HC-One Limited

Burnham House

Inspection report

Burlington Road
Slough
Berkshire
SL1 2LD

Tel: 01753517789
Website: www.hc-one.co.uk/homes/burnham-house/

Date of inspection visit:
10 March 2016
11 March 2016

Date of publication:
13 June 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Burnham House provides nursing care and support for up to 72 older people, some of whom may be living with dementia. On the day of our visit there were 26 people living in the service.

Since our last visit in April 2015 we found the service had made significant improvements.

The service acted in accordance with some aspects of the Mental Capacity Act 2005 (MCA). Mental capacity assessments were undertaken for people who lacked capacity to make specific decisions. Care records showed the service sought consent from people who were not able to make specific decisions in line with legislation.

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 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 and whether any conditions on authorisations to deprive a person of their liberty were being met We found conditions on authorisations to deprive people of their liberty were not being met.

We recommend that the service seek advice and guidance from current legislation in relation to adhering to conditions in DoLS.

There were no calendars to orientate people living with dementia of the date and time.

People and relatives were kept safe from abuse because staff had attended relevant training and knew what to do if they suspected abuse had occurred. Risk assessments clearly outlined potential risks and risk management plans showed what staff should do to minimise those risks. Call bells were responded to in a prompt manner.

We observed there were sufficient numbers of staff to provide care and support to people; this was supported by our review of staff rosters. We noted staffing levels were regularly reviewed to ensure there was enough staff to meet people's needs.

People received care and support from staff who received appropriate induction; training supervision and appraisal. This was supported by our reviews of staff records and what staff had told us. Staff demonstrated an understanding of how to work with people who were unable to make specific decisions.

People's meal times were given at the appropriate times and they were supported to have enough to eat and drink. This was supported by care records which showed people's nutritional and hydration needs were being met.

Admission assessments ensured the service captured essential information about people in order to establish what their care and support needs were. People said staff were responsive to their needs and their social needs were met. People and their relatives knew how to raise concerns and the complaints log evidenced all complaints received were responded to appropriately.

People and their relatives expressed happiness with the service but had concerns about the frequent changes in registered managers. They said they were kept up to date with changes in the service and were able to provide feedback. Quality assurance systems were in place to improve the welfare and safety of people who used 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 was safe.

People and relatives were kept safe from abuse because staff had attended relevant training and knew what to do if they suspected abuse had occurred.

Risk assessments clearly outlined potential risks and risk management plans showed what staff should do to minimise those risks.

Call bells were responded to in a prompt manner.

Is the service effective?

Requires Improvement

There were aspects of the service that were ineffective.

Conditions placed DoLS were not always being met by the service. This meant the service was not meeting the requirements of the MCA.

People received care and support from staff who received appropriate induction; training supervision and appraisal.

People's nutritional and hydration needs were being met.

Is the service caring?

Good

The service was caring.

People said staff were caring, compassionate and polite.

People and relatives said they were involved and supported in planning and making decisions about their care.

People and their relatives said staff promoted their independence and supported them to make choices.

Is the service responsive?

Good

The service was responsive.

Admissions assessments ensured people received care that was responsive to their individual needs.

People and their relatives knew how to raise concerns and the complaints register showed complaints received were responded to appropriately.

People said the service met their social needs.

Is the service well-led?

Good

The service was well-led

People expressed happiness with the service but did raise concerns about the frequent changes in registered managers.

People said they were kept up to date with changes in the service and were able to provide feedback.

Quality assurance systems were in place to improve the quality and safety of people who used the service.

Burnham House

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 checked 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 was an unannounced inspection which took place on 10 & 11 March 2016. The inspection team consisted of an inspector and a specialist advisor on the care of the elderly and dementia care.

Before the inspection we reviewed all the information we held about the service. We looked at notifications the provider was legally required to send us. Notifications are information about certain incidents, events and changes that affect a service or the people using it.

On this visit we did not request 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 were unable to speak at length to some of the people who used the service, due to their capacity to understand. We used 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 talk to us.

During our visit we received feedback from a paid representative under the Deprivation of Liberty Safeguards (DoLS). This person was assigned by the local authority to be the relevant person for a person who was subject to DoLS but had no family or friends to represent them.

We spoke with five people, four relatives of people who used the service; registered manager, interim manager; one registered nurse, four care workers; an activity co-ordinator and maintenance worker. We looked at five care records; five staff records and records relating to the management of the service.

Good

Is the service safe?

Our findings

At our previous inspection on the 6 and 7 April 2015 we found staffing levels did not meet the needs of people living on the first floor dementia units; the dependency tool used to assess if staffing levels met people's needs was not regularly reviewed; there no systems to monitor the response times when call bells were pressed. We served a requirement action in respect of a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this visit we found the service had moved all the people who lived on the first floor dementia unit to the ground floor. This was because there were 26 people who lived in the service and management thought staff would be able to safely manage their care needs if everyone was situated on the same level. We reviewed staff rotas and saw there was sufficient staff to provide care, treatment and support to people. We noted staff dependency levels were regularly reviewed to ensure staffing levels met people's dependency needs.

