/or dehydration had their food and fluid intake monitored. They told us of the good quality and range of the meals provided.

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.

A complaints procedure was available. People told us they felt confident to speak to staff about any concerns if they needed to. The registered manager acted on feedback in order to ensure improvements were made to the service when required.

Communication was effective, ensuring people, their relatives and relevant agencies were kept up to date about any changes in people's care, support needs and the running of the service.

The service was well organised and managed. The provider undertook a range of audits to check on the quality of care provided. Staff and people who used the service said the manager was supportive and approachable. Both the registered manager and the senior team had high expectations of staff and gave them as much support and training needed to provide a reliable, efficient and compassionate service to people. Staff were proud of their work in supporting people at Brackenthwaite.

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.

People were kept safe and the risk of abuse was minimised because the provider had systems in place to recognise and respond to any allegations or incidents.

People received their medicines as prescribed and medicines were managed safely.

There were robust systems in place to ensure people's risks in relation to the environment were minimised.

The home was sufficiently staffed to provide care and support to people when they needed it.

Is the service effective?

Good

The service was effective.

People's rights were protected. Best interest decisions were made on behalf of people, when they were unable to give consent to their care and treatment. Recording in this area could be strengthened.

Staff were well supported to carry out their role and they received the training they needed.

Effective communication ensured the necessary information was passed between staff to make sure people received appropriate care.

People received a balanced diet to meet their nutritional needs.

Is the service caring?

Good

The service was caring.

Staff were kind, caring and had developed good relationships with people living at the home. The staff treated people respectfully and protected their privacy and dignity.

People were well supported in making choices and decisions about the care they received and in promoting their independence.

Advocates were made available to represent the views of people who are not able to express their wishes.

Is the service responsive?

Good

The service was responsive.

People's care and support plans reflected people's current needs, wishes and preferences and possible risks that needed to be managed.

People were provided with activities and entertainment of their choosing.

People had information to help them complain. Complaints were investigated and any action taken was recorded.

Is the service well-led?

Good

The service was well-led.

The service had a registered manager in post.

There was an open and positive culture which reflected the opinions of people living at the home.

There were clear values underpinning the service which were focussed on providing high quality person centred care.

There were robust systems in place for monitoring the quality of the service.

Brackenthwaite

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 18 September 2017 and was unannounced.

The inspection team consisted of one adult social care inspector and one expert-by-experience in the care of a family member living with a dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for older people.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send into the Care Quality Commission within required timescales.

We spoke with ten people who lived at Brackenthwaite and four relatives. We spoke with the registered manager, two senior supervisors, and five care workers, one domestic, two members of catering staff and a visiting healthcare professional.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us. We undertook observations in communal areas and during mealtimes.

We reviewed a range of records about people's care and how the home was managed. We looked at care records for six people including their medicines records. We checked recruitment, training and induction records for four staff, staffing rosters, staff meeting minutes, the maintenance book, fire risk assessment and log and quality assurance audits the manager had completed.

We contacted commissioners from the local authorities who contracted people's care.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe in the home. One person told us, "I feel completely safe here. There's always staff to hand." Another person said, "They are quick to come if I push my buzzer." Another person told us, "I can talk to staff if I am worried about anything and they make me feel better."

Relative told us they felt their relatives were safe. We received comments such as, "There's always seems enough staff when we come, we feel [relative] is very safe here", and "The manager and staff are absolutely fabulous at putting you at your ease. I know my relative gets the very best care here. I'm 100% sure of that." And another relative said "I know [relative] is safe here, he has been so much better since he came in."
We had not received any information of concern from the service or from other agencies in relation to allegations of abuse. People we spoke to at the service told us that the staff were "lovely" and "very kind" and no one raised any concerns with us about their safety during our inspection. We saw that people using the service had been provided with information about safeguarding and how to report any concerns to the manager or outside agencies, such as the local authority.

People were supported by staff who recognised the signs of potential abuse and knew how to minimise the risk of people who used the service coming to harm. We saw staff received regular training and guidance in protecting people from the risk of abuse. Staff we spoke with had a good knowledge of how to recognise the signs that a person may be at risk of harm and how to escalate concerns to the manager or to external organisations. A staff member said, "We have lots of training on moving and handling and safeguarding."

Safe staff recruitment practices were in place. This process included making sure that any new staff had all the required employment background checks, security checks and references taken up. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before applicants were offered their job. Copies of interview questions and notes were also available to show how each staff member had been appointed.

