Kidderminster Care Limited

Brownhills Nursing Home

Inspection report

29-31 Hednesford Road
Brownhills
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West Midlands
WS8 7LS

Tel: 01543374114

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 6 and 7 July 2016. At the last inspection in July 2015, we found the provider was meeting the regulations however improvements were required in relation to staffing levels and activities. At this inspection we found improvements were still required.

Brownhills Nursing Home is registered to provide accommodation with nursing and personal care for up to 50 older people including people with dementia and people with physical disabilities. On the day of the inspection there were 47 people living at the home. The home had been without a registered manager since May 2016; however there was a new manager in post who had submitted an application to become registered. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People did not always received support from sufficient numbers of staff, which meant their needs were not always met in a timely way. People told us they felt safe and we found they were supported by staff who knew how to protect people from harm. Risks to people's safety had been assessed and care and support was delivered in a way that kept people safe from harm. People received their medicines as prescribed and systems used to manage medicines were safe.

People were not offered choices in terms of food and drink. People were supported by staff who felt they had received training to equip them to do their job. People were asked for their consent before care and support was provided by staff. People's capacity had been assessed and recorded so that staff knew how to support people when making choices and decisions. People had access to healthcare when they required it and people's health needs were monitored by staff and any changes were identified and reported.

Staff were not always aware of people's needs and preferences. People told us staff were caring but did not always have time to spend with them. People told us they were not always involved in decisions about their care. People were supported by staff in a way that maintained their dignity and protected their privacy.

People and their relatives told us there were not enough leisure opportunities and people were not always encouraged to follow their interests or hobbies. People knew how to complain if they were unhappy about the care they received and there were processes and systems in place to manage complaints.

People, relatives and staff did not always feel the home was well managed. Systems in place to monitor the care provided were not effective in making the improvements required that were identified at the last inspection. Staff expressed their confidence in the manager who they felt had made positive changes to the home. The manager demonstrated the skills and knowledge required for their role.

During this inspection we found breaches 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 the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not always enough staff to meet people needs. People told us they felt safe and were supported by staff who knew how to keep people safe from harm. Systems used to manage medicines were safe and people received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

Although people were not always offered a choice a food and drink. People were supported by staff who receiving training relevant to their role. People were asked for their consent before care and support was provided. People had access to healthcare professionals when they needed them.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were not always aware of people's individual needs and preferences. People were supported by staff who were friendly and caring. People and their relatives did not always feel listened to or involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not responsive.

People did not have access to sufficient leisure activities. People's changing needs were recognised and staff were kept updated so people received care relevant to their needs. People and their relatives knew how to raise a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People and their relatives had not been asked to share their

views about the care they received. People, relatives and staff felt the home was not always well managed. Systems used to monitor the quality of care provided had not always been effective at identifying concerns and driving improvement.

Brownhills 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, 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 6 and 7 July 2016 and was unannounced.

The inspection team included one inspector, a specialist nurse advisor, whose area of expertise was older people and dementia and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who use this type of service. As part of the inspection we looked at the information we held about the service. This included statutory notifications, which are notifications the provider must send us to inform us of certain events, like serious injuries. We also contacted the local authority for information they held about the service. This helped us to plan the inspection.

During the inspection we carried out observations of the care and support people received. In addition, we undertook the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with nine people who lived at the home, six relatives, seven staff members, the manager and a visiting healthcare professional. We looked at eight records about people's care and support, seven medicine administration records, three staff files and the systems used to monitor the quality of care provided.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in July 2015 we found people living at the home were not always supported by sufficient numbers of staff and improvements were required. At this inspection we found that in terms of staffing levels, improvements had not been made. We observed the levels of staffing on each of the two floors of the home and found there were not enough staff to respond to people's needs in a timely way. On the first floor we saw that people who required support to mobilise were not able to do so, as staff were not available to assist them. One person who required pain relieving medicines had to wait for 20 minutes before receiving them. It was clear throughout the inspection that although staff were very busy, they were finding it difficult to provide the level of support people required. Staff told us the level of staffing and waiting times we observed were usual for the home. They explained they had raised concerns with the provider about staffing levels and had been told there were enough staff to meet people's needs.

