

Tamaris Healthcare (England) Limited

# Brandon Lodge Care Home

## Inspection report

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Date of inspection visit:  
20 February 2017

Date of publication:  
29 March 2017

## 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 inspection took place on 20 February 2017 and was unannounced. This meant the staff and registered provider did not know we would be visiting.

Brandon Lodge Care Home provides care and accommodation for up to 38 people with nursing and residential care needs. On the day of our inspection there were 36 people using the service.

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 2008 and associated Regulations about how the service is run. At the time of our inspection, the registered manager for Brandon Lodge Care Home had recently left the service and the deputy manager was in charge. The deputy manager told us a new manager had been appointed but hadn't started work at the home yet.

We last inspected the service in February 2015 and rated the service as 'Good', however the Safe domain was rated 'Requires improvement' due to insufficient numbers of staff on duty. At this inspection we found the service was 'Good' in all areas and met all the fundamental standards we inspected against.

Accidents and incidents were appropriately recorded and risk assessments were in place. The registered provider had a safeguarding adults policy in place and staff had been trained in safeguarding vulnerable adults.

Appropriate arrangements were in place for the administration and storage of medicines.

The home was clean, spacious and suitable for the people who used the service and appropriate health and safety checks had been carried out.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The registered provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Staff were suitably trained and received regular supervisions and appraisals.

The registered provider was working within the principles of the Mental Capacity Act 2005 (MCA) and was following the requirements in the Deprivation of Liberty Safeguards (DoLS).

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of visits to and from external health care specialists.

People who used the service and family members were complimentary about the standard of care at

Brandon Lodge Care Home.

Staff treated people with dignity and respect and helped to maintain people's independence. Care plans were in place that recorded people's plans and wishes for their end of life care.

Care records showed that people's needs were assessed before they started using the service and care plans were written in a person centred way.

Activities were arranged for people who used the service based on their likes and interests and to help meet their social needs.

The registered provider had an effective complaints procedure in place and people who used the service, family members and staff were regularly consulted about the quality of the service.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service is now Good.

### Is the service effective?

Good ●

The service remains Good.

### Is the service caring?

Good ●

The service remains Good.

### Is the service responsive?

Good ●

The service remains Good.

### Is the service well-led?

Good ●

The service remains Good.

# Brandon Lodge Care Home

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered 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 20 February 2017 and was unannounced. One Adult Social Care inspector and an expert by experience carried out this 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.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. We also contacted Healthwatch. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work. Information provided by these professionals was used to inform the inspection.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to inform our inspection.

During our inspection we spoke with 11 people who used the service and six visitors. We also spoke with the deputy manager, the registered provider's resident experience care specialist, a registered manager from another of the registered provider's locations, the administrator, activities coordinator, maintenance staff, nurse and two care staff.

We looked at the personal care or treatment records of three people who used the service and observed how people were being cared for. We also looked at the personnel files for three members of staff and records relating to the management of the service, such as quality audits, policies and procedures. We also

carried out observations of staff and their interactions with people who used the service.

# Is the service safe?

## Our findings

People we spoke with told us they felt safe at Brandon Lodge Care Home. People told us, "Oh I feel very safe" and "Yes, of course".

The home was on two floors, with a residential unit on the ground floor and a nursing and residential unit on the first floor. Access to the home was via a locked front door and all visitors were required to sign in. Corridors were wide to accommodate wheelchair users and communal areas were spacious. Communal areas, bathrooms, shower rooms and toilets were clean and appropriate hand washing and personal protective equipment (PPE) was in place.

At the previous inspection it was identified that there were insufficient numbers of staff on duty in order to meet the needs of people using the service. At this inspection we discussed staffing levels with the deputy manager, looked at staff rotas and observed staffing throughout the home.

Staffing levels on the first floor nursing and residential unit included one qualified nurse and four care staff for the 25 people who used the service. Staffing levels on the ground floor included one senior care staff member and one care staff member for the 11 people who used the service. We observed staff go about their duties and saw there was a calm and unhurried environment. When call bells rang, they were answered in a timely manner. The service used a care home equation for safe staffing (CHESS) tool. CHESS is a dependency tool used to calculate safe staffing levels. The resident experience care specialist told us this had led to staffing levels being increased in the home.

The deputy manager told us staff absences were covered by the registered provider's bank staff or by permanent staff at the home who were available to work extra shifts. Four members of the care staff were due to go on maternity leave and the registered provider had recruited four new members of staff to cover. Staff, people who used the service and visitors we spoke with did not raise any concerns about staffing levels. This meant there were sufficient numbers of staff on duty to keep people safe.

The registered provider had an effective recruitment and selection procedure in place and carried out relevant security and identification checks when they employed staff to ensure staff were suitable to work with vulnerable people. These included checks with the Disclosure and Barring Service (DBS), two written references and proof of identification. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults.

Accidents and incidents were appropriately recorded and analysed on a monthly basis. Risk assessments were in place for people who used the service. These described potential risks and the safeguards in place to reduce the risk. These included mobility, risk of falls, nutrition and choking. Records we saw were up to date and regularly reviewed. This meant the registered provider had taken seriously any potential risks to people and put in place actions to prevent accidents from occurring.

