St Brendans Residential Home

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Inspection report

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Date of inspection visit:
15 March 2016

Date of publication:
12 May 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 15 March 2016 and was unannounced.

St Brendans Residential Home provides care and support to older people living with dementia. At the time of our inspection there were 24 people using the service.

There was a registered manager in post. 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.

People felt they were safe living in the service. There were risk assessments in place which detailed the ways in which people could be protected from risk of harm. Staff knew how to report any signs of abuse and which agencies to contact if they had any concerns about people's safety. Equipment was regularly checked to ensure that it was appropriate for use, and staff were trained to move people safely. There were robust recruitment procedures in place to ensure that staff were recruited safely to work in the service. Staffing levels were appropriate to meet people's needs. People's medicines were stored and administered safely.

Staff received a full programme of training and induction that enabled them to carry out their roles effectively. Training was regularly refreshed and updated as required. The manager regularly supervised staff and they received performance reviews and refreshers on their knowledge. Staff understood the Mental Capacity Act 2005 (MCA) and how this applied in practice. Deprivation of Liberty Safeguards (DoLS) authorisations that were in place were appropriate to keep people safe. People's healthcare needs were identified and met, and they had access to health services as required. People had enough to eat and drink and there were varied menus in place with snacks throughout the day.

The design and decoration of the service was not always suitable for people living with dementia. There was little evidence of personalisation, and some elements of the environment could be confusing or disorientating. We have made a recommendation about creating a dementia-friendly environment for people.

Staff demonstrated a caring attitude towards people and respected their privacy and dignity. People were given opportunities to discuss issues through residents meetings and surveys. The service had received many compliments about the care provided to people.

Care plans detailed people's needs and support they needed throughout the day, but they were not always person-centred. Some information was included about people's background and social history, but it was not always clear how this was used to help people enjoy full and active lives. People's activity programs were basic and limited, and people told us they did not have opportunities to go out or keep busy throughout the day. We have made a recommendation about following current guidance on activities for

people living with dementia. There was a complaints system in place which handled and resolved people's grievances efficiently.

People, their relatives and staff were positive about the manager of the service. The visions and values of the service were clear and staff understood their job roles and responsibilities. There was a robust system in place for identifying improvements that needed to be made in a variety of areas. Staff had the chance to contribute to the running and development of the service through team meetings.

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.

There were robust recruitment procedures in place, and enough suitably trained and qualified staff available to meet people's needs.

There were risk assessments in place to identify and minimise the risk of harm to people using the service.

People's medicines were administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The design and decoration of the service was basic and not always suitable for people living with dementia.

Staff were regularly supervised and received enough training to enable them to deliver effective care and support.

People's healthcare needs were met and they had enough to eat and drink throughout the day.

Is the service caring?

Good

The service was caring.

People were cared for by staff who knew and understood them, and showed patience and compassion.

People had their dignity and respect observed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was not always an appropriate program of activities in place to keep people stimulated throughout the day.

Care plans were detailed in listing people's basic needs but were

not always reviewed with the person or their relatives.

There was an effective system in place for handling and resolving complaints.

Is the service well-led?

Good

The service was well-led.

People and their relatives were positive about the manager, and staff told us they felt supported to develop their skills.

There were robust auditing systems in place to identify improvements that needed to be made.

Staff and people using the service had opportunities to attend regular meetings to contribute to the development of the service.

St Brendans Residential 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, 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 15 March 2016 and was unannounced. The inspection was carried out by one inspection from the Care Quality Commission, one expert by experience and a specialist practice advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of accessing services for older people living with dementia. The specialist advisor was a qualified nurse who specialised in advising on services for people with dementia and brain injuries.

Before the inspection, the provider completed 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 reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. We also reviewed local authority inspection records.

During the inspection we spoke with nine people using the service, three relatives and nine members of staff. We looked at care plans for five people, training, recruitment and induction records for five members of staff and reviewed the local authority's most recent inspection report. We looked at records for medicine administration, surveys, internal audits, and minutes of team meetings.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe. One person said, "I'm safe here, much safer than on my own." Another person told us, "Yes, it's a safe place to live."

