Brendoncare Foundation(The)

Brendoncare Ronald Gibson House

Inspection report

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09 March 2018

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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 was an unannounced inspection that took place on 6, 7 and 9 March 2018.

Brendoncare Ronald Gibson House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home with nursing is registered for up to 56 people. There are three units at the home. Windsor unit is an intermediate care unit, providing short term rehabilitation services for people to support them to return home, after injury or illness. Wessex unit provides care for people living with dementia. Warwick unit provides care for frail or older people, some of whom were receiving palliative care.

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

At the last comprehensive inspection of this service in January 2016, it was rated good overall with a rating of requires improvement in effective. This was because people's rights were not being protected in accordance with the Mental Capacity Act 2005. We conducted a focussed inspection in September 2016 and found the service was now meeting this requirement, however, we could not improve the rating for effective from requires improvement as to do so requires consistent good practice over time. At this inspection, in March 2018, all key questions are rated good and the service is rated good overall.

People and their relatives were very satisfied by the care and support that the home provided particularly regarding the pleasant, friendly and relaxed atmosphere that staff created. There were suitable numbers of staff who met people's needs in a kind, thoughtful and person centred way.

The home had thorough recording, auditing and quality assurance systems that were comprehensive and up to date. The systems consistently monitored and assessed the quality of the service provided and information was regularly reviewed and recorded in a clear and easy to understand way.

People's health needs were discussed with them and they had access to community based health professionals as well as nursing and care staff. People had balanced diets that also met their likes, dislikes and preferences and protected them from nutrition and hydration associated risks.

People and their relatives said the meals provided were of good quality and there was a variety of choice. Staff supported people to eat their meals and drink as required whilst enabling them to eat at their own pace and enjoy the experience.

The home was clean, well-furnished and maintained and provided a safe environment for people to live and

staff to work in.

Staff were familiar with the people they supported and were appropriately skilled and trained to meet people's needs well. They were also aware of their responsibility to treat people equally and respect their diversity and human rights. They treated everyone equally and fairly whilst recognizing and respecting people's differences.

Staff thought the registered manager and organisation provided excellent support and there were opportunities for career advancement.

People and their relatives said they found the registered manager and staff were approachable, responsive and encouraged feedback from them.

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 remains Good.'

Is the service effective?

Good

The service was effective.

At the previous focussed inspection, the home's staff were meeting the requirements of the MCA to ensure that people's rights were protected. We could not improve the rating for effective from Requires Improvement because to do so requires consistent good practice over time.

People received care and support from well trained and qualified staff. Their care plans monitored food and fluid intake and balanced diets were provided. The home was decorated and laid out to meet people's needs and preferences.

The home had Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) policies and procedures and staff was provided with training. People underwent mental capacity and DoLS assessments and 'Best interests' meetings were arranged as required.

Staff teams worked well together internally and across organisations.

Is the service caring?

Good

'The service remains Good.'

Is the service responsive?

Good

'The service remains Good.'

Is the service well-led?

Good

'The service remains Good.'

Brendoncare Ronald Gibson House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection and took place on 6, 7 and 9 March 2018.

This inspection was carried out by one inspector over three days.

There were 52 people living at the home. We spoke with seven people, ten relatives and visitors, ten staff, and the registered manager and the organisation's Head of Care Services.

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 also considered notifications made to us by the provider, safeguarding alerts raised regarding people living at the home and information we held on our database about the service and provider.

During our visit we observed care and support provided, was shown around the home and checked records, policies and procedures. These included staff training, supervision and appraisal systems and the home's maintenance and quality assurance systems.

We looked at the personal care and support plans for six people and five staff files.

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

People felt safe living at Brendoncare Ronald Gibson House and their relatives were confident in leaving people in the home's care. One person told us, "A safe environment." Another person said, "I am safe here." A relative told us, "They [staff] bother and make a fuss of him as he is very vulnerable because he can't communicate." Another relative said, "This is my first visit and I'm pleasantly impressed, this is 100 times better than the old home." They were referring to the home their relative had moved from.

There were enough staff to safely provide care for people in a relaxed atmosphere that made them feel safe and the numbers on the staff rota matched those on duty. This meant the home met people's needs in a safe, enjoyable and unrushed way and this was demonstrated by people's positive body language, familiarity with and responses to staff. The home was currently recruiting to two vacant posts.

