Brendoncare Foundation(The)

Brendoncare Alton

Inspection report

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Overall summary

We carried out an unannounced comprehensive inspection of this service on 2, 4 and 12 December 2014. Breaches of legal requirements were found in relation to care and welfare and staffing. After the comprehensive inspection, the provider wrote to us to say what they would do to meet these legal requirements. They told us they would complete their action plan for staffing by 29 May 2015 and for care and welfare by 28 August 2015.

We undertook this focused inspection on 7 September 2015 to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Brendoncare Alton on our website at www.cqc.org.uk.

Brendoncare Alton is registered to provide care for up to 80 people who need care and nursing support. There are five units: Jade, Blue and Pink units care primarily for people who are physically frail and Cedar and Oak units look after people who are living with dementia. We visited all the units during the course of the inspection. At the time of the inspection there were 75 people using the service.

The service has a manager who has submitted an application to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our focused inspection on 7 September 2015 we found the provider had met the requirements in relation to people's care and welfare. Staff had undergone further training and understood how to meet people's needs when their behaviours challenged staff.

However, the provider had not fully completed the action plan they had written to meet shortfalls in relation to staffing. There were not always sufficient staff deployed to meet the needs of two people assessed as in need of one to one observation from staff due to the risk of them falling. The provider had been recruiting staff to the service and this process was ongoing. In the interim they ensured shifts were covered by agency staff if their own staff were unable to cover them. As a result there had been an increase in the use of agency care staff which people, their relatives and staff told us had impacted negatively upon the delivery of people's care, which took longer. They also told us there were insufficient staff to meet their care needs in a timely way. People whose behaviours challenged staff had information about how to respond to their needs in their care plans. However, for some people this information was only contained within their personal care plan rather than in a specific behavioural care plan. To ensure staff had guidance in

Summary of findings

situations other than the delivery of people's personal care. Staff told us they had struggled to complete this due to the lack of permanent staff. There was a breach of the legal requirements in relation to staffing.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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?

The service was not always safe.

The provider had not met the regulation in relation to staffing, despite recruiting. There was a shortage of permanent staff, resulting in a high use of agency care staff. There were not always sufficient staff deployed to meet people's care needs in a timely manner. There were not always enough staff to meet people's assessed needs for one to one observation to keep them safe from falling. Staff did not always have the time to ensure people's care plans reflected their needs in relation to behaviours which could challenge staff in situations other than when being provided with personal care.

The provider had met requirements in relation to people's care and welfare. Staff had received training to ensure they understood how to safely manage people's behaviours which challenged them.

Requires improvement

Brendoncare Alton

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.

We undertook an unannounced focused inspection of Brendoncare Alton on 7 September 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our inspection of 2, 4 and12 December 2014 had been made. We inspected the service against one of the five questions we ask about services: Is the service safe? This is because the service was not meeting some legal requirements in this area.

The inspection was undertaken by an inspector and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of this type of service. During our inspection we spoke with four people and six people's relatives. As many people who lived on Cedar and Oak units experienced dementia and could not all speak with us. We used the Short Observational Framework for Inspection (SOFI) in the Oak unit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The manager was absent on the day of the inspection. We spoke with the Head of Care, the Practice and Staff Development Manager and a further six staff.

We reviewed records relating to six people's care and support and looked at other records relating to the service which included staff rosters, assessments of staffing requirements for the service, agency staff use and staff training. We observed the lunch service on four of the units.

Requires improvement

Is the service safe?

Our findings

At our inspection of 2, 4 and 12 December 2014 we found where people's behaviours challenged staff the care approach was not always personalised to meet their individual health and care needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010 Care and welfare. This corresponds to Regulation 9(1)(a)(b) (3)(a) person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always sufficient numbers of staff on duty to meet the care needs of people in the service. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) 2010. This corresponds to Regulation 18(1) staffing of the Health and Social Care Act 2008 (Regulated Activities) 2010.

At our focused inspection on 7 September 2015 we found the provider had met the requirements in relation to care and welfare. However, they had not fully completed the action plan they had written to meet shortfalls in relation to staffing.

The Head of Care told us staff on Cedar and Oak units had received further training since the last inspection on managing people's behaviours when these challenged staff, which records confirmed. They told us staff were a lot clearer about what techniques they could use and their practices had changed. A nurse confirmed they had attended this training and was able to describe how staff managed people's behaviours. Records showed the learning from this training was discussed with staff from Oak Lodge on 7 September 2015. Since the previous inspection staff had updated their training and understood how to support people when their behaviour challenged staff. This ensured care for people whose behaviours challenged staff was delivered safely.