The service had a safeguarding policy in place. The staff we spoke with were able to describe the steps they would take if they felt anyone was at risk of harm. We saw that contact details for the local authority were available and displayed around the service. The service kept a comprehensive log of incidents that had occurred within the home and the actions that had been taken as a result. Any safeguarding incidents had been reported to the local authority and CQC as required. Staff received training to help them to understand their responsibility to report any incidents or concerns to these agencies. They were later tested on their knowledge during supervisions and team meetings to ensure their continued understanding. This meant they were able to describe the different risks to people and how they would record and report these.

There were risk assessments in place to help people to remain safe. Each person had a risk assessment for falls which detailed the help they needed with moving and mobility equipment. If somebody had experienced a fall in the past, details of this were recorded and measures identified to reduce the risk of recurrence. People also had risk assessments in place if they displayed any behaviour that might have had a negative impact on others. These identified the triggers or any anxieties or patterns of behaviour that might have heightened the risk. Staff we spoke with were able to describe the ways in which they would help people to calm if they saw an escalation in these behaviours. All risk assessments were reviewed monthly by the person's key worker to ensure that they remained up to date and relevant.

Checks were carried out to ensure that all of the equipment being used in the service was safe and in working order. We saw that these checks took place weekly for certain equipment and then monthly for others. Staff were supported to use equipment safely through appropriate manual handling training. People's care plans included details of how equipment was to be used and which mobility aids were in place. The service had robust measures in place which detailed the steps staff would take in an emergency. Each person had a personalised evacuation plan (PEEP) in place which detailed how they would be supported in case of fire or other emergency situation. There were contingency plans in place in case people needed to be relocated or any event took place which would affect their ability to deliver care.

There were enough suitably trained and experienced staff available to meet people's needs. During our inspection there were five care staff on duty, in addition to the manager. We observed that the manager was involved in providing care and support when required. The staff team also included domestic staff and cooks who attended to specific duties around the home. People told us that staff were usually able to attend to them quickly when required. Two staff worked together during the night, and one person told us that they were usually prompt in responding to their needs. They said, "I did have to use my bell one night, I wasn't feeling very well. They came straight away." The manager told us that if there were any shortages in staffing, she was available in case of emergencies. There was a pool of bank staff employed who could also cover shifts at short notice if required. This enabled the service to avoid the use of agency staff to ensure consistency for people. There were pictures of the staff team displayed in communal areas so people knew

who would be working with them.

People's medicines were administered safely. Medicines were stored in a locked medicine trolley and this was attached to the wall of a locked medicine room. There was an order book and register book for controlled drugs. These were checked daily and the records were accurate and up to date. Controlled drugs were stored in a separate cupboard. On the day of the visit the medicine was delivered and the registered manager told us that she was going to check them against the prescription. The medicine bottles were labelled with the dates they had been opened. The creams were labelled with the people's names both on the box and the tubes. The medicine administration record (MAR) charts had the people's photographs, were legible and signed with no gaps in the recording of the medicine dispensed. The medicine room was clean and the sharps box used by the district nurse had the date of assembly. During the medicine round the registered manager wore a tabard with a 'do not disturb' sign. The registered manager showed us the medicine policy and told us that the service offered by the new pharmacy was much improved. She showed us the monthly audit and the recorded action taken by the pharmacy to resolve any discrepancies.

There were robust recruitment policies in place to ensure that staff were recruited safely to the service. Applicants were subject to an interview which assessed their suitability for the role, and were required to make health declarations to ensure they were fit and able to fulfil their duties. Two references were sought from former employers where possible, and these had been verified prior to the member of staff commencing their employment. Disclosure and Barring Service (DBS) checks were completed for all new members of staff. These helped to ensure that only staff who were of the appropriate character were employed to work in the service.

Requires Improvement

Is the service effective?