Staff had access to policies and procedures regarding protecting people from abuse and harm and were trained in them. This was reflected in their care practices that we observed. Staff outlined their interpretation of what abuse was and the action required if it was encountered. Their responses corresponded to the provider's policies and procedures. Staff said that protecting people from harm and abuse was included in their induction and refresher training and an essential part of their jobs.

The organisation provided staff with safeguarding training and they were aware of how to raise a safeguarding alert and when this was required. The staff handbook also contained safeguarding information. Previous safeguarding issues had been suitably reported, investigated, recorded and learnt from.

People's risk assessments contributed to them being able to enjoy their lives safely. They identified areas of risk relevant to people that included all aspects of their lives and specifically health, welfare and social activities. The risk assessments were reviewed and updated as people's needs and interests changed. Relevant information was shared by staff, during shift handovers, staff meetings and when they occurred. Risk assessments were also used as opportunities for discussion if something had gone wrong so that lessons could be learnt. The home kept accident and incident records and there was a whistle-blowing procedure that staff said they were aware of and understood.

The building risk assessments were very comprehensive, regularly reviewed and updated. The home's equipment was regularly checked and serviced. This included individual fire evacuation plans for people.

Staff had received infection control training that was reflected in their working practices and the home carried out infection control checks. The home also minimised the risk of infection by holding a good stock of equipment that included gloves and aprons for giving people personal care.

There was a thorough staff recruitment procedure that included advertising the post and providing an application form, job description and person specification. Prospective staff were short-listed for interview. The interview contained scenario based questions to identify people's care philosophy, communication

skills and knowledge of the type of care the home provided. If there were gaps in the knowledge of prospective staff, the organisation decided if they could provide this knowledge, within the induction training and the person was employed. References were taken up, work history checked for any gaps and Disclosure and Barring Services (DBS) security checks carried out prior to staff starting in post. There was a six month probationary period. The home had disciplinary policies and procedures that staff confirmed they understood.

Staff had received training in and understood de-escalation techniques to appropriately deal with situations where people may display behaviour that others could interpret as challenging. These were focussed on people individually and staff had appropriate knowledge to do this successfully. Staff actions were recorded in people's care plans.

Medicine was safely administered to people. The staff who administered medicine were appropriately trained and this was refreshed annually. They also had access to updated guidance. A sample of medicine records for people were checked and found to be complete and up to date. This included the controlled drugs register that had each entry counter signed by two staff members who were authorised and qualified to do so. A controlled drug register records the dispensing of specified controlled drugs. Medicine kept by the home was regularly monitored and audited. The drugs were safely stored in a locked facility and appropriately disposed of if no longer required. There were medicine profiles for each person in place.

Good

Is the service effective?

Our findings

Staff received induction and annual mandatory training. The induction was comprehensive took place over four days, included core training aspects and information about staff roles, responsibilities, the organisation's expectations of staff and the support that staff could expect to receive from the organisation. All aspects of the service and people who use it were covered and new staff shadowed more experienced staff. This increased their knowledge of the home, people and provided a good standard of quality care. The training matrix and annual training and development plans identified when mandatory training was due.

Training encompassed the 'Care Certificate Common Standards' and included dementia awareness, tissue viability, fire, manual handling, first aid, food hygiene and health and safety. The Care Certificate is an identified set of 15 standards that health and social support workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new support workers and was developed jointly by Skills for Care, Health Education England and Skills for Health. Staff meetings included opportunities to identify further training needs. Quarterly supervision sessions and annual appraisals were partly used to identify any gaps in training.

The organisation's training spreadsheet informed the registered manager if less than 95 percent of training had been carried out and they then submitted an action plan with training dates for staff that had not completed training. It also included training expiry dates for the forthcoming month.

Staff received equality and diversity training that enabled them to treat everyone equally and fairly whilst recognizing and respecting people's differences. This was reflected in staffs' positive care practices and confirmed by people and their relatives. People were treated very respectfully, equally and as equals with staff not talking down to them. One relative told us, "Never any arrogance or aggression."

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 people 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).