There were not always sufficient staff to provide people's one to one care and ensure their safety. Two people had been assessed as requiring one to one observation from staff in order to manage the risk of them falling. One person needed this level of care on Oak unit and one on Cedar unit. On the day of the inspection there were only three care staff on Oak unit in the morning and one nurse. The provider's required level of staffing for this unit in the morning was five care staff and one nurse. On Cedar unit there were only two care staff in the morning. The required level of staffing for this unit in the morning was four care staff and one nurse. This included a member of staff on each unit to provide one to one observation for these two people. We asked staff how they were managing this risk to the person on Cedar unit and they told us they had asked the person to sit down and to stay seated for their own safety. Staff on Oak unit said there was a risk the person would fall and they were observing them every 30 minutes. This person was seen a number of times moving about with no staff in the vicinity in case they fell. Both units were short of staff on the day of the inspection and the provider was therefore unable to provide this level of care which left people at risk of falling. The Head of Care told us this situation occurred "Seldomly apart from today." However, records showed there had been a number of occasions since June 2015 when there were insufficient staff deployed to meet these people's assessed needs which had left them at risk.

The Practice and Staff Development Manager and the Head of Care told us the provider had been recruiting heavily since the last inspection. Records showed since 1 January 2015 seven care staff had left the service whilst fourteen care staff had been recruited. Four care staff and three bank care staff were due to start work during September 2015. They told us they wanted to recruit to 120% of their staffing needs to enable them to cover staff sickness and annual leave. To achieve this they required a further four nurses and four care staff. In the interim they covered vacant shifts which their own staff could not cover with agency staff. Records showed that despite the provider's efforts to recruit sufficient staff there had been an increasing use of agency care staff over the period of May to August 2015.

People and their relatives told us the permanent staff were very good but there was a high use of agency staff which resulted in poorer quality of care for people. One person's relative told us "My mum wouldn't get up yesterday or take her medicines as two agency staff tried to get her up." They also said "The staffing situation has deteriorated since the last inspection." Staff told us the high use of agency staff caused stress to the regular staff, and people could be more agitated. At lunchtime on Oak unit we observed the agency staff member did not speak with people. They did not know who needed a plate guard to enable them to eat their meal and the regular staff had to ensure this was provided. The agency staff member needed to be told who

Requires improvement

Is the service safe?

required their food cut up. Staff on Oak unit told us people's medicines were normally administered during the lunch service. However, because people had received their morning medicines late that day due to staff shortages, they would be given their medicines after lunch. People on Oak unit had not received their medicines at the prescribed time on the day of the inspection due to staff shortages. This may have been a risk to people if they needed their medicines administered at a specific time. On Pink unit staff told us that two of the three staff on duty normally worked on other units and the third was an agency staff member. None of them were members of the regular staff team on the unit who knew people well. The agency staff member told us "I am relying on the floater (care staff) to tell me what to do." A person said "Today is absolute chaos" and "They don't know us the agency staff." Records demonstrated the use of agency care staff was particularly high on Oak and Cedar units where people needed consistency in the staff providing their care, due to the nature of their care needs. The high use of agency staff had impacted negatively upon people's care.

People and their relatives said there were not enough staff. One commented "I have to wait as long as 20 minutes to be attended to. One morning there was only one girl (carer) on and she had to do it all on her own and there are several people that needed getting up here". A relative said "Call bells ring for some time; it can mean a loss of dignity. There is not always the assistance there for eating and drinking; staffing is an issue." Staff told us "It is hard to give people proper, high quality care" and "We could do with more staff." People were observed on Cedar unit waiting for a period of time for lunch to be served.

The provider used a staffing needs dependency assessment tool to assess the joint staffing needs for Oak and Cedar units and for Jade, Pink and Blue units. The tool had identified that for Jade, Pink and Blue units' one person had very high care needs and 17 people had high care needs. Records showed across the three units 28 people required two care staff to move them safely, which indicated they had high care needs. All of these units were staffed with one nurse and two care staff during the day and if required a 'floating' care staff in the morning. A 'floater' is an additional member of staff who is deployed to assist where needs are greater. Records showed a 'floater' had not been rostered since 23 August 2015. Each of these units only had two care staff although a number of people required two care staff to move them. People and staff told us there were not always sufficient care staff to meet people's care needs in a timely manner.

There was a lack of consistency in care planning for people whose behaviour challenged staff. Some people had behavioural care plans whilst for other people the management of their behaviours was only addressed within their personal care plan. One person's behavioural chart demonstrated out of seven incidents only three were related to the provision of their personal care. They did not have a behavioural care plan. This was a risk as agency staff in particular may not have had sufficient guidance about how to respond appropriately to this person. There was a lack of evidence to demonstrate incidents involving people's behaviours which challenged staff had been robustly reviewed, analysed and consistently cross-referenced to people's care plans. The Practice and Staff Development Manager confirmed the data gathered from people's behavioural charts was not always used by staff to update people's care plans. Staff told us they had not been able to review a person's personal care plan. This was due to there being only one permanent nurse on duty on the unit in the day until recently. Staff struggled to ensure people had behavioural care plans where required due to the pressures of a lack of permanent staff.

The failure to ensure sufficient staff were deployed to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The failure by the provider to ensure sufficient staff were deployed to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

The enforcement action we took:
The provider has been served with a warning notice which requires that Regulation18 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014 is met by 30 November 2015.