Our findings

During our inspection we found that the design and decoration of the service was not always appropriate to meet people's needs. During our time spent on the upper floors and in some of the stairwells, we noticed that lights were routinely switched off and that parts of the home were left in darkness. The director explained that this would not happen unless those parts of the house were not in use, but we observed on several occasions that both people and staff were using these parts of the building. On the upper floor there was one room labelled 'toilet' which was inappropriate for use and filled with old and derelict equipment. No attempt had been made to label this room out of use. In one communal area we noticed that a clock was set to the wrong time. In the larger communal area downstairs there were still Christmas decorations visible midway through March. For a service which largely catered for older people living with dementia, these elements of the environment might have proved confusing or disorientating. People had been asked as part of the service's quality assurance audit whether they were happy with the design and decoration of their room and whether they'd like any improvements to be made, to which people replied they were happy. We saw that a programme of redecoration was scheduled and that people would be asked for their views, but found at the time of our inspection that the environment wasn't always dementia-friendly.

We recommend that the provider reviews and acts on current guidance on creating dementia friendly environments.

People told us they felt staff delivered effective care. One person said, "They're good at what they do. Some of them are wonderful, actually, they're busy girls but they get the job done." Staff told us they received a comprehensive induction when they first started with the service. One member of staff told us, "I worked with more experienced staff at first. We follow them for a few days before starting to work on our own. I read through a lot of files and care plans and they check that you know what you're doing at the end." We saw induction checklists that confirmed that the induction program was detailed and supported new staff to understand their roles. For example we saw that staff were observed during each stage of delivering care to people by a senior staff. They were then signed off as being competent or given feedback on areas to improve. This helped to ensure that staff were confident in their roles before they began providing care alone.

Staff told us they received a good variety of training to support them in their roles. One member of staff said, "The service prepares us to do our job and further our careers." There were training records in place which identified when staff training was due. We looked at these and found that staff had completed training in subjects such as safeguarding, manual handling and medicines administration. The service also offered some specialised training which was specific to people's individual needs. For example we saw that the staff team and the kitchen staff had all completed a training course in adding thickener to people's drinks. This was in response to a larger number of people developing this need. Staff were supported and encouraged to take their National Vocational Qualifications (NVQs) in social care and care staff were all given an opportunity to undertake level 2 and 3. The manager told us that for staff who had expressed an interest in management, they had been supported to take their level 5 qualification.

Staff we spoke with understood the principles of the Mental Capacity Act (MCA). The Mental Capacity Act 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). Where DoLs authorisations were in place for people using the service, we found that these were appropriate to support people to keep safe. Mental capacity assessments and records of best interest meetings were contained within people's care plans. The registered manager told us that there had recently been a delay in response from the local authority and that some applications were still pending. However we saw that these applications had been made as required and that the manager had contacted the local authority for updates regularly.

Staff were able to tell us about the ways in which they sought consent from people before providing care. One member of staff said, "We always explain to people what we are doing, even if they don't always understand it is important to me that I do it." During the inspection we observed that one person had a cut on their head and a member of staff needed to attend to them and make sure they were warm. The staff member approached gently and said "I need to help you with your blanket, to make sure you are warm while you have a little sleep. Is your head hurting?" Consent forms were included in care plans and covered a variety of areas where people were required to give consent. For example, we saw that people had been asked to sign to indicate that they consented for external agencies to read their care plans if necessary. Other aspects of their care such as having their hair cut or aromatherapy were also included.

People told us they had enough to eat and drink. One person said, "I always have enough to eat here. I don't need to buy anything extra." There were visual menus displayed in the dining area, and menus were planned in advance so that people knew what was available. One person told us they always had a choice of what to eat, saying: "They give you whatever you want, really. There's a good selection here. If you don't like something then it's no bother to have something else." We saw that there was always a suitable alternative to each meal, and that people's choices and preferences were taken into account. The cook had a list of people's special dietary needs to ensure that food provided was suitable for them.

People told us they had access to healthcare services as required. One person said, "The doctor comes in, we can ask to see the doctor or else they sort it and a lady comes in to cut my toenails". People's conditions were listed in their care plans and detailed how they affected the person. If people's needs changed, then any new or temporary conditions were added to their care plans. We saw that notes from other professionals such as SALT (speech and language therapy) were included and all visits were recorded. People's needs around pressure care were identified, and there were detailed instructions in place for ways in which these could be managed through the correct therapies and equipment. The staff were prompt in identifying and meeting people's healthcare needs and making appropriate referrals where necessary.