We considered staffing levels were sufficient to provide safe and individual care to people. The manager told us staffing levels were determined by a dependency tool. This was used to check against each person's dependency profile to calculate if there were sufficient staff to meet people's needs safely. We saw appropriately numbers of staff in place on all shifts to meet people's individual needs. The staff rotas we looked at confirmed these levels were adhered to. Staff reported that the staffing levels were "good" and this gave them time to give people care that was paced according to people's needs. We observed unhurried and safe care being delivered to people, for example when a person was being hoisted staff took their time and ensured the person felt comfortable and safe.

People received their medicines in a safe way. Up-to-date policies and procedures were in place to support staff and to ensure medicines were managed in accordance with current guidance. We observed a medicines round and saw the supervisor remained with each person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. We found that there were no gaps in signatures and all medicines were signed for after administration. All medicines

were appropriately stored and secured.

A Personal Emergency Evacuation Plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plans were reviewed monthly to ensure they were up to date. These were used in the event of the building needing to be evacuated in an emergency.

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and kept people safe. The risk assessments included risks specific to the person such as moving and assisting, mobility, nutrition and pressure care. For example, we observed staff moving people in wheelchairs and using hoists. These were all used appropriately, safely with the correct equipment and in line with the individual risk assessment.

The home had an effective system for highlighting risks across people's care plans: these were very clearly identified in care plans to instruct staff on how to keep people safe.

Routine safety checks and repairs were carried out such as checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Good

Is the service effective?

Our findings

People who could speak with us told us that the staff in the home knew what support they needed and that they provided this at the time they needed it. Relatives praised the staff team and spoke very highly of the support provided. They told us that the staff were very good and met the needs of people who used the service. One relative said, "Staff are always well informed and helpful." One person told us, "I see my Doctor if I need to, the girls just send for him."

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. Staff were aware of and had received training in the MCA and the related DoLS. The manager and staff understood the DoLS and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. The registered manager told us several DoLS applications had been authorised and other were being processed by the local authority.

We checked peoples care records and found it difficult to tell what level of ability and support people needed to make either day to day or more complex decisions. We found that people's capacity was mentioned in a number of different places within the care plans but the details were very brief. People's ability to make decision and to have capacity was not set out in a way that care staff would know which decisions people were capable of making and which required more support.

We recommend that the service reviews, and seeks advice from a reputable source on how to assess and record people's capacity and ability to give consent; to include any support needs people may need to communicate their wishes. Reference should also be made to people's legal status, such as whether a Lasting Power of Attorney was in place, and what type.

The service did not advocate the use of excessive control or restraint. Staff told us people rarely displayed distressed behaviours or ones that may challenge. The staff knew people well, enabling them to quickly spot the signs of changes in their moods and communication. We checked peoples care plans around the support people required and found that plans were written in good detail about watching for signs and knowing peoples triggers so that staff could positively intervene and defuse most situations.

The staff training records showed staff were kept up-to-date with safe working practices. The registered manager told us there was an on-going training programme in place to make sure staff had the skills and knowledge to support people. Training courses included distressed behaviour, nutrition and malnutrition, continence care, wound management, pressure area care, privacy and dignity awareness, person centred care, falls awareness, equality and diversity and management training to carry out supervisions and appraisals. The majority of support staff had achieved a National Vocational Qualification (NVQ), at level two, now known as the Diploma in Health and Social Care.

Staff told us they were well supported to carry out their role. All staff said they had regular supervision to discuss the running of the service and their training needs. They said they could also approach the manager at any time to discuss any issues. They also said they received an annual appraisal to review their progress and work performance. Staff were positive about the opportunities for training to understand people's care and support needs and said they could ask for additional training if needed.

Staff liaised with health care professionals to make sure people's care and treatment needs were well met. Staff had close working relationships with district nurses, GPs and Community Psychiatric Nurses (CPNs) and worked well with adult social care professionals in co-ordinating people's care. People had the necessary aids and equipment for their comfort and safety, for instance mobility and bathing aids, and profiling beds. Detailed records were kept about people's health needs and all contact with healthcare professionals.

People were positive about the food on offer saying they had enough to eat and received 'nice' and 'lovely home cooked' food. People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. We saw a board was available in the kitchen to show information and capture any changes that had been communicated about people's dietary requirements.

Good

Is the service caring?

Our findings

People we spoke with were all very positive about the care and support provided by staff. Their comments included, "The girls (care staff) are great, they ask you about things", and another "It's like family. I couldn't ask for better they are brilliant" and another person said, "They are all very good to me."

A relative said, "It's been great for [relative] this place, he was losing his confidence at home but he has got it all back here." Another told us, "The staff are so kind, they show great affection for [relative]. Its very reassuring."