During mealtimes people experienced delays in receiving the support they required to eat their meals. In the first floor dining area a number of people required full assistance to eat their meal. Some people waited for over 15 minutes for support with their meals. Staff were conscious of the needs of people and did reassure them that they were aware they were waiting. However, in their haste staff did not always ensure people had a positive experience and we observed that staff were standing over people when supporting them to eat. Hot desserts were brought from the kitchen to the upstairs dining area and left for a period of over 20 minutes before being served. A member of the inspection team intervened when staff started to serve the desserts advising the staff member that they were now cold. One relative expressed concern about whether there were enough staff to support their family member's with meals. They commented, "I like to be here for at least one meal time so I can help, and I can go home knowing they have eaten".

People and their relatives expressed mixed views about whether there were enough staff available to support them. One person told us, "I do have to wait a while sometimes for the staff to come to me when I call, but they are so nice when they do come that I don't mind waiting a bit." A number of relatives told us they were concerned about staffing shortages and whether their family member's needs were being met in a timely way. One relative told us, "There are too few staff to offer anything other than the basic care." We spoke with staff who told us that staffing levels had been discussed at a recent meeting with the provider, after some staff members had raised concerns. Staff members told us they had been advised by the provider that the number of staff on each shift was adequate. However, staff were still concerned about the quality of care they could provide based on current staffing numbers. One staff member told us, "More staff would help; we would get to spend more time with people." Another staff member said, "The staffing levels can get frustrating and relatives get frustrated too. Our concerns have been fed back to the provider." We found there were not sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the manager and provider about our concerns in terms of staffing levels and the manager

told us staffing levels had been agreed between the previous manager and the provider. They told us they would be looking in to alternative options for calculating the number of staff required to support people. The provider advised that they had agreed for a member of staff to be recruited to take responsibility for activities. They advised that this would enable them to offer people a wider range of activities.

People told us they felt safe. One person told us, "I came here for respite but I feel so safe and everyone is extremely kind, so I hope I can stay". We asked relatives how they felt about their family member's safety and one relative told us, "I think people are safe, but the carers could interact a bit more." Where people were not able to express their views we saw they appeared comfortable and relaxed when in the presence of staff members.

People were protected from harm by staff who knew how to recognise possible signs of abuse. Staff understood their responsibilities in recognising and reporting suspected abuse and knew to raise concerns with both the manager and other external agencies if necessary. One staff member told us, "If I had concerns I would tell the nurse or the manager. If needs be I would contact the owner or CQC." Staff were aware of the whistle-blowing policy and one staff member told us they had reported concerns in the past and felt they had been dealt with appropriately. Whistle-blowing means raising a concern about a wrong-doing within an organisation.

We saw that the provider used risk assessments which helped to ensure people's care and support was delivered in a way that kept them safe from harm. One person living at the home was at risk of a certain type of infection and we saw the risks to the person, and other people had been assessed and staff were following guidance recorded in people's care records. The manager told us that any changes to people needs that may present a new risk were discussed with the nurses and the staff team during handovers and staff we spoke with confirmed this. The manager had oversight of all ongoing concerns to people's safety and was able to explain to us how they had identified any patterns or trends in relation to accidents and incidents to prevent them from reoccurring. For example they had introduced monitoring systems for incidents, such as falls.

Everyone we spoke with told us they happy with the way they received their medicines. One person told us, "Medicines are always on time and never forgotten." We looked at systems used to manage medicines and found they were stored, administered and recorded safely. Nursing staff administered medicines and we observed they had a warm friendly approach when supporting people to take their medicines. Systems used to manage medicines were regularly audited by the clinical lead who demonstrated a good understanding of medicines and people's individual health needs.

Requires Improvement

Is the service effective?

