Savace Limited

Bramcote Hills Care Home

Inspection report

Sandringham Drive
Bramcote
Nottingham
Nottinghamshire
NG9 3EJ

Tel: 01159221414

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 1 and 2 March 2017 and was unannounced.

Accommodation for up to 63 people is provided in the service. The service is designed to meet the needs of older people living with or without dementia. There were 53 people using the service at the time of our inspection.

A registered manager was in post and was available throughout the inspection. 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.

Staff knew how to keep people safe and understood their responsibilities to protect people from the risk of abuse. Risks were managed so that people were protected from avoidable harm and not unnecessarily restricted.

Sufficient staff were on duty to meet people's needs and staff were recruited through safe recruitment practices. Medicines were safely managed.

Staff received appropriate induction, training and supervision. People's rights were protected under the Mental Capacity Act 2005.

People received sufficient to eat and drink, though the mealtime experience in one dining area and the completion of fluid chart documentation could be improved. External professionals were involved in people's care as appropriate.

Staff were kind and knew people well. People and their relatives were involved in decisions about their care, though documented evidence of this could be improved. Advocacy information was made available to people.

People received care that respected their privacy and dignity and promoted their independence.

People received personalised care that was responsive to their needs. Care records contained information to support staff to meet people's individual needs, though activities could be further improved.

A complaints process was in place and staff knew how to respond to complaints.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident in raising any concerns with the management team and that

appropriate action would be taken.

The provider was meeting their regulatory responsibilities. There were effective systems in place to monitor and improve the quality of the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff knew how to keep people safe and understood their responsibilities to protect people from the risk of abuse. Risks were managed so that people were protected from avoidable harm and not unnecessarily restricted.

Sufficient staff were on duty to meet people's needs and staff were recruited through safe recruitment practices. Medicines were safely managed.

Is the service effective?

Good

The service was effective.

Staff received appropriate induction, training and supervision. People's rights were protected under the Mental Capacity Act 2005.

People received sufficient to eat and drink, though the mealtime experience in one dining area and the completion of fluid chart documentation could be improved. External professionals were involved in people's care as appropriate.

Is the service caring?

Good

The service was caring.

Staff were kind and knew people well.

People and their relatives were involved in decisions about their care, though documented evidence of this could be improved. Advocacy information was made available to people.

People received care that respected their privacy and dignity and promoted their independence.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs. Care records contained information to support staff to meet people's individual needs, though activities could be further improved.

A complaints process was in place and staff knew how to respond to complaints.

Is the service well-led?

Good

The service was well-led.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident in raising any concerns with the management team and that appropriate action would be taken.

The provider was meeting their regulatory responsibilities. There were effective systems in place to monitor and improve the quality of the service provided.

Bramcote Hills Care 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 1 and 2 March 2017 and was unannounced.

The inspection team consisted of an inspector, an expert by experience and a specialist nursing advisor with experience of dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed the information we held about the home, which included notifications they had sent to us. A notification is information about important events which the provider is required to send us by law. We also contacted the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with seven people who used the service, seven visiting families, a visiting healthcare professional, the cook, a domestic staff member, a laundry staff member, a housekeeper, an activities coordinator, a maintenance person, four care staff, a nurse, the registered manager and a representative of the provider. We looked at the relevant parts of the care records of six people who used the service, three staff files and other records relating to the management of the home.

We used 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.

Good

Is the service safe?

Our findings

Everyone we spoke with told us that they felt safe living in the home. A person said, "It's very safe. I get a nice feeling here." Visitors felt that their family member was safe. A visitor said, "I feel [my family member]'s safe as it's quiet and secure."

Staff were aware of safeguarding procedures and the signs of abuse. A staff member said, "If I had any [safeguarding] concerns I would raise with managers. If I wasn't happy with their response I would go to the Council and the CQC." A safeguarding policy was in place and staff had attended safeguarding adults training. Information on safeguarding was available to give guidance to people and their relatives if they had concerns about their safety. Appropriate safeguarding records were kept by the service of any safeguarding referrals they made and appropriate action had been taken to reduce further risks.

People told us that they were not unnecessarily restricted. A person said, "I can go anywhere, sit in the lounge, go for a ciggie in the car park or stay in here. A [staff member] used to go to the smokers den with me but now I can go by myself. I can go to my solicitor too now by myself." Another person said, "I stay in my room as I prefer not to mix. There's no restrictions. I get up to what I like." A visitor said, "[My family member]'s not stopped from doing anything they want to do."