Good

Is the service caring?

Our findings

People and their relatives told us that the staff were caring, kind and respectful. One person said, "The carers are very nice, they'll do anything for me." Another person told us, "I'm happy here, the carers are so kind to me."

Staff we spoke with demonstrated knowledge and compassion towards the people they cared for. One member of staff told us, "I believe that I know the resident I am working with because I talk to [them] all the time and I have my picture on the wardrobe where [they] can see it. I also write [their] care-plans and I get on with [their] family very well." During our inspection we observed that staff took time to talk with people where possible, and spoke kindly and gently to them. We saw a member of staff engaging with a person during a singing session and the staff was very knowledgeable about a number of the people's taste of music. People were not rushed and staff showed patience and spoke with them in an upbeat and positive manner.

Each person had a key worker in place and we saw that they were named in people's care plans. This enabled people to have a point of contact if they had any issues that needed to be discussed. When people joined the service, they were provided with welcome notes which gave them details about the service. These notes set out the reason for their care planning, the values of the service, and confirmed that people's personal information would be kept securely at all times. Staff were able to tell us about confidentiality and how they ensured that people's information remained private. One member of staff said, "I would never speak about anybody's personal business. Just because some people are older or have dementia doesn't mean they can't understand us or deserve to have their information disclosed to other people. I treat them as I'd like to be treated if I was living here."

The service had received a number of compliments which praised the quality of care received by relatives during their time in the service. One relative had written to the manager to say "From the first time I met you all, I just knew [relative] would be looked after properly."

Staff demonstrated a commitment to respecting people's privacy and dignity. One person told us, "They always knock on our doors before they come in." Another person said, "They are always careful about closing doors when we are washing, they are very good." During the inspection we observed that one person had a part of their body exposed while asleep in a communal area. A member of staff had already noticed this and gone to fetch a blanket to cover them up. We saw in care plans that people were asked whether they were comfortable being supported by someone of an opposite gender. Where one person had stated that they weren't, the plan had made it explicitly clear that their personal care was only to be completed by a staff member of the same sex.

Requires Improvement

Is the service responsive?

Our findings

During our inspection we observed that there were periods where people were not stimulated or engaged in any activity. People told us that there wasn't much to do in the service and that they were bored. One person said, "No I don't play the games, lots of the people don't have ability and so it isn't much fun, there's nothing for me to do." A relative told us, "They don't do anything, nothing interesting at all except an occasional music thing." People also expressed that they rarely left the service and that there were not many outings available. One person said, "No I've never been out for an outing". Another person told us, "No, none of us goes out except to the hospital." The service had a system in place for auditing people's activities over the course of the month. We reviewed these and found that they were very limited activities provided and lacked variety or meaning for the people that lived at the home. There was no personalised activity program in place for individuals or any evidence of how people's unique interests and hobbies were being catered for. For example, one person who enjoyed reading told us that they would like more large print books. They said, "I like to read but I don't know if there is a mobile library."

We did observe that one of the care staff was asked to play dominos with people in the communal area and did so positively and enthusiastically. We saw that some activities had taken place, like visits from therapy dogs, church services and games, but these were infrequent and there did not appear to be any activities available for days at a time. The provider told us they had employed an activity co-ordinator previously but had decided to instead encourage the care staff to fulfil this role. We observed that while staff were friendly and caring in their interactions, they could not spend much time on this because they were required to attend to other duties. The lack of a member of staff dedicated to keeping people active and engaged in service of this size, meant that people were under stimulated.

We recommend that the provider reviews and acts on current guidance on providing activities to people living with dementia.

People told us they were not always aware of what was in their care plans and could not remember going through them with staff. A relative we spoke with said they had not been consulted or involved in any way. They told us, "I don't remember going through any care plans or anyone asking me to sign anything."