Our findings

People told us the food they received was filling and we observed that portion sizes were ample. However, we observed that people were offered no choice in terms of their meals. Despite there being two choices listed on the communal notice board, staff told us that there was only one option. At lunchtime meals were served ready plated with sauce already added. One person told us, "There is no choice of menu; you have to like it or go without." This person had asked if there was an alternative to what they had been given and was told 'no'. Little effort had been made to make lunchtime a pleasant dining experience, there were no condiments available, and some people remained in the same chairs as they had been in all morning. People were offered drinks throughout the day; however, there was little choice in terms of hot or cold drinks. During lunchtime everyone was given juice to drink, with no alternatives offered. We discussed our concerns with the manager who told us they would make improvements. On day two of the inspection we saw that new jugs had been purchased so that people could add sauce to their meal if preferred. Where people had specific dietary requirements staff were aware of these and were able to share with us how they ensured meals were safe for people to eat, for example, pureed diets for people with swallowing difficulties.

Most people we spoke with felt staff had the appropriate skills and knowledge and were trained to be able to meet their needs. One relative shared with us how they felt confident in the ability of the nursing staff to respond quickly to their family member's clinical needs. One staff member told us, "I think the training here is good, I have recently done training in infection control." Another staff member told us they had recently undertaken some training in moving and handling and said this had enabled them to improve the way they supported people when they were being hoisted. Other staff shared examples from their induction when they first stated working at the home. One staff member said, "I got some good training and was treated well. I worked with other more experienced staff for three days and was given lots of information about people." We observed that staff had a good knowledge of people's needs and understood how to best support people. For example we saw staff knew how people who were assisted to mobilise liked to be supported and they took time to explain things to them in a way they understood.

Staff told us they received supervision from the manager. One staff member told us, "Regular supervisions have been introduced since the arrival of the new manager. They are approachable and I feel I can seek advice." Another staff member said, "I have supervisions with the manager and get feedback on my role." We observed the manager had a presence throughout the home on the day of the inspection and was keen to support staff where possible.

People were asked for their consent before care and support was provided by staff. Throughout the inspection we observed staff asking people for their consent, including whether they were happy to be hoisted and where they would like to sit. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found assessments had been carried out to assess whether or not people lacked capacity to make certain decisions and these were recorded and shared with

the staff team. Staff we spoke with demonstrated a good understanding of people's individual capacity and shared examples of decisions people were able to make for themselves. People's care records reflected that people and their relatives had taken part in best interests meetings to ensure they were happy with decisions made about their care and support. For example, when considering whether the use of bed rails was appropriate to keep a person safe.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that a number of people currently living in the home had a DoLS authorisation in place and the manager had a good understanding of their responsibilities in this area. However, although all of the staff we spoke with had received training in DoLS, they were not all aware of people living at the home who were subject to an authorisation. However, because they followed guidance in people's care records they did not act in a way that unlawfully restricted people. We discussed DoLS with the manager who recognised that some people's authorisations required a review and advised that information would be shared with the staff team to ensure staff did not act in a way that unlawfully restricted people.

People's healthcare needs were monitored by staff and there were systems in place to ensure that staff were able to identify any changes. People told us they were able to access relevant healthcare professionals when they needed them. One person said, "I've seen the dentist and the optician." We saw that where there were specific instructions in people's care records staff were aware of these and followed the guidance when providing care. For example, staff followed guidance for people who required catheter care and appropriate referrals had been made where people required additional support or follow up treatment. We spoke with a visiting healthcare professional who told us they felt the staff had improved in their responsiveness to identifying people's health issues. They also spoke positively about the nursing team and the clinical lead, who they felt communicated well in order to ensure people's health needs were met.

Requires Improvement

Is the service caring?

Our findings

All of the people and relatives we spoke with felt staff were caring. One person who preferred to stay in their room said, "The staff do care, they frequently ask me if I want a cup of tea and even get one for my brother when he visits." However one relative we spoke with felt interactions between staff and people could be warmer. They told us, "I think the care is good, but there could be more warmth. The atmosphere doesn't always feel friendly." We observed that staff were often focused on tasks and did not have time to spend with people. For example, when a member of the inspection team advised a staff member that food served at lunchtime had gone cold before it was served the staff member responded, "I am not contracted to warm the dinners, only to serve them."