Hot water temperature checks had been carried out for all rooms and bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) guidance Health and Safety in Care Homes (2014). Window restrictors were checked on a monthly basis and equipment that was in place to meet people's needs, including hoists, shower chairs and wheelchairs, had been regularly checked.

Electrical testing, gas servicing and portable appliance testing (PAT) records were all up to date. Risks to people's safety in the event of a fire had been identified and managed, for example, fire alarm and fire equipment service checks were up to date, and fire drills took place regularly. People who used the service had Personal Emergency Evacuation Plans (PEEPs), which meant appropriate checks and records were in place to protect people in the event of a fire.

The registered provider had a safeguarding adults policy in place, which defined what abuse is, the procedures for staff to follow and information sharing protocols. The deputy manager understood safeguarding procedures, statutory notifications had been submitted to CQC and staff had been trained in how to protect vulnerable people.

We looked at the management of medicines and saw people had 'Drug therapies and medication needs' care plans in place. These described the person's needs with regard to medicines and the expected outcome. The care plans also recorded the person's level of need. For example, were they able to self-medicate, whether they needed some support with their medicines or whether they required staff to administer their medicines.

Medication competency checks were carried out on staff to ensure they were following the correct procedures with regard to the administration and storage of medicines. Records we saw were accurate and up to date and medicines were securely stored in a locked treatment room. We found medicines were appropriately administered and stored.



## Is the service effective?

### Our findings

People who used the service received effective care and support from well trained and well supported staff. People who used the service and family members told us, "We are all very happy", "We are all convinced it is good care she is receiving", "I can call the carers anytime and they come to see me" and "I am very happy here". A visiting healthcare professional told us the care was "good" and they had no concerns.

Staff were supported in their role and received regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. A supervision and appraisal matrix was on the office wall so the deputy manager was aware when supervisions and appraisals were due. One member of staff's appraisal was overdue but the deputy manager was aware and it was planned.

Staff mandatory training was up to date for all but one member of staff. Mandatory training is training that the registered provider thinks is necessary to support people safely. We discussed this with the deputy manager who told us they were aware of the overdue training for one member of staff and it had been booked. New staff completed an induction to the service and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training for new staff working in health and social care.

People who used the service were supported with their dietary needs. People had 'Nutritional needs' care plans and risk assessments in place where appropriate. People's weights and any specialist dietary requirements were recorded. We saw one person was a diabetic and their illness was controlled via their diet. The care plan stated the person was aware of their needs and was to receive a "Well balanced, healthy diet with a good fluid intake." Records showed the person was weighed monthly and a malnutrition universal screening tool (MUST) assessment had been carried out. MUST is a screening tool used to identify whether people are at risk of malnutrition. The MUST identified the person was at low risk of malnutrition. The care plan was reviewed monthly and up to date.

Another person had been referred to the speech and language therapist (SALT) due to being at high risk of choking. The SALT guidelines stated the person was to have a pre-mashed diet, no bread and normal fluids. We saw this guidance was included in the person's MUST and they also had a choking risk assessment in place. This meant staff were aware of the person's dietary needs and the potential risks.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the

principles of the MCA. We found the deputy manager had applied for DoLS where required and was waiting for authorisations from the local authority before submitting the statutory notification to CQC. Mental capacity assessments and best interest decisions had been carried out for people and were regularly reviewed. This meant the registered provider was following the requirements of the MCA and DoLS.

People who used the service had 'Care plan agreement' and 'Photography consent' forms in place. Some of the people who used the service had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form in place, which means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). Records we saw were up to date and showed the person who used the service, family members and relevant healthcare professionals had been involved in the decision making process.

People who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits to and from external specialists including GPs, chiropodists, SALT, dietitians and social workers.

## Is the service caring?

### Our findings

People we saw were well presented and looked comfortable with staff. We saw staff talking to people in a polite and respectful manner and staff interacted with people at every opportunity. People were assisted by staff in a patient and friendly way and we saw and heard how people had a good rapport with staff. For example, we observed lunch in the dining room and saw there were a lot of friendly conversations between people and staff. Staff knew people's preferences, for example, whether they preferred tea or coffee with their lunch.

A family member told us, "I am very happy my mother is being cared for. She has been in other homes for respite but we have chosen this home now. We are very pleased with the care and attention given." A person who used the service told us there were, "Lovely carers here." Another person told us, "I can talk to the carers anytime. They always have time for me, even during the night if I need assistance."

Staff treated people with dignity and respect. At lunch, people were offered protective aprons to protect their clothing whilst eating. We saw staff knocking on bedroom doors and asking permission before entering people's rooms. Staff closed doors before attending to people or carrying out personal care.

Care records described what people could do for themselves and what people needed assistance from staff with. For example, one person required assistance from staff with their personal care and dressing needs. The care plan stated, "[Name] will wash their own hands and face with prompts from the staff, giving step by step instructions." This meant that staff supported people to be independent and people were encouraged to care for themselves where possible.