People told us that staff supported them to move safely. We observed people being assisted to move safely and staff used moving and handling equipment competently. Staff told us they had sufficient equipment to meet people's needs and if they required any additional equipment they could raise this with the management team and it would be provided.

Individual risk assessments were completed to assess people's risk of falls, developing pressure ulcers, malnutrition and choking. There were also risk assessments when people used the lift, went on visits out of the service with a relative and diabetes risks. Actions were identified to reduce these risks as much as possible. When a person was independently mobile but falling frequently, staff had made appropriate referrals to external professionals.

We saw documentation relating to accidents and incidents and the action taken as a result, including the review of risk assessments and care plans and the involvement of external professionals. Accidents and incidents were analysed to identify any trends or themes so that actions could be taken to reduce any risks of them happening again.

Pressure-relieving mattresses and cushions were in place for people at high risk of developing pressure ulcers and they were functioning correctly. We saw that people received support to change their position to minimise the risk of skin damage in line with their assessed needs as set out in their care plans.

We saw that the premises were well maintained and checks of the equipment and premises were taking place. We saw that action was taken promptly when issues were identified from premises and equipment checks. There were plans in place for emergency situations such as an outbreak of fire and personal

emergency evacuation plans (PEEP) were in place for all people using the service. This meant that staff would have sufficient guidance on how to support people to evacuate the premises in the event of an emergency. A business continuity plan was in place and available for staff to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

People and visitors gave mixed feedback on whether there were enough staff to meet people's needs. A person said, "There seems to be enough in the day but night is a bit short." A visitor said, "They could do with more [staff]. I can't find someone at times. And more would help give more time with people." However, another visitor said, "Staffing levels are fine."

Care, domestic, laundry, maintenance and kitchen staff all felt that they had sufficient time to complete their work effectively. A staff member said, "It's the most staff I've ever known in a care home." During the inspection we observed staff promptly attending to people's needs and call bells were responded to within a reasonable time.

Systems were in place to identify the levels of staff required to meet people's needs safely. The registered manager explained that they considered people's dependencies when setting staffing levels and monitored them closely to ensure that staffing levels remained at the correct level.

Safe recruitment and selection processes were followed. A new member of staff said their references had to be checked prior to them commencing work. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

People were happy with how their medicines were managed. A person said, "I'm supervised okay with mine." A visitor said, "[Staff] stay with [my family member]." However one person said, "[Staff] wait with me but once in a while they leave them for me." We raised this issue with management who agreed to continue observing medication administration to ensure that this did not take place.

Staff administering medicines told us they had completed medicines training and received competency checks for medicines administration. We observed the administration of medicine; staff checked against the medicines administration record (MAR) for each person and stayed with the person until they had taken their medicines. MARs contained a photograph of the person to aid identification, a record of any allergies and people's preferences for taking their medicines. We checked medicines administration records and found they had been completed consistently. However, we found a tablet in a person's bedroom. We raised this issue with management and appropriate action was taken.

Processes were in place for the ordering and supply of medicines. Staff told us they obtained people's medicines in a timely manner and we did not find any evidence of gaps in administration of medicines due to a lack of availability. Medicines were stored securely in locked trolleys, cupboards and a refrigerator within a locked room. Temperature checks were recorded daily of the room and the refrigerator used to store medicines.

Good

Is the service effective?

Our findings

People felt staff were capable in their role, with the exception of some agency staff members. A person said, "I think they're superb. [A staff member] counselled me on my depression when I came without me realising it. I've seen them cope with falls and all sorts." A visitor said, "The long standing staff are great." We talked with a visiting professional with expertise in dementia, about their opinion of staff knowledge about dementia. They said, "There is good and bad in the skill mix. Some staff are very good and some not so good." We observed that staff competently supported people throughout the inspection.

Staff felt supported by management. They told us they had received an induction which prepared them for their role. Staff also told us they had access to training to enable them to keep themselves up to date and they felt they had the knowledge and skills required for their role. They told us they received regular supervision and records we saw confirmed this.

Training records showed that staff attended training which included equality and diversity training. There were gaps in the training but a training plan was in place to address those gaps and systems were in place to ensure that staff remained up to date with their training.

Most people we spoke with told us that staff usually asked for consent before giving care. A person said, "They do indeed ask me first and I'd expect that." A visitor said, "They don't do anything without asking [my family member] first."