People received safe care because staff responded to call bells promptly and calls bells were regularly checked. We observed all staff wore pagers which enabled them to know which call bell had been pressed and respond accordingly. Most of the people we spoke with said their call bells were answered in a 'timely manner'. We pressed a call bell whilst visiting a person in their room, a staff member responded to it within 10 seconds. However, one person complained that on a particular day when they had suffered from chest pains, 'the call bell took over an hour to be responded to'. We noted this incident had been reported to registered manager and appropriate action was taken.

The registered manager informed us they had instructed the maintenance worker to carry out daily checks to ensure call bells were in working order. This was confirmed by the maintenance worker who stated, "I check the maintenance book when I arrive in the morning to see what work needs to be done. I carry out a daily walk around and check call bells and sensory mats to ensure they are in working order."

People had individual risk assessments which showed potential risks and what action staff should take to minimise them. These covered areas such as risk of pressure sores; falls; malnutrition or dehydration. The majority of the risk assessments were up to date and regularly reviewed however, we found two people's risk assessments were either partially completed or not regularly reviewed. We spoke with the registered manager about this who told us they were in the process of auditing care records and had not as yet reviewed the care records in question.

People and their relatives told us the service was safe. Comments included, "I think it is", "If I had any concerns I would certainly raise it with the manager. I don't worry about X (family member) at all when I am leaving the home" and "From what we have seen, it is safe. We feel we don't need to worry." During our visit we observed no unsafe care practices.

People were safe because staff understood what they should do to keep people safe from abuse. Staff were knowledgeable and explained safeguarding procedures and what they would do if they felt issues were not

being dealt with. Their discussions about how to keep people safe from abuse was found to be in line with the service's safeguarding adult's policy and procedures. A review of the staff training matrix and staff's training records showed they had undertaken the relevant training to ensure people were kept safe from abuse.

Safer recruitment practices and procedures were consistently being carried out to ensure people were protected from unsuitable staff. We noted job application forms were fully completed and showed explanations for gaps in employment; essential checks to ensure potential candidates had no criminal convictions were undertaken; references were sought and obtained and medical health questionnaires to ensure potential candidates capability to work were fully completed.

People received their medicines in a safe manner. Relatives stated their family members received their medicines promptly and regularly. Comments included, "X gets their medicines regularly, I've seen them come along with a trolley" and "X has just started on new medicines and they are given promptly." We noted protocols for the administration of 'as required' medicines and topical medicines (for example, creams and ointments) were followed consistently. Medicines were stored and administered correctly. We observed a registered nurse whilst they administered medicines. We saw each person's medicines were stored in a box and placed in a medicine trolley. After all medicines were administered the trolley was then locked away in the clinical room. We noted care records contained people's medical histories and allergies.

Personal emergency evacuation plans were in place for people. We noted the minutes of a meeting held with night staff in November 2015 which discussed procedures staff should follow in the event of a fire. This ensured people could be safely evacuated from the building in the event of an emergency.

People were kept safe from infection because staff ensured they used the appropriate personal protection equipment (PPE) and followed correct infection control procedures. This was observed during our visit. People and their relatives were very complimentary about the cleanliness of the service. Comments included, "I find it is very well kept", "It's beautiful now" and "I am so pleased with it."

Requires Improvement

Is the service effective?

Our findings

We checked the provider's compliance with the Deprivation of Liberty Safeguards (DoLS). We found the registered manager had submitted DoLS applications appropriately to the local authority.

However, where the 'supervisory bodies' placed additional conditions in DoLS these were not always followed. We spoke to a paid representative for one person who was under a DoLS, they said there had been some issues as staff were not following the conditions outlined in the person's DoLS. We reviewed the person's DoLS and spoke to the registered manager who explained they had not been aware of the conditions. This meant the legal requirements of the MCA were not always being met.

We recommend that the service seek advice and guidance from current legislation in relation to adhering to conditions in DoLS.

Changes to people's care needs recorded in care plans were sometimes difficult to follow as there appeared to be some notes that were disorganised in terms of chronology however they were factual. Staff said they would verbally communicate any changes in people's circumstance which enabled them to respond in a timely manner.

We observed there were no calendars to orientate people of the date and time. One relative commented, "They (people who live in the service) need a calendar to tell them what day or time it is. X (family member) keeps asking what day is it."

People and their relatives felt staff were experienced and skilled to provide care and support. Comments included, "I am not experienced with care homes but staff seem to be experienced", "From what I can see they are experienced. For instance, if X (family member) needs the bathroom out comes the hoist and ample staff to support them", "Yes, I think staff are skilled and able to do their jobs" and "Staff are very on the ball."