People were respected and valued. We noted there was lots of laughter and banter between people living in the home and staff. There were appropriate hugs and kisses, and touch was used in a very reassuring manner. For example a hand placed on an arm or round a shoulder. The conversations staff had with people was meaningful; about families, the current news and children. One person told us, "It's great here, they look after us, I asked that one [staff member] to marry me but she said only if I won the lottery!" At this point a number of residents joined in the laugher and it was obviously that this was common place and warmth and empathetic relationships had been developed.

Staff demonstrated a caring and respectful attitude towards supporting people in the home. The staff had taken care that people were well dressed and well groomed. Everyone had slippers or shoes on with stockings or socks, where they wanted them. One staff member told us, "It's important that people look nice and how they have always kept themselves. Ladies with handbags and jewellery; gentlemen shaved with wristwatches and their wallets with them." One person commented on how the staff made sure her hair was always nice and another said staff looked after her clothes when they went to the laundry.

We observed the atmosphere was calm and relaxed. Staff were seen attending to people's personal needs in a discreet manner to ensure people's dignity. We saw how they re-adjusted clothing and glasses, plumped up cushions behind people's backs and placed blankets across knees. This was all done in consultation and while chatting to people, asking them what they would like done. One person was asked if they would like another cup of tea, they replied they really fancied a milky coffee and the staff member said this wouldn't be a problem and went to get one.

All staff were trained in the values of person-centred care, with an emphasis on caring for people as unique individuals with diverse needs. The registered manager said this training encompassed care planning, promoted privacy, dignity and independence and adhering to the person's preferences. They told us standards of care practices were made clear to staff and were checked to ensure they were consistently applied.

Attention to detail was also reflected in people's care plans. For example, one person's plan for personal care stated 'Make sure I have a face cloth ready when I have a wash in the morning as I like to do this myself." Another care plan stated, "I like to use Cumbrian dialect and sometimes swear but mean no offence."

Staff told us they were designated as keyworkers for people, with particular responsibilities towards the planning and provision of their care. This helped with communication and consistency of providing people with their care. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance with a gentle touch on the arm. They asked the person's permission before they carried out any intervention.

We saw and were told about the methods used to support people in expressing their views and making decisions about their care. Easy read information was displayed, such as the day's menu and posters about how to report complaints or safeguarding concerns. Working with other professionals, the service had made information available to some individuals in formats they could understand. For instance, photo boards designed to display the staff on duty, family visits and help in making choices of activities and food.

There was information displayed in the home about advocacy services and how to contact them. The registered manager told us people had utilised the involvement of an advocate where there was no relative involvement. An advocate is an independent worker who can help speak up for people and ensure their rights are promoted.

Good

Is the service responsive?

Our findings

People told us that the home met their needs fully. One person told us, "It is very good, I'm not usually one for sitting in here (sitting room) I like my bed, and I lie on top and have a rest! But I always get to choose." Another person said, "I can say what I want, I can tell people [staff] what I don't want as well." Another person said, "I go out a lot, I meet my friends downtown."

We observed that staff treated people in a way that was person-centred. Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs. This which enabled them to provide a personalised service. A relative said, "They [staff] look after [relative] great" and "He does his own care plan, he's fully capable of that."

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example these covered areas such as nutrition, personal care, communication and moving and assisting needs.

Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. Evaluations were detailed and included information about peoples' progress and well-being. We saw how this worked in the home's application of a Falls Prevention Plan; this included detailed risk assessments, care plan instructions for staff to follow and tools to measure the changes to people's mobility. The home sought advice from an external healthcare professionals such as an occupational therapist as a result of this carefully monitoring of changes to people's health.

The home had recently taken part in a local healthcare initiative to improve the care of people who maybe prone to pressure ulcers. We saw national good practice tools that had been used to assess and monitor people's skin called a safety cross.

A healthcare professional said of the home, "Brackenthwaite have been very involved in the Pressure care collaborative and they are vigilant at monitoring people. We have definitely seen benefits for people in the home."

Staff responded well to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in people's needs. For example, the speech and language therapist was asked for advice with regard to swallowing difficulties and communication. Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording the food and fluid intake of some people, when personal hygiene was attended to and other interventions to ensure people's daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences. One relative told us, "They are very good at letting us know if anything is wrong,

or if the GP has been called."

We found, in the sample of care plans we looked at, that people's choices and preferences had been discussed and recorded in detail. Information about the social interests of people was well recorded. Detailed information was available for each person with a record of their likes and dislikes, which had been collected from people or their relatives, where people could not communicate. This was available to help staff and give them some insight into people's previous interests and hobbies when a person was no longer able to tell staff themselves. A really useful addition to the care plans were "pen pictures" in the front of each person's care plan which contained information relating to people's life history and key areas that were important to that person.