We saw that staff knew people's personal histories and were able to tell us about some people's likes and dislikes; however they did not always have time to engage with people. We saw examples throughout the inspection of people asking for assistance and staff telling people they would need to wait for another member of staff as they were busy. A relative reported that most of the care was satisfactory but they were concerned about whether staff took the time to support their family member to use their hearing aid. On the day of the inspection the person had not been supported by staff to wear their hearing aid and so had difficulty hearing people. We observed that staff used raised voices to communicate with the person and when we asked a member of staff about the person's hearing aid they told us they weren't aware of it. Staff told us they tried to support people in a caring way. One staff member told us, "It's important to speak to people nicely and respect them. I treat people as I would like a member of my family to be treated". We saw that staff responded to people in a compassionate way when they were showing signs of anxiety.

People and their relatives expressed that they had not always been involved in decisions about their care and support; however things had improved since the arrival of the new manager. One relative said, "We have been able to discuss our concerns more recently, the new manager is available when we visit."

People told us staff treated them with respect and listened to them when supporting them with day to day care. We saw examples of staff maintaining people's dignity in the way they supported them. For example ensuring bedroom and bathroom doors were closed when in use, and being discreet when asking people about personal care. We also saw staff knocked on people's doors before entering their rooms. We saw care practices displayed by nursing staff during medicines administration rounds were caring, patient and focussed on the person they were supporting.

People were supported to maintain relationships that were important to them. People's relatives were able to visit at any time. We saw family member's visited throughout the day and staff were friendly and welcomed them. Relatives told us they had begun to develop a rapport with the new manager and we saw the manager was available to people when they visited.

Requires Improvement

Is the service responsive?

Our findings

People were not supported to take part in activities that interested them. We saw that people were reliant on staff being available to support them to engage in activities that interested them. However, there were not always staff available to support these choices. For example, on the first day of the inspection we saw that the activity being offered was colouring. We observed some people were sitting at tables in the communal areas with paper and pens in front of them, but no-one was engaged in the activity, instead people sat with their head on the table, or had fallen asleep. Staff were unable to encourage or support people with the activity for over 30 minutes as they were busy supporting other people who required care and support in their bedrooms.
Other than the colouring activity there did not appear to be an activities programme in place. People who were able to occupy themselves did so, by reading or spending time with relatives. Relatives expressed concern about the lack of stimulation available for people. One relative told us, "The home lacks stimulation and reduces quality of life." Another relatives said, "There is a garden outside, but no-one had ever offered to take people outside for some fresh air and a change of scenery." We saw that most people spent the whole day sitting in the same chair, other than when they were supported with personal care or to eat their meals. Staff told us they tried to support people to follow their interests but did not always have time to do so. One staff member said, "We do the best we can. I know that [person's name] likes football so I talk to them about that, another person likes making models." Another staff member said, "There should be a plan, sometimes people have their nails painted, I think there will be a positive change with the new manager." We discussed our concerns about the lack of activities or stimulation with the manager who told us activities were usually led by a member of staff who was on leave at the time of the inspection. The manager also advised that they had identified more needed to be done in terms of activities, and had begun the process of recruiting a full time activities co-ordinator.

People told us they were consulted about day to day care tasks but had not had the opportunity to discuss their individual needs or been invited to express their preferences. Relatives expressed similar views. It was apparent from discussions with relatives that previous managers had not always responded efficiently to their needs and that there had been some communication issues. However, they gave positive feedback about the new manager who they felt was engaging with them gradually.

People and relatives told us they contributed to their initial assessments for care and support. We saw people had care plans that recorded their personal information. Staff had recorded information about people's life histories, personal preferences and their personal support needs. Staff we spoke with were aware of people's personal preferences. For example, one staff member shared with us that one person preferred to receive care and support from female staff only, and explained how this was facilitated. We saw people's changing needs were recorded in their care plans. Staff communicated changes in people's needs through communication systems. For example, a handover book and a verbal handover between staff at the beginning of each shift. People's care plans were reviewed regularly by the nursing staff; however there was little evidence to suggest that people or their relatives had been involved in reviewing their care and support.