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. Mental capacity was part of the assessment process to help identify if needs could be met. The Mental Capacity Act and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Applications had been submitted by the provider and applications under DoLS had been authorised. The provider was complying with the conditions applied to the authorisation. Best interests meetings were arranged as required. Best interests meetings took place to determine the best course of action for people who did not have capacity to make decisions for themselves. The capacity assessments were carried out by staff that had received appropriate

training and recorded in people's care plans. Staff received mandatory training in The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with understood their responsibilities regarding the Mental Capacity Act 2005 and Deprivation of liberty safeguarding. Staff continually checked that people were happy with what they were doing and the activities they had chosen throughout our visit.

There was a clear policy and procedure to inform other services within the community or elsewhere of relevant information regarding changes in people's needs and support. This was of great importance as one unit was dedicated to providing rehabilitation support so people were enabled to return to living independently in the community. This meant there was constant communication with health care professionals, such as visiting physiotherapists to establish when people could be discharged. Records also demonstrated that staff liaised and worked with relevant community health services including hospital discharge teams, GPs and physiotherapists, making referrals when required and sharing information.

People's care plans contained information regarding health, nutrition and diet. Full nutritional assessments were carried out and regularly updated. This was using the Malnutrition Universal Screening Tool (MUST) tool to assess a person's nutritional status. If required weight charts were kept and staff monitored how much people had to eat and drink. There was also person specific information regarding any support required at meal times, including any possibility of choking. Staff had also received training regarding choking and dysphagia. Dysphagia is difficulty or discomfort in swallowing, as a symptom of disease. Each person had a GP and staff said that any concerns were raised and discussed with the person's GP and relatives as appropriate. Staff, including the catering team provided nutritional advice. People had annual health checks depending on the nature of the support they received. People's consent to treatment was regularly monitored by the home and recorded in their care plans.

Over the duration of the lunch we observed, people with dementia had an enjoyable experience with much laughter, joking and smiling. Staff encouraged people to eat meals in a supportive way, making the effort to ensure people, who needed encouragement to eat, received it. Although people's needs were met by staff in a re-assuring way, sometimes the care was a little task focussed and rushed. A lot of staff spoke with people at eye contact level that elicited a positive response, whilst others spoke to people in a standing position that resulted in a less positive response. This was acknowledged by the management team who were introducing further staff guidance.

People's meal choices were explained and staff revisited them as many times as people required to help them understand what they were. They also spent time explaining to people what they were eating during the course of the meal and checked they had enough to eat. Whilst concerned to make sure people had enough to eat this could be slightly overzealous with a number of staff supporting individual people which was a little confusing for them. One person explained to staff that they had eaten enough, but the staff member persisted. This meant that the person's mood changed from good to irritated. This was acknowledged by the management team who were introducing further staff guidance.

The meals were of good quality and special diets on health, religious, cultural or other grounds were provided. They were well presented, nutritious, hot and monitored to ensure they were provided at the correct temperature. Staff supported people in a timely way at mealtimes and no one had to wait for their lunch. Regular meetings took place between people and catering staff to discuss the quality of the meals, how they were served and choices. People said they enjoyed the meals.

The home was clean, well decorated, well-maintained and with no unpleasant odours. The layout was

conducive to providing people with a homely atmosphere and suitable communal and personal accommodation. This meant people had the space to socialize as much or as little as they wished.

Good

Is the service caring?

Our findings

People and their relatives were involved in deciding how care and support would be delivered. They said that the way staff provided care and support was what was needed and delivered in a friendly, patient, relaxed and professional way. One person said, "If I was not in here, I would have been ill." Another person told us, "Not bad at all, we have a laugh with everyone [staff]." A relative said, "I have never seen a lack of care or unprofessionalism from any of the care staff." Another relative told us, "Staff have a beautiful attitude and are very good at getting people involved."

Our observation of staff communication skills showed that people were spoken with in an unrushed way so that they could understand what staff were saying. This was done in a re-assuring manner with most staff making contact at eye level and using appropriate body language. People responded well to this and it enhanced the ability of staff to meet people's needs in a way that they wanted and felt comfortable with.

The home provided people with a service that was based on treating them with dignity, respect and compassion. Staff were attentive, responded to people promptly and addressed them by their preferred name, nickname or title. Staff knocked on people's bedroom doors and waited for a response before entering and were discreet if people required a visit to the toilet. People and their relatives told us that staff listened to and acknowledged them and valued their opinions whilst delivering support in a friendly, patient and helpful way. One person said, "The carers [staff] are wonderful." Another person told us, "The older ones [staff] teach the younger ones and they are great." A relative said, "Staff are welcoming, well-trained and very friendly." Another relative told us "A jolly lot [staff] who provide a convivial atmosphere."