Staff received appropriate supervision and appraisal to ensure they were able to meet people's individual needs. Staff files showed supervisions were undertaken in line with the service's supervision policy; new staff members (including agency staff) received an induction into the service and on-going support and training was planned and delivered accordingly. Appraisals evidenced discussions held in regards to staff member's personal development.

The service acted in accordance with some aspects of the Mental Capacity Act 2005 (MCA). Mental capacity assessments were undertaken for people who lacked capacity to make specific decisions. Staff demonstrated an understanding of the MCA and how it related to their job roles.

Care records showed consent was sought and how decisions were made for people who could not make specific decisions. We saw the signatures of people or those who represented them who had consented for their photographs to be taken or for bedrails to be used.

Arrangements were in place for people to have a healthy and nutritious diet. The menu of the day was clearly visible with a selection of foods which provided people with well balanced meals. People were observed eating their meals in a relaxed environment. Staff were not rushed and spent time interacting and supporting people with their meals. Staff showed patience towards an individual who accepted several alternative foods on offer then refused to eat when the food was presented. The person eventually was satisfied with a meal of their choice. The chef was available throughout the lunch time period and they interacted with people and checked to see if they were happy with the meals provided.

People were offered drinks and snacks throughout the day. A drinks dispenser with a selection of juices which people could dispense at any time during the day. This ensured people were adequately hydrated.

Care records captured people's nutritional needs. Nutritional screening assessments undertaken gave staff specific instructions on how to ensure people's nutritional and hydration needs were met. Food and fluid intake charts reviewed were up to date, these records were regularly reviewed and up to date.

A certificate was displayed which showed the service had been given the highest rating for food and hygiene by the local authority. This meant the service's standards for food and hygiene was very good.

People had access to healthcare services and appropriate referrals were made when there were changes to people's needs. For instance, we reviewed the care record for a person who kept having falls. We saw a referral was made to the relevant health professional.

Good

Is the service caring?

Our findings

People and relatives said they were very happy with the care provided. We heard comments such as, "Staff are very caring here, there's always someone here talk to X (family member)", "I think they (staff) are very caring and know X (family member) well", "They (staff) treat X like an elderly relative, and tell us that they love to see X smile because X has a lovely smile."

People told us they were treated with kindness, compassion and dignity. One person commented, "I receive good care here. I like it. The staff comes when I call and are professional and compassionate."

There was a calm and relaxed atmosphere throughout visit. We observed positive and caring relationships between the people and the staff who supported them. Staff sat in the lounge and had jovial conversations with people and were heard communicating respectfully and in a way that people could understand. Staff were attentive to people's needs and supported people in a way that maintained their privacy and dignity.

Positive caring relationships were developed between people and staff who provided care, treatment and support to them. This was because staff had a good knowledge of people's care needs. What staff told us was supported by what was written in people's care records. For instance, one staff member told us about the care needs of one person which included how they liked care to be delivered. The person's relative supported what the staff member had said.

People and relatives said they were involved and supported in planning and making decisions about their care. Comments from relatives included, "My sister is more involved in meetings concerning X's care", "They (staff) will contact my family and provide updates. Yes, we do feel involved" and "Always, we are always included and informed when something needs to be done." People told us their care was 'somewhat 'discussed with them, in detail, and their agreement was sought verbally about the input they would like from staff. This was evidenced in care records reviewed.

People said staff promoted their independence and supported them to exercise choice. People said they were able to be independent and gave examples such as being able to do their own personal care. We heard staff giving people options and choices for example, if they wanted to go into the lounge or to their rooms; take part in activities and given a choice of meals on offer.

People could be confident they would be supported at the end of their lives. Care records showed end of life decisions that was discussed with people and their family members. This ensured staff aware of people's end of life wishes. Do not attempt to resuscitate (DNR) forms were clearly visible in the care records they were applicable to. DNRs were forms completed by a doctor that instructed the service not to carry out cardiopulmonary resuscitation (CPR) if a person's breathing stops or their heart stops beating. We noted where possible people or their family members signed to confirm their involvement in this decision. Training records showed staff had undertaken the relevant training.

Good

Is the service responsive?

Our findings

People's care needs were assessed prior to them receiving care. This information was captured on 'Admission assessments' and gave a comprehensive picture that recorded people's past medical history and current care and support needs. These covered areas such as health, physical and social needs and helped the service to assess whether it could effectively meet those needs.

The service was able to provide care, treatment and support that was responsive to people's individual needs. Social and psychological care assessments captured people's personal histories; family histories; present circumstances and religious and cultural needs. These also captured people's personal preferences and choices and hobbies and interests.