People told us if they were unhappy about something they raised concerns directly with the staff. A number of relatives told us they had not felt the need to make formal complaints as most issues raised were resolved by the clinical lead. One relative told us, "[Name of clinical lead] is very helpful, any questions or problems, we just go straight to them." Another relative said, "The manageress and [name of clinical lead] are very approachable and sort out any concerns we have." We saw throughout the inspection that relatives spoke with the manager who dealt with any queries or concerns. A complaints form was available in the reception area of the home for use by relatives. We looked at the log of recent complaints and found there were systems in place to ensure complaints were investigated and responses provided to the complainants. The manager told us, "There are no outstanding complaints; I encourage relatives to say if they are not happy. There are no relative's meetings at the moment, but I have discussed starting a support group for relatives, as some have said that would be helpful."

Requires Improvement

Is the service well-led?

Our findings

Due to a recent management change people and their relatives were still getting to know who the manager of the home was. The registered manager had left the home in May 2016, and a new manager had been appointed. However, neither the registered manager or the provider had notified us of this, as required by law. The new manager told us they had submitted an application to CQC to become the registered manager. We found that the manager and clinical lead were committed to making improvements in the service in order to develop the quality of care people received. Since the arrival of the manager they had worked together to identify areas of improvement.

Quality assurance systems were in place to identify areas for improvement; however, these systems were not robust enough to identify the issues that we found during this inspection. We saw that a range of checks were completed on care plans, health and safety audits, medicines including stock counts and audits by external organisations such as the local infection control team. However, we found that issues highlighted in our last inspection had not been addressed by the provider. We asked to see provider audits that had been carried out since the last inspection in July 2015. We were told by the provider that audits had been carried out, but were not available for us to view as they were not kept at the home. The provider did not have effective systems in place to assess, monitor and improve the quality and safety of services provided.

At the last inspection we highlighted concerns about people's needs not being met by sufficient numbers of staff. We found these concerns had not been addressed. People were still waiting for prolonged periods of time when they needed support to mobilise, eat their meals or receive pain relieving medicines. At the last inspection we also highlighted concerns about the lack of activities and stimulation available to people. At this inspection we found people were not supported to follow their interests or hobbies. Although at the last inspection we had been told changes would be made to offer people a range of activities, we found that these changes had not taken place.

Following the inspection the provider sent us copies of minutes from resident's meetings held since the last inspection in July 2015. They also submitted a summary of quality assurance surveys from July 2015. The provider advised they had sent out questionnaires to relatives in July/August 2016, in the weeks following this inspection, as part of their annual quality assurance process.

We saw from the resident's meeting minutes that people had been asked to express their views about the activities available at the home. However, we saw no evidence at the inspection that these suggestions had been taken on board by the provider. People told us they did not feel actively involved in the development of the service and relatives told us they had not been asked for their views. Although the provider had sought people's views they had not acted on feedback from relevant persons, for the purposes of continually evaluating and improving the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager shared with us how they planned to introduce new systems which would enable them to effectively monitor the quality of care being provided. We saw that the manager and clinical lead had conducted audits which gave them an opportunity to identify any patterns or trends in incidents or accidents which meant they could act to reduce the likelihood of them happening again. For example, falls monitoring.

Most of the relatives we spoke with felt that the new manager was trying to interact with them to improve the care and organisation of the home. One person told us, "New staff have recently been appointed but they are not always well informed. "All of the staff we spoke with acknowledged that improvements had been made since the arrival of the new manager. However, they told us it was "a challenge" to meet some people's complex needs with the current number of staff.

Staff told us they felt supported by the manager. One staff member said, "The manager is very approachable, I can always speak to them." Another staff member told us they were pleased about changes the manager had made, "We now have allocated breaks which works well. I think they [manager] have made us all feel happier, I feel like things are happening now." We saw that the manager had a good understanding of people's needs, and people were comfortable engaging with them. We spoke with the manager who explained the changes they had made since they arrived. They were honest about the improvements that were required and were confident they had already made positive improvements to the home. The manager demonstrated a strong understanding of their responsibilities as a registered person. We reviewed the information we held about the provider and saw that other than the departure of the registered manager, they had notified us of things they were required to do so by law. We also saw that the provider had ensured information about the service's inspection rating was displayed prominently as required by the law.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not sought and acted on feedback from relevant persons or evaluated and improved their practice based on feedback. Regulation 17 (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not taken sufficient steps to ensure there were sufficient numbers of suitably skilled and experienced staff to meet people's needs. Regulation 18 (1)