Care records also described how people were provided with choices and were able to make their own decisions, for example, with what clothes they wanted to wear. One person's care plan stated, "[Name] is very choosy with their clothing. [Name] will choose their own outfits, underwear etc."

Bedrooms were individualised, some with people's own personal possessions. We saw many photographs of relatives and social occasions in people's bedrooms.

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. We discussed advocacy with the deputy manager who told us one of the people using the service at the time of our inspection had an independent advocate.

We discussed end of life care with the deputy manager, who told us none of the people using the service at the time of our inspection were receiving end of life care. We saw blank 'Palliative and end of life needs' care plans were available should people's needs change.

## Is the service responsive?

### Our findings

The service was responsive. We saw that care records were reviewed and evaluated every three months and a full review took place annually.

People's needs were assessed before they started using the service, which ensured staff knew about people's needs before they moved into Brandon Lodge Care Home. Dependency assessments had been carried out for each person who used the service, which identified whether the person had a low, moderate or high area of need. These were reviewed monthly and included consent and capacity, medication, mobility, nutrition, continence, personal care, skin integrity, psychological and emotional needs, and communication.

People's care records were person centred, which means the person was at the centre of decisions made about their care. Care plans were in place for each person who used the service. These described the person's assessed need, what the expected outcomes were and details of the support and care to be provided.

For example, we saw one person had been identified as being at very high risk of pressure damage due to poor mobility. The person's 'Skin integrity / tissue viability needs' care plan described the person relied on care staff for all movements and to check skin integrity. The expected outcome was for staff to carry out care needs to reduce the risk of skin trauma and to use pressure relieving aids and creams as required. The person had a Waterlow assessment in place that was reviewed monthly. Waterlow is used to assess the risk of a person developing a pressure ulcer. The Waterlow identified the person to be at very high risk of pressure damage. We saw the care plan had been reviewed monthly and was up to date.

Daily records were maintained for each person who used the service. Records we saw were up to date and included information on the person's diet, health, personal care, night time checks and sleep patterns, and activities.

We found the registered provider protected people from social isolation. The home employed two activities coordinators. On the day of our visit, one of the activities coordinators from the service was meeting with coordinators from some of the registered provider's other services to share ideas and best practice. The activities coordinator told us this was a monthly meeting and they found it very useful.

We observed people taking part in group exercise activities in the lounge in the morning and playing 'Play your cards right' in the afternoon. There was a four week activities planner on the noticeboard, which included nail painting, bingo, baking, card games, word searches, seated exercises, hymn sing-a-longs, movie afternoons, and arts and crafts.

The registered provider had an effective complaints policy and procedure in place. A copy of the procedure was on display in the entrance foyer. We looked at the complaints log and saw there had been three recorded complaints in the previous 12 months. Complaint records included copies of letters, witness

statements and debrief forms, and had been appropriately resolved. People we spoke with did not have any complaints about the service.

## Is the service well-led?

### Our findings

At the time of our inspection visit, the service had a registered manager, however, the registered manager had recently left the service and the deputy manager was in charge on the day of our inspection. A registered manager is a person who has registered with CQC to manage the service. The deputy manager told us a new manager had been appointed but hadn't started work at the home yet. During our inspection visit, the deputy manager was supported by the registered provider's resident experience care specialist and a registered manager from another of the registered provider's locations.

We saw that records were kept securely and could be located when needed. This meant only care and management staff had access to them ensuring people's personal information could only be viewed by those who were authorised to look at records.

The service had a positive culture that was person centred, open and inclusive. Staff we spoke with felt supported by the management team. Staff meetings took place regularly, where staff were given the opportunity to discuss any issues and were kept up to date with information about the home and the registered provider.

We looked at what the registered provider did to check the quality of the service, and to seek people's views about it.

Audits of care records were carried out monthly and checked care plans, risk assessments, dependency, consent and daily notes. Actions were put in place for any identified issues. A senior member of staff conducted a home walkabout on a daily basis and recorded their findings on an electronic tablet.

Quarterly residents' and relatives' meetings took place. An electronic tablet was available in the entrance to the home and people and visitors were encouraged to use the tablet to provide feedback on the quality of the service. Feedback from people who used the service was obtained at the end of each activity session and also on an informal basis, and recorded on one of the electronic tablets. All the information provided was collated by the registered provider and fed back to the home.

Visitors were asked to provide feedback by using the home's iPad in the foyer. A 'Questionnaire, suggestions and comments feedback board' was on the ground floor corridor wall. This provided an example of feedback the home had received about the mealtime experience and what the home had done about it. For example, the service had changed the menu to include the dishes people preferred, made it clearer to people what the options were at mealtimes and purchased some new coloured crockery.

This demonstrated that the registered provider gathered information about the quality of their service from a variety of sources.

The service had made links with the local community. The deputy manager told us people who used the service attended events at the local community centre, a church service took place monthly and local

school children visited the home at Easter, Christmas and harvest festival. Durham Cathedral choir service also visited the home.

The registered provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.