Brabyns House Limited

Brabyns House

Inspection report

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Marple
Stockport
Greater Manchester
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Tel: 01614274886

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 27 September 2016 and was unannounced. The home was last inspected on 2 April 2014 and the registered provider was compliant with the regulations in force at that time.

The home is registered to provide accommodation and care for up to 39 older people, including people who are living with dementia. On the day of the inspection, there were 35 people living at the home. The home is situated in Marple, close to Stockport, in Greater Manchester. The premises had two floors and the first floor was accessed by a passenger lift. There were attractive gardens and car parking spaces to the front of the premises.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with 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.

On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. However, we found the home's recruitment and selection policies and procedures had not been operated effectively. This meant there was a lack of evidence that only people considered suitable to work with vulnerable people were employed at Brabyns House.

This was a breach of Regulation 19 (2) 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.

Some notifications had not been submitted to CQC as required by regulation. This meant that we were not able to determine whether appropriate action had been taken following any accidents or incidents.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009: Notifications of other incidents.

Staff told us they were well supported by the registered manager and senior staff group. They confirmed that they received induction training when they were new in post and told us they were happy with the training provided for them.

People told us that they felt safe living at the home. People were protected from the risks of harm or abuse because there were effective systems in place to manage any safeguarding concerns. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

There was evidence that the registered provider was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

We checked medication systems and saw that medicines were stored, recorded and administered safely, although minor improvements were needed. Staff who had responsibility for the administration of medication had received appropriate training.

People who lived at the home and relatives told us that staff were very caring and that they respected people's privacy and dignity. We saw that there were positive relationships between people who lived at the home, relatives and staff, and that staff had a good understanding of people's individual care and support needs.

People's family and friends were made welcome at the home. A variety of activities were provided to meet people's individual needs, and people were encouraged to take part.

People told us they were very happy with the food provided. We saw that people's nutritional needs had been assessed and their individual food and drink requirements were met.

There were systems in place to seek feedback from people who lived at the home, relatives and staff. People told us they were confident their complaints and concerns would be listened to. Any complaints made to the home had been investigated and appropriate action had been taken to make any identified improvements.

Staff, people who lived at the home and relatives told us that the home was well managed. Quality audits undertaken by the registered manager were designed to identify that systems at the home were protecting people's safety and well-being, and we saw that some audits had resulted in improvements being made.

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 sufficient numbers of staff employed to ensure people received safe and effective support. However, the home's policies and procedures had not been adhered to when new staff had been employed.

Staff had received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse.

There were medication policies and procedures in place and staff had received training on the administration of medication. Minor improvements were needed to make the management of medication more robust.

The premises were clean, hygienic and well maintained.

Is the service effective?

Good

The service was effective.

Staff undertook training that gave them the skills and knowledge they required to carry out their roles.

People's nutritional needs were assessed and the meals provided met people's individual dietary needs.

People's physical and mental health care needs were met. Health and social care professionals were consulted appropriately and they told us their advice was followed by staff.

Is the service caring?

Good

The service was caring.

We observed positive relationships between people who lived at the home, staff and relatives. Staff were kind, considerate and patient.

People's individual care and support needs were understood by

staff, and people were encouraged to be as independent as possible, with support from staff.

We saw that people's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their individual care and support needs and their life history. This helped staff to have an in-depth knowledge of people's needs.

Activities were provided and were flexible to meet the needs of people who lived at the home.

People were encouraged to give feedback about the service they received. There was a complaints procedure in place and people told us they were confident any complaints would be listened to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a manager in post who was registered with the Care Quality Commission (CQC), and people told us that the home was well managed. However, not all notifications were being submitted to CQC as required by regulation.

Quality audits were being carried out to monitor that staff were providing safe and effective care.

There were opportunities for people's family and friends and health and social care professionals to express their views about the quality of the service provided.

Brabyns 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 was planned to check whether the registered 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.

The inspection took place on 27 September 2016 and was unannounced. The inspection was carried out by three adult social care (ASC) inspectors.

