Care Quality Commission

Mrs H M Vincent and Mr B W Vincent

Burger Court Nursing Home

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**

Overall summary

Burger Court provides accommodation for up to 17 people at any one time. The inspection was unannounced. On the date of the inspection, 2nd December 2014, 10 people were living in the service.

A registered manager was 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 and associated Regulations about how the service is run.

We found the registered provider had systems in place to protect people against risks associated with the management of medicines; appropriate arrangements for the recording, safe administration, safe keeping, using and disposal of medicines were in place.

Staff we spoke with understood their responsibilities under the Mental Capacity Act 2005 (MCA), for example how to ensure the rights of people with limited mental capacity when making decisions were respected. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Summary of findings

People told us care was really good at the home and they were treated well by staff and the management team. We observed staff were kind and caring and demonstrated a good understanding of people's individual needs.

Arrangements were in place to assess people's healthcare needs and care plans were in place for staff to follow to help them meet these needs. There was regular input from a range of health professionals.

Care plans were regularly reviewed to ensure they met people's individual needs. People and /or their relatives were involved in care plan reviews and it was evident their comments in relation to care and support were recorded and acted on.

People spoke positively about the food.

People's feedback was sought and acted upon. Staff and people who used the service told us the new registered manager had made positive changes.

Audits were in place to regularly monitor that the home was meeting the required standards. These included cleaning, medication and care plans.

Incidents were reviewed to ensure learning was shared to either prevent a reoccurrence or to ensure staff were clear of the actions they should take in the future.

Summary of findings

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. Staff were knowledgeable in recognising signs of potential abuse and the reporting procedures to the local authority.

Risk assessments were undertaken to establish any risks present for people who used the service, which helped to protect them.

There were sufficient numbers of staff deployed to ensure that people had their needs met in a timely way. The recruitment practices were robust to ensure staff were matched to people using the service.

Is the service effective?

Good

The service was effective. Appropriate arrangements were in place to provide staff with a range of training and support.

People's capacity had been assessed under the Mental Capacity Act 2005, and documentation demonstrating the processes followed was clear.

People's healthcare needs were assessed in order for staff to provide appropriate care. Arrangements were in place for people to access a range of healthcare services.

Is the service caring?

Good

The service was caring. People told us staff and management were kind and compassionate to them and treated them well. This was confirmed by the observations we saw on the day of the inspection.

Detailed information on people's preferences was recorded in people's care plans indicating staff had taken the time to understand people and their individual needs.

Mechanisms were in place to listen to people. For example, individual rehabilitation programmes had been developed with the involvement of people who used the service and they were involved in regular care plan review and their comments recorded.

Is the service responsive?

Good

The service was responsive. People's needs were assessed in a number of areas to allow staff to deliver appropriate care. Assessments were regularly updated to ensure they were responsive to people's changing needs.

People and/or their relatives were involved in care plan reviews and it was evident their comments in relation to their care were recorded and respected.

Is the service well-led?

Good

The service was well led. A new registered manager was in place and staff spoke positively about them and the changes they had implemented.

People were involved in the running of the service through periodic meetings and their views on the standard of the home was regularly sought.

Staff in the home were aware of their and roles and responsibilities.

Summary of findings

We found there was a friendly welcoming atmosphere to the home.

Burger Court 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, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 3 December 2014 and was unannounced. The inspection team consisted of two adult social care inspectors.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with people who used the service, care workers, and the registered manager. We spent time observing care and support being delivered. We looked at three people's care records and other records which related to the management of the service such as training records and policies and procedures.

Before the inspection, we reviewed all the information held about the provider.

Good

Is the service safe?

Our findings

People told us that they were happy and felt safe at the service. One person said, "It's great here, they are helping me get back to my own flat." Another person said, "Yes, I feel safe here."

We spoke with both trained nursing staff and support workers who demonstrated a good understanding of protecting vulnerable adults. They told us they were aware of how to detect signs of abuse and were aware of external agencies they could contact. They told us they knew how to contact the local safeguarding authority and the Care Quality Commission (CQC) if they had any concerns. They also told us they were aware of the whistle blowing policy and felt able to raise any concerns with the manager knowing that they would be taken seriously. One support worker had recently made a safeguarding referral thus demonstrating the provider's policies and training was being translated into effective care.