Reviews of care gave people and their family members the opportunity be involved and they were able to give input into how care was being delivered. We heard various comments from relatives such as, "They do happen, my sister attends most meetings", "Yes, care reviews do happen. I am very involved" and "I have attended care reviews. We are always included and informed when something has to be done." This was supported by care records which showed copies of invitation letters sent to out to relatives inviting them to attend six monthly care review meetings and detailed notes of meetings signed and dated by people, their representatives, staff and any other health professionals present.

People were supported to take part in social activities. We found significant improvement had been made in this area. We spoke to the activity co-ordinator who had a range of activities planned and had completed specific training on activities in a care home setting. We observed their interaction with people was kind compassionate and caring. People were happy and relaxed in response to their approach. There was a good programme of internal and external activities in place, and there was linking with external agencies such as the local library who visited the service on a regular basis.

A relative provided positive feedback after seeing their family member outside of their room enjoying the sunshine and participating in "Great entertainment". The person spoke specifically about their appreciation of the activity co-ordinator.

The service ensured the social needs of people who chose not to participate in group activities or who were restricted to their rooms were met. For instance, one relative gave an example of how the activity co-ordinator responded to their family member who preferred to remain in their room. They commented, "X does like to stay in their room but they (staff) try to get him involved in activities. X loves music so the activity co-ordinator got a CD player for him to play his music. This made such a difference."

People and their relatives said staff were responsive to their needs. For instance, a relative talked to us about how the service organised one to one care for their family member who was prone to falls.

People received consistent co-ordinated, person centred care when they moved between different services. We observed a person who was moving out of the service on the second day of our visit. We saw

comprehensive details which included, on-going referrals made to other health professionals; information relating to on-going health issues and the health professional involved in the person's care; medical history and current prescriptions. The transfer form was fully completed and outlined the person's next of kin details; religious and cultural needs; dietary and fluid preferences and requirements; degree of dependency and GP details. This ensured the person would receive continuity of care.

People and their relatives said they knew how to raise a complaint and felt comfortable to do so if needed. Comments included, "I would speak with the manager or the administrator" and "Yes, I know what to do but I have no concerns". The service's complaints policy and procedure was visibly displayed and outlined what people should to and who they should contact if they wanted to make a complaint. A review of the complaints register showed the service responded to complaints appropriately and to the complainant's satisfaction.

Good

Is the service well-led?

Our findings

At our previous inspection on the 6 and 7 April 2015 we found we found the staffing tool used to assess whether there were sufficient staff to support the needs of people on the first floor was not reviewed regularly. We found there were no formal structured monitoring systems in place to see how staff responded to call bells and no evidence of action taken against staff who failed to respond in a prompt manner. The home had three registered managers within the previous 10 months.

During this visit we found further improvements had been made. The staffing tool used to assess level of staffing to meet people's dependency needs was in place and regularly reviewed. Formal systems were in place to monitor staff responses to call bells and action was taken when they did not respond in a timely manner.

Before our visit we were informed that the registered manager of the service was leaving. The constant change in registered managers presented a cause of concern for people and relatives. When we asked people and their relatives if they thought the service was well led we heard comments such as, "It's difficult to say because there are so many changes in managers" and "My main concern is the changes in managers. Relatives see such a difference in standards of care when a manager leaves." During our visit we met the new manager who had made an application to register with the Care Quality Commission (CQC).

People and relatives felt management kept them informed about changes in the service. We heard comments such as, "We get letters if there are changes in the home, they informed us when they decided to move everyone from the first floor to the ground floor", "They (staff) do ring and keep us updated of any changes" and "We get newsletters to tell us what's happening." This was supported by our review of the first edition of the 'Burnham House Newsletter' dated September 2015, which updated people on the change of registered manager and refurbishment of the service.

Staff team meetings occurred on a regular basis. This was supported by review of minutes of meeting. We noted discussions held quality standards in the service and how staff were to achieve this. The service recognised the work of staff with 'Kindness in Care' certificates being awarded. These were given to staff who were nominated by their peers. For instance, two staff members were awarded outstanding contribution towards promoting activities to people.

Quality assurance systems were in place was in place to improve the quality and safety of people who used the service. This included various audits such, infection control audits, care plan audits, medicine audits: health and safety audits and the monitoring of responses to call bells. These noted areas of concerns, what actions were required and the dates they were to actioned by.

The service sought feedback from people and their relatives. Relatives meetings recorded people giving suggestions to improve the service. For instance, we noted suggestions for the service to communicate with relatives via electronic mail. The registered manager stated this has now commenced.

People sent thank you correspondence to the home. Comments included, "My uncle is very happy at Burnham House. I have visited the home and was very impressed with the recent refurbishment. Staff are always friendly and polite" and "This is the best manager the home has ever had, they are the kindest caring manager." This was supported by a relative who told, "I like the fact when I come in on a Sunday the manager is here, which you don't normally get."