Before this inspection we reviewed the information we held about the home. This included information we had received from the local authority who commissioned a service from the registered provider, information from an infection control nurse and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was asked to submit a provider information return (PIR) before this inspection. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was submitted within the required timescale.

On the day of the inspection we spoke with seven people who lived at the home, five relatives, a health care professional, four members of care staff, the chef, the administrator and the registered manager.

We looked around communal areas of the home and some bedrooms. We also spent time looking at records, which included the care records for four people who lived at the home, the recruitment and training records for three members of staff and other records relating to the management of the home, including quality assurance, staff training, health and safety and medication.

Requires Improvement

Is the service safe?

Our findings

People who lived at the home told us they felt safe. One person said, "I feel very safe here as doors are locked at night and I am a good sleeper. Staff check on me twice but they don't disturb me. I have a buzzer if I need it and staff answer quickly." This was supported by the relatives who we spoke with.

The home had policies and procedures in place to guide staff on safeguarding people from abuse. We saw the registered manager used the local authority's safeguarding tool to record all accidents, incidents and allegations of abuse, and to consider whether they needed to submit an alert to the safeguarding adult's team. This decision making tool was submitted to the local authority safeguarding team on a monthly basis. We found that notifications were submitted to the Care Quality Commission (CQC) as part of the registered provider's statutory duty to report safeguarding incidents.

We spoke with staff about safeguarding adults from abuse, how they would identify abuse and the steps they would take if they witnessed abuse. Staff were able to describe different types of abuse and the action they would take if they became aware of an incident of abuse. They told us they would initially report any incidents to either the senior member of staff on shift, or the registered manager. They also told us they knew how to escalate the concerns if they felt the issue had not been appropriately addressed. Staff told us, "If I saw anything of concern I would go straight to [Registered manager]. If nothing happened then I would contact the CQC." Another member of staff said, "I know the procedure, I would have no problems taking any concerns further." The home's training record showed that staff had completed training on this topic during 2015 or 2016.

We checked the recruitment records for three members of staff. These records evidenced that an application form had been completed, references had been requested and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with vulnerable adults. Documents such as photographs to identify the person's identity had been retained. However, one person had only one employment reference in place, the references for two people had been received after they had commenced work at the home, and the outcome of the DBS check had not been recorded for two people. Following the inspection the home's administrator sent us information that showed DBS clearance for these two people had been obtained prior to them commencing work. The DBS check for one person had arrived after they had been working at the home for a period of two months. This meant that there was insufficient evidence that only people who were considered suitable to work with vulnerable people had been employed at Brabyns House.

This was a breach of Regulation 19 (2) 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.

New employees were issued with a job description; this meant they were clear about the role for which they had been employed.

The registered manager told us in the PIR document that they used a 'needs analysis form' to help them determine the staffing levels required to meet the needs of people who were currently living at the home. We observed that there were sufficient staff members on duty to enable people's needs to be met. We noted that there was always a staff presence in communal areas of the home and that people did not have to wait for attention. A member of staff told us, "There's enough staff. If anybody rings in sick then staff will cover shifts and the seniors and manager will help out." A relative told us, "There are always staff around."

The registered manager told us that the standard staffing levels on day shifts were six or seven care workers, including one deputy manager and one senior care worker. Staffing levels on a night were two care workers and a senior care worker. The registered manager was on duty in addition to care staff during the day, Monday to Friday. We checked the staff rotas and saw that these staffing levels had been consistently maintained.

In addition to care staff, there was a chef, a kitchen assistant, four domestic staff and a laundry assistant on duty each day. An activities coordinator worked from 10.00 am until 4.00 pm over five days a week, and an administrator worked over four days a week. This meant care staff were able to concentrate on supporting and caring for people who lived at the home.

Accidents and incidents were recorded and audited on a monthly basis and the results were collated in a report. The audits identified the number of incidents and accidents, a description of what had happened, the outcome and the person responsible for ensuring they were accurately recorded. We saw that when people had sustained an injury, appropriate medical assistance had been sought and this had been recorded. For example, one person had sustained a cut on their arm and the district nurse had attended to dress the wound. We saw that falls were audited and that this included the frequency of falls. The registered manager explained that, following a fall, they would take a urine sample, check the person's temperature, increase observations on the person and contact their GP for advice.