Risks assessments were carried out across a range of identified issues. These included the risk of suicide, absconding, violence and aggression, arson and sexual exploitation. Against each identified risk was a contingency plan designed to mitigate risk; for example, a ligature knife in a locked cabinet in the staff office. We saw the risk assessments were a topic of continual review.

The service carried out regular fire drills to ensure people and staff knew how to respond to the fire alarm and each person had a personal emergency evacuation plan. The fire alarm system was appropriately maintained.

We completed a tour of the premises as part of our inspection. We inspected two people's bedrooms, bath and shower rooms, the laundry and various communal living spaces. We took the temperature of water from taps in areas where people who used the service had access. We found the water temperatures were within an acceptable range. All radiators in the home were covered to protect vulnerable people from the risk of injury. We saw fire-fighting equipment was available and emergency lighting was in place. During our inspection we found all fire escapes were kept clear of obstructions. We saw that upstairs windows all had opening restrictors in place to comply with the Health and Safety Executive guidance in relation to falls from windows. We inspected records of the lift, gas safety, electrical installations, water quality, pest control and fire detection systems and found all to be correctly inspected by a competent person.

We saw that Control of Substances Hazardous to Health Regulations 2002 (COSHH) assessments had taken place to prevent or control exposure to hazardous substances. All cleaning materials and disinfectants were kept in a locked room out of reach.

Whilst medicines were administered to people by trained nursing and care staff, one person at the home had been found to have the capacity to self-medicate and was doing so. Staff had carried out an individual risk assessment to find out how much support the person needed to carry on taking and looking after their medicines themselves (self-administration). We saw that the self-medication was subject to regular audit to ensure compliance. We spoke with the person concerned who demonstrated a good knowledge of their medicines and told us they willingly participated in the regular checks on compliance.

We found medicine trolleys and storage cupboards were secure, clean and well organised. We saw that the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The treatment room was locked when not in use. Drug refrigerator and room temperatures were checked and recorded to ensure that medicines were being stored at the required temperatures. Most medication was administered via a monitored dosage system supplied directly from a pharmacy. The staff maintained records for medication which was not taken and the reasons why, for example, if the person had refused to take it, or had dropped it on the floor. A record was kept to show medicines which had been destroyed.

We looked at medication charts and reviewed records for the receipt, administration and disposal of medicines. We could not conduct a sample audit of medicines to check their quantity because the dispensed amounts of individual medicines had not been recorded. The registered nurse told us the matter would be attended to. We found medication administration records (MAR) were complete and people had received the medication they had been prescribed.

Good

Is the service safe?

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. Whilst no such medicines were currently in use the home had the necessary storage facilities available.

Creams and ointments were prescribed and dispensed on an individual basis. The creams and ointments were properly stored and dated upon opening. All medication was found to be in date.

The MAR sheets identified a record of any allergies.

Arrangements for the administration of PRN (when needed) medicines protected people from the unnecessary use of medicines. We looked at prescription sheets and care records to ascertain the frequency of use of, as necessary (PRN), antipsychotic medication to control behavioural. In discussion with nursing staff and the scrutiny of the MAR sheets we were assured that non-pharmacological interventions were the preferred method of addressing untoward behaviour.

We saw that the provider was employing effective staff recruitment and selection systems. We saw there was a clear process which ensured appropriate checks were carried out before staff began work. We saw from records the provider had a robust system to ensure all registered nurses had a current Pin number issued by the Nursing and Midwifery Council (NMC) to signify they were entitled to work.

We examined staffing rotas to determine if there was adequate staffing provision to meet the needs of people. Our analysis of people's needs indicated that sufficient staff were available to meet people's needs. Where deterioration in people's mental health occurred further staff were brought in to meet the need. Staff with whom we spoke confirmed this to be the case.

Good

Is the service effective?

Our findings

People were supported by staff with the knowledge and skills they required to carry out their role. Staff told us they had access to good quality training and education. On the day of our inspection eight staff were taking part in a training day on the management of violence and aggression.

We scrutinised the year's programme for planned training. This showed mandatory training in the areas of first-aid, safeguarding, health and safety and manual handling was up-to-date.

Our discussion with staff showed they had the skills, knowledge and experience to deliver effective care. We checked records of staff training and supervision which showed staff were being supervised and had participated in yearly appraisals.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We were told that one person using the service was subject to authorised deprivation of liberty. Our scrutiny of people's care records demonstrated that all relevant documentation was securely and clearly filed. Furthermore we saw that all conditions imposed within the authorisation were adhered to, for example the need for close supervision whilst in a community setting.