Positive staff care practices reflected that staff went over and above their job roles to make sure people's needs were met. They stimulated people patiently and skilfully and encouraged them to have conversations with each other as well as staff. This was achieved by staff applying their knowledge of people and their needs and preferences that enabled them to lead happy and rewarding lives. This was done individually and as a team. People were treated with kindness and understanding with staff taking an interest in them. Their approach to care was supported and underpinned by the life history information contained in people's care plans that people, their relatives and staff contributed to and regularly updated.

There was an advocacy service available that people had access to if required.

The home had a confidentiality policy and procedure that staff said they were made aware of, understood and followed. Confidentiality was included in induction and on-going training and contained in the staff handbook. There was a policy regarding people's right to privacy, dignity and respect, that staff followed throughout the home, in a courteous, discreet and respectful way, even when unaware that we were present.

There was a visitor's policy which stated that visitors were welcome at any time with the agreement of people. Relatives we spoke with confirmed they visited whenever they wished, were always made welcome and treated with courtesy.

Good

Is the service responsive?

Our findings

People and their relatives told us that the registered manager, staff and organisation asked for their opinions formally and informally. This meant people could be empowered to make decisions and staff could then take action on them. The registered manager and staff went out of their way to make themselves available to people and their visitors, if they wished to discuss any problems or just wanted a chat. The staff speedily resolved any issues people had. This meant people had the opportunity to decide the support they wanted and when and support was delivered in a timely and appropriate way that people enjoyed. One person said, "They [staff] take a personal interest and always care for residents [people]." Another person told us, "They [staff] always check people are okay." A relative said, "We are kept up to date with information."

Staff were committed as a team, irrespective of their roles and shared information with each other throughout the home, complemented the key worker system and this extended the sharing of people's issues and concerns with the teams. Staff possessed talents outside their working remits, such as dancing that were put to good use to enhance people's quality of life.

There was easy to understand written information about the home in sufficient detail to enable people to understand the type of care and support they could expect. It also laid out the home's expectations of them.

The home carried out assessments of people's needs with them and their relatives and if it was identified that needs could be met, people and their relatives were invited to visit. Many people had first experienced a respite stay at the home, before moving in permanently or had prior knowledge as relatives had used the service. If a service was commissioned by a local authority or the NHS, assessment information was requested from these bodies or from a care home if they had been transferred.

People were invited to visit as many times as they wished before deciding if they wanted to move in and fully consulted and involved in the decision-making process. These visits were also used to identify if they would fit in with people already living at the home in the longer stay units. Staff said it was essential to capture people's views as well as those of relatives so that care could be focussed on the person.

People's assessments were the basis of their initial care plans. The care plans were focussed on people as individuals and were live documents. They included people's interests and were added to with staff when new information became available. The information gave people the opportunity to identify activities they may wish to do. However the daily notes did not really reflect this being prescriptive of a person's day and tended to be more focussed on their health rather than being balanced with their quality of life. This was acknowledged by the management team who were introducing further staff guidance.

People's needs were regularly reviewed, re-assessed with them and the care plans updated to meet any needs that had changed. People were encouraged to take ownership of their care plans and contribute to them when they wished. Care plan goals were underpinned by assessments of risk to people. The detail of

the information contained in people's care plans varied depending on the type of care they received with the short term rehabilitation unit care plans being shorter and focussed on the support required for them to return home. One relative said, "We are kept informed including invites to the care plan reviews."

The home provided a variety of activities based on people's wishes and staff knowledge of people's likes and dislikes. The communal activities were reviewed regularly to make sure they were focussed on what people wanted. The success of this approach was reflected in the high participation of people in the activities. During the inspection people were consulted, by staff about what they wanted to do and when. In activity sessions people were encouraged to join in but not pressurised to do so.