Care plans were detailed enough to include a list of people's basic needs and support they needed throughout the day. People's healthcare needs and the support that they required with personal care were listed in detail and were thorough and comprehensive. There were specific protocols in place around the differing care needs that people had at night. We saw that where people's needs had changed, their care plans were updated accordingly. The service had completed assessments on people's sensory activity levels and their level of independence. We reviewed daily charts for people to ensure that they were having their needs met. We saw that checks took place regularly and that staff had signed to indicate when people had been repositioned or given personal care.

There was some information relating to people's backgrounds and social histories but these varied in quality and detail. Some care plans had a 'My Life Story' in place which included some information about

the person's background and their life before living at the service. We saw information relating to their previous occupations, places they had lived in and their family and interests. However it was not always clear how the service were using this information to create a person-centred service for people. One person's care plan had identified that an outcome for the person would be to 'develop a regular program of activity'. However there was no evidence of this being implemented or how this need was being met.

People and their relatives told us they knew who to complain to. One person said, "No reason to complain here." Another person told us, "No I never complain, nothing to complain about." Complaints that had been received had been dealt with appropriately. For example we saw that a family member had complained about the condition of their relative's room. We saw that the person's room had been cleaned and the issue raised with the member of staff during their supervision. A letter had been sent issuing an apology and explaining the measures that had been taken to resolve the issue.

Good

Is the service well-led?

Our findings

People we spoke with told us that they knew who the manager was and found her helpful and approachable. One person said, "I could ask [the manager] if I needed anything." Staff were equally positive about the manager and told us she had been supportive and helped them to develop their skills and knowledge. One member of staff said, "She works with me to support people and she doesn't mind doing that at all". Another member of staff told us, "I think I can discuss anything with her. She cares and she is just great."

The manager was actively involved in providing care and support to people during our inspection. We observed that she always placed people's needs above her other responsibilities, ensuring that she was available when people requested assistance. She told us she enjoyed being part of the care team, saying, "I like to make sure I'm visible and involved with what's happening on the floor. There's nothing I expect them to do that I wouldn't do myself." She was able to tell us about each individual person that used the service and knew their backgrounds and needs. During the inspection we found that there was a person whose needs did not seem appropriately met by a service of this type. The manager agreed and was able to demonstrate the ways in which she had attempted to work with the local authority to resolve this quickly.

Visitors were asked to complete questionnaires following time spent in the service. The feedback was largely positive, but any concerns were noted and acted upon. For example we saw that a social worker had raised concerns in regard to the health of a person that they were visiting. The service had adjusted their daily routines to ensure that they were taking this feedback on board. Staff were also given satisfaction surveys and asked for their feedback. We saw that some staff had raised concerns regarding a lack of opportunity to develop their skills. We spoke with the manager who was able to describe the extra training and vocational qualifications they had offered to try and promote further development of their staff.

The manager used a robust auditing process for quality monitoring in the service. Tools had been developed to monitor key areas of people's care and identify any issues that needed to be resolved. There were audits in place which looked at people's activities, personal hygiene, care plans, medicines and mealtime experiences. Any issues identified by these audits were then added to action plans which were completed by the manager. For example we saw that where some rooms required redecoration, the exact improvements had been noted and dates scheduled to complete the work as required. Following a recent local authority monitoring visit, the areas identified for improvement had been discussed in staff meetings. The manager had taken steps to resolve the concerns highlighted and set timescales for each of the actions they needed to take.

Staff told us they attended regular team meetings. One member of staff said, "We meet every couple of months, sometimes more. They're good, it's nice to get together as a whole team as you don't always see some of your colleagues." We looked at the minutes of meetings that had taken place over the previous year. We saw that the manager used these to regularly refresh staff knowledge on key areas such as safeguarding and mental capacity. Staff were also given important updates about issues affecting the home. We saw in one set of minutes that the manager had identified a need to appoint 'champions' in the service.

This meant that individual members of staff would have the opportunity to take on a specific role to support their development. For example we saw that one member of staff had been complimented on their ability to hold effective residents meetings. This member of staff was appointed champion in this area and conducted each of these meetings going forward.

The visions and values of the service were displayed outside the home as 'specialising in dementia care'. Staff we spoke with understood these values and their job descriptions set out the conduct and standards required of them at all times.