We saw that most staff asked permission before assisting people and gave them choices. However we observed at lunchtime that not all staff asked people before putting a clothing protector on them. Where people expressed a preference staff respected them.

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.

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 DoLS. We checked whether the service was working within the principles of the MCA.

Mental capacity assessments were completed and best interest decisions documented when people were unable to make some decisions for themselves. However, when sensor mats were being used to warn staff when people moved out of bed, we did not find evidence of consent or a capacity assessment and best interest decision in relation to this decision. When people were being restricted, DoLS applications had been made. Staff had an appropriate awareness of MCA and DoLS.

Care records contained guidance for staff on how to effectively support people with behaviours that might challenge others. Staff were able to explain how they supported people with periods of high anxiety. We observed staff effectively support people with behaviours that might challenge others.

We saw the care records for people who had a decision not to attempt resuscitation order (DNACPR) in place. There were DNACPR forms in place and they had been fully completed.

People spoke positively about the food choices available and told us that they received meals that met their needs. A person said, "I always enjoy it and have a choice and get a good meal." Another person told us, "It's very good food. We get a choice of two meals or could ask for another option." A visitor said, "[My family member] likes the food. [They] say it's very good." Another visitor was positive about the quality of the food but said, "[My family member] can eat normally but sometimes chooses not to eat as large portions put [them] off. I've said to bring [their] meal in a bowl or small plate instead so [they] can pick it up to eat and not be over-faced. Some do, some don't – like today I arrived and [my family member]'d dropped off with a big plate of uneaten food on the tray on [their] lap sliding off. Other times they put a big plate on [my family member]'s table and then [they] can't manage to reach it to pick it up. No continuity." We raised this issue with management who agreed to remind staff of the person's needs in this area.

We observed the lunchtime meal in three dining rooms and the main lounge. Food looked appetising and portion sizes were good. People received more food if they asked for it. Staff generally provided adequate support for people in two of the dining rooms and the main lounge. However, we saw one staff member standing over a person while supporting them to eat and some staff holding the next spoon of food near people's mouths while people were still chewing.

In the third dining room staff supervision and assistance for people were inconsistent. Three different staff were involved in the intermittent assistance of people to eat, with no continuity or awareness of who had eaten what. Lack of supervision between courses also led to disquiet in the room between several people, with one person upsetting two other people with their language and calling out, causing them to cry. We also saw that a person was given a plate of pasta which they proceeded to eat slowly with a knife and then used their hands. Staff did not see this taking place and were not available to provide this person with the support they required.

People told us that they had sufficient to drink. A person said, "I have two jugs here that get refilled plus the trolley comes now and then." A visitor said, "I've no concerns on [my family member's] fluids as [they] drink squash well and have a couple of milkshake supplements a day." We saw that people were offered drinks throughout the inspection, however, fluid charts were not well completed which meant that there was a greater risk that staff would not promptly identify when people were not having sufficient to drink. One of the sets of records we reviewed was for a person who had been admitted to hospital with an infection and dehydration, their care plan also stated they were at risk of dehydration, therefore we would have expected this person's fluid charts to have been monitored and reviewed carefully.

People were weighed regularly and appropriate action taken if people lost a significant amount of weight. Food charts were in place for people where appropriate and were well completed. A person with diverse needs regarding their food choices told us that these were met by staff.

People told us they were supported with their healthcare needs. A person said, "The dentist came then said I needed to go to the surgery for treatment as a result. I've seen the optician here and get the chiropodist about every 6 weeks." Another person said, "I've got some new glasses and they're brilliant. So glad they came in here to see me." Care records contained record of the involvement of other professionals in the

person's care.

Good

Is the service caring?

Our findings

People told us that staff were kind, caring and considerate. A person said, "[Staff] are very kind to me. I really can't sing their praises enough." A visitor said, "They're kind and welcoming to me too." Another visitor said, "I don't think [my family member] could have been in a more caring location. Staff are really good at making sure the family are okay too."

Staff had a good knowledge of the people they cared for and their individual preferences. We saw good interactions between staff and the people they cared for. These interactions indicated empathy for people and a caring approach by staff. We saw staff respond appropriately and promptly to people showing signs of distress.

Some people and visitors told us that they felt involved in the care planning process, while some visitors felt less aware and did not have regular updates on their relative. A person said, "I'm very much at home with them and can talk to them about anything. I've seen my care plan. They chat to me about the arrangements being made for me to go into assisted housing soon." A visitor said, "I don't feel involved as I have to ask if I want to know anything." Another visitor said, "I've not seen a care plan yet, but we ask a lot of questions and we get answers." A third visitor said, "I was involved in discussions at the start and have also been involved in reviews."