A timetable of weekly activities was available that took into account people's interests and ability to participate. One person said, "I do get a programme of activities and it is up to me what I do." Staff reminded people of what was taking place during each day. The activities co-ordinator facilitated a programme of activities that people had chosen. These included a therapy dog, bird feeding and animal watch, coffee mornings, IPad what is your favourite song one to one sessions, poetry, musical entertainment, film club, 'Babies fun time' and dancing. There was also 'League of friends' reminiscence visits and a hairdresser. One person said, "Plenty to do." Relatives told us that they thought people enjoyed the activities provided and they were appropriate.

The home provided end of life care and staff had received appropriate training from the organisation. Qualified nursing staff also attended external training for end of life competencies at a local Hospice and a palliative care nurse visited the home to provide training. There was specific reference to end of life in people's care plans including guidance and people's wishes. When providing end of life care, the home facilitated relatives to be involved in the care, if they wished during a distressing and sensitive period for them. The home liaised with the appropriate community based health teams and organisations such as palliative care teams.

People and their relatives told us they were aware of the complaints procedure and how to use it. The procedure was included in the information provided for them. There was a robust system for logging, recording and investigating complaints. Complaints made were acted upon and learnt from with care and support being adjusted accordingly. Staff said they had been made aware of the complaints procedure and there was also a whistle-blowing procedure. They also knew of their duty to enable people to make complaints or raise concerns.

People and their relatives were invited to general home meetings and those specific to themselves. The meetings were minuted and people were supported to put their views forward including complaints or concerns. The information was monitored and compared with that previously available to identify that any required changes were made.

Good

Is the service well-led?

Our findings

The registered manager operated an open door policy. This meant people and their relatives felt comfortable in approaching the registered manager as well as staff. One person told us, "The [registered] manager and staff have gone out of their way to make me feel at home." Another person said, "Always says hello [registered manager]." One relative told us, "The [registered] manager is approachable and very understanding." Another relative said, "The [registered] manager welcomes everybody." People's conversation and body language showed that they were very comfortable with the registered manager and staff.

The organisation projected a clear vision and values that staff understood and embraced. The vision and values made clear what people could expect from the organisation, home and staff. This included publishing an organisation annual review. People were also kept up to date with what was going on in the organisation by a newsletter and one for Brendoncare Ronald Gibson House. Staff said the vision and values were described and explained as part of their induction training and revisited during staff meetings. The management and staff practices reflected the vision and values as they went about their duties.

The home worked in partnership with other agencies, including the local Clinical Commissioning Group.

Staff had personal development plans and the organisation provided staff with opportunities for personal advancement and to develop knowledge and skills. A number of senior posts at the home were filled by staff that had been promoted internally. There was also a 'My home life' leadership development programme that provided learning sets to promote consistent leadership at the point of care delivery and a programme of development delivery days for deputy managers .

There was a 'Going the extra mile' award scheme for staff and volunteers that was operated on a local and organisational basis with nominations made by people, their relatives, other staff and volunteers, visitors and care professionals. Staff who received an award were put forward for an 'Aiming high' award that recognised staff that had endeavoured to achieve the organisation's mission statement. There were also long service awards.

The home's lines of communication and areas of responsibilities were very clear throughout the home and organisation and staff were aware of their areas of responsibilities. Staff said they would be comfortable using the whistle-blowing procedure if they needed to.

People engaged with the local community attending and hosting various activities. These included the mothers and babies group that visited frequently and visits from local schools. There were also the 'Friends' of Brendoncare Ronald Gibson House who ran a number of events, raised funds and promoted the home within the local community.

Staff said they were well supported by the registered manager and management team. They thought that the suggestions they made to improve the service were listened to and given serious consideration. They

said they really enjoyed working at the home. A staff member told us, "The manager is very hands on." Another member of staff told us, "I love my job with a passion."

Our records demonstrated that appropriate notifications were made to the Care Quality Commission when needed.

The quality assurance system contained performance indicators that identified how the home was performing, any areas that required improvement and areas where the home was performing well. It contained a range of feedback methods and the records we saw were up to date. This was enabled by up to date, state of the art electronic auditing systems. The audits included care plans, medicine, risks, pressure care and ulcer management, falls, nutrition, health and safety, people's involvement and activities. There was also a business continuity plan and quarterly clinical governance meetings, chaired by the board. There were twice yearly quality assurance and quarterly contract monitoring visits and an annual pharmacy review. The registered manager also conducted regular night visit checks. Annual policy and procedure reviews were carried out. Annual surveys were also sent out to people, their relatives and staff.