People were able to participate in a variety of activities. We saw that people's routines were flexible and we saw people making choices to have a lie-in or to eat their meals when they chose. There was an orderly calm atmosphere while people chose to read a newspaper, listen to the radio and chatted to staff or visitors. One person said, "We do as we please here." There was an activities list on the wall listing chair aerobics, nail bar, bingo, sing-along, coffee and cake afternoon, dominoes, reminiscence sessions, movie afternoons and afternoon tea. We saw once a month there was a food taster day. There was a quiet room with games and an electric organ which led out onto a patio garden area. This was enclosed and had hard walkways with raised beds and patio furniture for people to use.

There was also an 'Informal activities list' which had assisted walks, hair styling, hand massage, carpet bowls', quizzes and musical afternoons. There were magazines and books around the home. Communal areas had access to televisions but these only went on when requested by people in the home. One person said, "I can't go out on my own now but I have been out two or three times with staff so that's been good." We saw one person asking about getting her mobile phone topped up and arranging to go with the staff the next day.

People said they knew how to complain or raise any concerns. The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the contract they signed when they moved into the home. A record of complaints was maintained and we saw the most recent one had been investigated and resolved appropriately. Several cards of appreciation were also available from relatives expressing thanks to staff for the care provided.

Good

Is the service well-led?

Our findings

People living at Brackenthwaite and their visitors spoke well of the service and how it was managed. No one that we spoke with during the inspection raised any concerns with us. People commented on the "family atmosphere" and people told us that they were "kept up to date" with any issues that might affect their relatives.

The home had a registered manager who became registered for Brackenthwaite in November 2016. They were fully aware of their registration requirements and had ensured that the Care Quality Commission was notified of any events which affected the service. The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary. Notifications are changes, events or incidents the provider is legally obliged to send to the Care Quality Commission within required timescales.

People also said us that the home had a good staff team that worked well together. The people who used this service, who we spoke to, all knew who the registered manager was and told us that she was very accessible. One person told us that the manager was, "Very good and easy to talk to. The manager listens to what I have to say." Relatives also told us the manager was approachable. Their comments included, "There's an open door" and "If I had any problems I'd see the manager."

There were clear values underpinning the service which were focussed on providing high quality person centred care. The registered manager promoted an ethos of involvement and empowerment to keep people who used the service involved in their daily lives and daily decision making. Staff and relatives were also involved and encouraged to give ideas about the running of the home. Staff told us that they felt able to share any concerns openly.

Questionnaires were used to gain the views of people using the service, relatives and visiting professionals. We saw people had responded to the set questions in a positive way. The outcome of the surveys was available. There were also key worker meetings involving the people who used the service, which ensured people's voice was heard.

There were regular staff meetings. We saw from the minutes that these meetings offered an opportunity for staff to share their views and to be updated by the management. Some meetings included updates on specific training areas such as the MCA or safeguarding and staff had been reminded about forthcoming training dates.

Staff spoke of how they felt they had a strong team. Senior staff told us that the registered manager was always available to speak to and talk things through with them. Staff we spoke to said they 'loved' working at Brackenthwaite. Staff we spoke with were also positive about the management and had respect for them. Staff commented, "The manager is approachable" and "There's good management, I'm well supported."

The service had a very strong leadership team who promoted clear values and an open culture. The registered manager demonstrated a good understanding of the importance of effective quality assurance systems in promoting a high quality of service. A quality assurance programme included daily, weekly, monthly and quarterly audits. Monthly audits included checks on health and safety, medicines management, care documentation, training, kitchen audits, accidents and incidents, hand hygiene, first aid and infection control. All audits showed the actions that had been taken as a result of previous audits. The provider's operations manager carried out regular visits to the service to assess the quality of the care provided. This helped the provider to maintain oversight of the home.

Regular analysis of incidents and accidents took place. The registered manager told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of re-occurrence. Records showed where a person had fallen more than twice they were referred to the falls clinic. Staff meeting minutes showed if an incident occurred it was discussed at a staff meeting.

Brackenthwaite worked in partnership with other organisations to make sure they were following current practice and providing a high quality service. For example the organisation had made numerous links with forums and networks that shared best practice in this and other areas, such as the pressure care collaborative and local mental health teams to develop positive ways of managing behaviours that may challenge the service.

Staff were very knowledgeable about the Care Quality Commission's role and the areas that we inspect. We saw that development plans and evidence had been mapped to the Key Lines Of Enquiry (KLOE's). These are characteristics of good practice set out under each of the five key questions we assess: is the service safe, effective, caring, responsive and well-led?