Care records contained documentation which stated that the person and/or their relatives would be invited to meetings to review their care plans and stating that the person was able to view their care plans at any time. However, there was no further documentation to indicate this had occurred. Care records did contain information regarding people's life history and their preferences and we also saw examples where relatives had been involved in the best interests decision-making process.

Advocacy information was available for people if they required support or advice from an independent person. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known.

Where people could not communicate their views verbally their care plan identified how staff should identify their preferences and staff were able to explain this to us. We observed staff clearly communicated with people and gave people sufficient time to respond to any questions.

People provided mixed feedback on whether their privacy and dignity were respected. A person said, "Some [staff] knock, some don't. But they shut the door and curtains when I'm dressing." Another person said, "They're very private and knock for me." However, a third person said, "It's not very private really as I can clearly hear the staff outside [my bedroom] on the chairs doing their assessment things [handover] so I hear it all." This person told us that they could hear these discussions even though their bedroom door was closed. We raised this issue with management who agreed to ensure that these discussions did not take place in this area in the future.

We saw staff took people to private areas to support them with their personal care and saw staff knocked on people's doors before entering. The home had areas where people could have privacy if they wanted it. Staff were able to describe the actions they took when providing care to protect people's privacy and dignity. A staff member said, "I always knock on people's doors before entering and shut people's curtains when providing people with personal care."

We saw that staff treated information confidentially and care records were stored securely. The language and descriptions used in care plans showed people and their needs were referred to in a dignified and respectful manner.

People told us they were encouraged to be independent where possible. A person said, "I'm encouraged to do what I can." Another person said, "I try to be independent when I can." Staff also told us they encouraged people to do as much as possible for themselves to maintain their independence.

A person said, "My [family member]'s not tied to any [visiting] times." A visitor told us, "I come unannounced any time." Staff told us people's relatives and friends were able to visit them without any unnecessary restriction. Information on visiting was in the guide for people who used the service.

Good

Is the service responsive?

Our findings

People told us they received care that was responsive to their needs. A person said, "I can go to bed and wake up to suit me, then I just ring. I decide on what to wear and where I fancy going." Another person said, "I go to bed at my time and same in getting up. Then I get my clothes out." However, people gave mixed feedback on how quickly their buzzer was responded to. A person said, "It can be quite a long time, 30 or more minutes. They may come in and cancel it and say they'll be back. Other times no one comes and I have to ring again." Another person said, "They come quickly enough when I ring."

Most people told us that they received a shower or bath when they wanted one though one person said, "I prefer a bath and get one two weekly. I'd prefer once a week but they don't always ask me and are too busy often." We discussed this with staff who assured us that people received showers or baths when they wanted them. We looked at records which confirmed this, though, staff did not always record when they had offered baths but the person had refused them.

Feedback from visitors was mixed. A visitor said, The care and attention [my family member] received was everything I would have expected and probably more." Another visitor said, "Yes [my family member] receives personalised care." However, two visitors raised concerns regarding the nail care provided to their family member by staff, though one visitor told us that there had been recent improvements in this area.

People's views were mixed of the activities that were provided. A person said, "We do painting sometimes. I join in if something's on but it isn't every day. The parachute and balls was fun yesterday." Another person told us, "If there's singing or music I'll go to it. I have a masseur who comes in that the home arranges for a weekly massage which I find helps." However, a third person said, "It's not my scene - a bit infantile for me. The day trips would be a good idea though." A visitor said, "[My family member] played dominoes with someone the other day. My main concern is it's not dementia specialist enough. I don't see any stimulation going on apart from the music motivation chap now and then and [my family member] doesn't join in that. We had an outing in a taxi to a coffee shop. Our curate comes in each month to give [my family member] communion."

We observed group activities and some one to one activities took place during our inspection. Care records contained information about people's interests and preferences. The management team told us that another staff member would be providing additional activities coordination time in the future. The activities coordinator told us that they would be attending training in the near future to support them to provide a greater range of activities for people living with dementia.

Care plans were in place to provide information on people's care and support needs. These provided personalised detail and were generally comprehensive however; there were a small number of omissions. For example, one person had a sensor mat in place when they were in bed to warn staff when they moved out of bed and this was not recorded in their care plans. Their mobility care plan stated they should be checked one to two hourly at night and their night time care needs care plan provided personalised details about whether they liked their door and/or window open, the number of pillows and similar information but

the use of a sensor mat had not been documented.