Staff had received training in the Mental Capacity Act 2005 (MCA) and DoLS and could demonstrate a good and competent understanding of the legal frameworks. Staff were able to give examples of instances when Best Interest Decisions had been made with the involvement of relevant professionals.

We spoke with one member of staff about the use of restraint. They were able to describe de-escalation techniques which meant that physical restrain was rarely used in the home. They described to us the value of providing a stimulating environment and effective communication to prevent behaviour that may be of risk to individuals.

We looked at the provider's restraint policy. The policy conformed to the requirements of the MCA and the Mental Health Act 1983 Code of Practice. We looked in detail of one occasion recently when physical restraint was required to prevent injury to an individual and potential injury to other people receiving care. We saw that the provider's policy had been strictly adhered to. The restrain was an action of last resort and had been of a nature which demonstrated a minimum physical response had been used for the shortest possible time. The incident was recorded in the persons care plan and on a separate incident form. We saw that the manager had been made aware of the matter at the earliest opportunity. We saw from care records that the person subject to restraint had been subsequently spoken with to observe for signs of injury or any emotional or psychological impact.

We spoke with staff about the role of Independent Mental Capacity Advocates (IMCA) as defined in the Mental Capacity Act 2005 (MCA). The answers we received demonstrated a good understanding.

The service supported people to have sufficient food to eat and liquids to drink. The preparation of food was part of the rehabilitation process to help people be self-sufficient in their own accommodation. We saw staff monitored food intake and where necessary monitored people's weight.

Records showed that arrangements were in place that made sure people's health needs were met. We saw evidence that staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. This had included GP's, hospital consultants, community mental health nurses, social workers, specialists in learning disorders and dentists.

Many people at the home were diagnosed with a severe mental disorder, were at risk of self-harm, may tend to neglect themselves and had a history of having being detained under the Mental Health Act 1983. As such people's care was coordinated under a Care Programme Approach (CPA). This approach ensures a multidisciplinary involvement in assessing, planning and reviewing people's mental health care needs. We saw that CPA meetings took place at the home with all relevant health and social care professional in attendance.

Good

Is the service caring?

Our findings

One person said, “Staff are really good here. I have a plan to live on my own in my own flat. Without the staff to help me I would not make it. They teach me to do my own washing and ironing.”

We observed staff and people in communal areas and noted there to be a calm and settled atmosphere. This helped people who had identified problems with anxiety which could result in aggressive and disruptive behaviours. Staff spoke quietly and gave encouragement for people to participate in conversations.

Staff demonstrated a very good knowledge of people’s needs, preferences and past clinical histories. This knowledge was used continually to foster an environment which was conducive to people’s rehabilitation needs. The home did not employ domestic cleaning, catering of laundry staff. These tasks were undertaken by people as part of their rehabilitation programme. A person we spoke with enjoyed participating in laundry tasks and knew of the need to develop their skills to enable them to live independently.

We saw that a therapeutic environment existed with all people participating in a rehabilitation programme. The programme along with general care plans had been constructed with the involvement of the person concerned. We saw that people were able to influence their care and on some occasions decline to participate in a particular therapy. For instance we saw that one person had made an appointment with their GP or a particular problem. Whilst staff had encouraged the person to attend the appointment the appointment had been cancelled. This demonstrated that people were involved in the decision making process and their decisions were respected even when it may not be wise to do so.

We saw that a person had been appointed with an Independent Mental Capacity Advocate (IMCA) as defined in the Mental Capacity Act 2005 (MCA). Whilst we did not speak with the person about the appointment it was clear the appointment was relevant as they had no-one who could be appropriately consulted when making a decision and they did not have the mental capacity to make decisions alone.

During our inspection tour of the property we noted that staff knocked on doors before entering people’s rooms, thus demonstrating staff respected people’s need for privacy.

We were told that the provision of care at the service was developed around the individual choices of people living at the home. This included choices around how people liked to have their bedrooms and the communal areas. We saw evidence of personalised bedrooms and Christmas decorations people had chosen for the communal areas. People that we spoke with confirmed that they were offered the opportunity to personalise their bedrooms.

Care plans and daily records of care given demonstrated known circumstances which triggered bouts of anxiety or challenging behaviours were well documented. Annotations in care plans showed that practical interventions were carried out by staff to ensure people were not distressed or subject to stressors which would have a detrimental effect on people’s mental health.

Good

Is the service responsive?

Our findings

People who used the service said they had individual choice at the home and their choices were respected. Comments included; “I am planning to leave here after Christmas”, “I can have anything in my room; I have a television and I like to play computer games” and “I need to learn to do my own cooking so I can have a flat of my own and the staff are helping me with that.”

The care plans contained relevant risk assessments for each person and focussed on people as an individual. People were assessed before they came to live at the service. The assessment along with other admission information provided the basis for planning care and treatment for people. People were involved in the process and consequently, care plans and associated risk assessments reflected their needs and preferences. If appropriate there were contributions from relatives.

We looked at three care plans which had been developed for each person. They were person centred, with individual information on people's wishes in relation to how their care was provided. The care plans showed how people liked to spend their time and how they liked to be supported. The care plan was targeted towards rehabilitating the person to enable them to live an independent life in the community supported, where necessary, by Assertive Outreach Teams (AOT’s) or the Community Mental Health Teams. The care plan recognised the need to build long term relationships with health care professional such as the AOT’s to minimise the need for in-patient mental health care.

We saw evidence of active involvement in care planning by visiting health care professionals such as community psychiatric nurses.

A large part of the care plan was dedicated to equipping people with daily living and social skills. The plan included, building relationships, household skills, self-medication, health awareness, cooking, laundry, leisure pursuits, shopping and road safety. Each element of the plan was scored from one to five with one being dependent and 5 being independent. This scoring system was updated monthly or whenever improvements were noted thus allowing progress to be objectively measured over time.

We saw that care plans related in some instances to the known difficulties people had with personal functioning and relating to people. Some had cognitive impairments that made it hard for people to plan ahead whilst other were vulnerable to exploitation. Care plans demonstrated how to address the challenges whilst recognising the person’s own wishes and ambitions.

We spoke with one person who had benefitted from their own bespoke rehabilitation programme. They were aware of the need for healthy eating referring to their weight gain and subsequent weight loss. The person knew of their rehabilitation plan goals and knew what they had to achieve in the short-term. The person was happy and content and looked forward to their future away from the home. The environment at Burger Court had provided the person with a structured environment and a therapeutic programme of support.

People participated in activities and pursuits as they chose. We saw that one room was equipped with a computer which was freely available for all to use. Others had a great interest in various sports and staff gave encouragement for people to become involved.

Good

Is the service well-led?

Our findings

Members of staff spoke positively about the manager of the service and the changes that had taken place since their arrival.

We noted from our records that the manager was submitting statutory notifications as required and was aware of their responsibilities.

Audits were regularly undertaken to assess and monitor the quality of the service. We saw evidence of daily and monthly audits carried out by both staff and the manager. For instance we saw the newly appointed registered nurse had instituted a thorough audit process to ensure medicines were appropriately administered and robustly accounted for. We saw the audit process recorded where issues had been identified and how they could be prevented in the future. This approach demonstrated a reflective approach to care designed to continually seek for improved quality.

We saw the outcome of a recent internal audit of infection control and prevention which recorded complete compliance.

We saw much evidence of the service working in partnership with the local mental health services to ensure people who had a history of poor mental health could be rehabilitated back into a community setting. The partnership working was designed to ensure the transition of people back into the community could be made seamlessly.

Staff meetings were held to provide an opportunity for open communication. Staff told us they were encouraged and supported to question practice. Our scrutiny of the staff meeting of the 24 October 2014 demonstrated an open and transparent culture existed at the home. Subject covered ranged from an improvement to communications to ideas for better supporting people whilst out in the community.

Service user meeting were held every week however a comment in the last minutes indicated service users would prefer a monthly meeting. Items discussed at the meeting demonstrated the rehabilitative nature of the service. Service users commented on the lack of cleaning in some areas and identified the need for them to be more thorough with their duties.

We looked at the incidents and untoward occurrences register. The information was clearly recorded. Each incident was given a unique number, the nature of the incident was described and actions taken at the time of the incident. The record subsequently detailed any need to report matters to external bodies such as safeguarding, the Care Quality Commission or police. Following closure of the incident we saw the matter was subject to further analysis and any learning points recorded.

We looked at staff supervision records to track certain incidents which showed matters were discussed in supervision meetings.