The care plan for a person with diabetes provided instructions on the frequency of blood sugar monitoring, the signs and symptoms of hypo and hyper-glycaemia and the action staff should take if they had concerns. However, it did not mention the requirement for annual diabetic retinopathy eye screening or foot checks. We checked and this person's needs were being met in this area.

Care records contained information regarding people's diverse needs and provided support for how staff could meet those needs. We saw that people were supported to attend religious activities in line with their preferences.

People and visitors gave mixed feedback on how effectively their concerns were responded to. A person said, "The things I've mentioned are my plates not being taken away before the next meal arrives. And about the storage radiator as the heat goes up, not out and it makes a noise. No changes yet." A visitor said, "I complained that [my family member] looks so dishevelled and unshaven. They got the senior nurse to sit with me and she wrote it all down but I've not heard anything since." However another visitor said, "I complained about [my family member's] early dehydration as I was very upset about it, but it's been cured now."

We looked at a recent complaint which was responded to appropriately. Guidance on how to make a complaint was in the guide for people who used the service and displayed throughout the home. There was a clear procedure for staff to follow should a concern be raised. Staff were able to explain how they would respond to any complaints raised with them.

Good

Is the service well-led?

Our findings

People couldn't recall attending meetings or completing surveys but felt listened to and could raise any issues that they had. We saw surveys had been completed by people and meetings for people took place where comments and suggestions on the quality of the service were made. Actions had been taken where appropriate.

Some visitors were aware of meetings and surveys. A visitor said, "I've not been to any meetings due to my shifts. I did a questionnaire a while ago I think." Another visitor said, "I've been to a meeting recently." We saw surveys had been completed by visitors and meetings for visitors took place where comments and suggestions on the quality of the service were made. Actions had been taken where appropriate. A visitor said, "Now I think they listen. We didn't at first as there was so much going wrong with [my family member's] health." Another visitor said, "They do listen to us and take things on board then we have to wait and see what changes."

A whistleblowing policy was in place and staff told us they would be prepared to raise issues using the processes set out in this policy. The provider's values and philosophy of care were in the guide provided for people who used the service. Staff were observed to act in line with them during our inspection.

We received mixed feedback on the atmosphere of the home. A visitor said, "The atmosphere can change daily depending on people's moods." Another visitor said, "It makes me feel tense. [My family member] hates all the swearing around [them]." However, a third visitor said, "Very pleasant, happy, homely atmosphere." Staff were very positive about the atmosphere of the home. A staff member said, "It's a lovely atmosphere, people are happy and it's calm. It's always been a peaceful home." Another staff member said, "It's a nice place to work. It's mellow." We found the atmosphere of the home to be relaxed and friendly. At times, some people did have behaviours that might challenge others but these were generally responded to promptly and appropriately by staff.

People told us that the management team were approachable and listened to them. A person said, "I go down and talk to [the registered manager]. I can raise anything and her door is always open." A visitor said, "They're good people, very much so. They ask me if all's okay."

Staff told us the registered manager was approachable and they felt able to talk freely with them about issues. A member of staff said, "It's a good place to work. Everyone pulls together." Staff told us staff meetings were held regularly and they were encouraged to raise issues at the meetings. We saw that staff meetings took place and the management team had clearly set out their expectations of staff. Staff told us that they received feedback in a constructive way.

The registered manager told us they had a five minute meeting at 11am each day to enable staff to report any issues and improve communication. We attended the meeting on the first day of the inspection and saw an update was provided by the activities coordinator on the activities they had initiated that morning and the entertainment booked for the afternoon, the maintenance person let staff know what he was doing that

day, the team leader gave an update on the external professional's visit that morning and other updates were given by the care coordinator and clinical lead.

A registered manager was in post and was available throughout the inspection. They told us that they felt well supported by the provider. The current CQC rating was clearly displayed. We saw that all conditions of registration with the CQC were being met and most statutory notifications had been sent to the CQC when required. Notifications relating to two DoLS authorisations had not been sent to the CQC. We raised this with management who agreed to do this immediately.

The provider had a system to regularly assess and monitor the quality of service that people received. We saw that regular audits had been completed by the acting manager and other staff, including a representative of the provider. Audits were carried out in a range of areas including infection control, medicines, health and safety, kitchen, laundry and care records. Actions had been taken where issues had been identified by audits.