Risk assessments had been completed for any areas that were considered to be of concern. We saw risk assessments for the use of bed rails, poor diet, self-medication and the risk of falls. When a person used equipment to assist them with mobility or pressure area care, their care plan recorded instructions for the safe use of the equipment, and how many staff were needed to assist the person with the task. We observed staff assisting people to mobilise and noted this was done safely and that the person was offered constant reassurance.

Medication was supplied by the pharmacy in a biodose system; this is a monitored dosage system where tablets are stored in separate pods for administration at a set time of day. The pods were colour coded to denote the time of day when medication needed to be administered, and the same colours were used to identify the time of day on the medication administration record (MAR) charts. MAR charts also recorded a picture of each medication prescribed to the person concerned. These arrangements reduced the risk of errors occurring.

We looked at MAR charts and found that they were mostly clear, complete and accurate. There was some confusion about the use of the code Q on MAR charts. The senior care worker explained that the pharmacist had requested that they use this code when medication was not required. However, the MAR chart recorded a different code to be used when medication was not required. The senior care worker told us that they would discuss this with the pharmacist again to ensure that this was rectified to reduce the risk of confusion for staff administering medication.

Pods and medication supplied in boxes or bottles were stored in a medication trolley. This was stored in a

medication 'area' of the home and secured to the wall when not in use. We saw that controlled drugs (CDs) were stored securely. CDs are medicines that require specific storage and recording arrangements. There was a suitable cabinet in place for the storage of CDs and a CD record book. We checked a sample of entries in the CD books and the corresponding medication and saw that the records and medication held in the cabinet balanced. Staff signed the MAR chart and the CD book when administering CDs. There was one anomaly where the dates recorded in the CD book did not match the date recorded on the MAR chart for the administration of the same medicine. This was corrected on the day of the inspection.

The home used an electronic ordering system so they did not have a copy of the prescription provided by the GP. This meant they were not able to check that the medication supplied by the pharmacy was the same as the medication prescribed by the person's GP. The senior care worker told us they would explore whether the home could receive a copy of each prescription. Medication that needed to be returned to the pharmacy was stored securely and recorded in a returns book. These records were accurate, although the most recent returns sheet did not include the date the pharmacy had collected the medication.

Only senior care workers and the registered manager were responsible for the administration of medication, and the training record showed that these members of staff had completed medication training.

We recommend that management of medication is audited regularly to ensure the home's policies and procedures are being adhered to.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for the electrical installation, the fire alarm system, emergency lighting, fire extinguishers, the passenger lift, hoists and slings, portable appliances, gas safety, and the emergency call bell. In-house checks were carried out on the risk of Legionella and daily checks were carried out on the fire alarm system. The most recent fire drill had taken place in September 2016. These measures helped to monitor that the premises remained safe for the people who lived and worked at the home.

There was a business continuity plan in place that provided staff with advice on the action to take in the event of an emergency such loss of heating, loss of utilities, IT failure, fuel shortage and severe weather conditions. We also saw personal emergency evacuation plans (PEEPs) for people who lived at the home. PEEPs record the support each person would require to leave the premises in an emergency, including any equipment that would be needed and how many staff would be required to assist.

The home was maintained in a clean and hygienic condition. The maintenance person had painted the four lounges in February 2016 and the dining room in January 2016. The home had achieved a rating of 5, the highest score available following a food hygiene inspection undertaken by the Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. A relative told us, "The home is clean, there are no odours and our relative's room is always spotless."

Prior to the inspection we received information from an infection control nurse, who shared with us the outcome of their last infection control assessment at the home. Some issues were raised by the infection control nurse and we saw that the home had produced an action plan that addressed the shortfalls identified.

We checked the facilities in the laundry room and noted that floors and walls were washable, but some improvements were needed to make it easier to keep these areas clean. In the downstairs bathroom we noted that there was mould on the bath seat straps and the rubber seal was perished around the bath. The

registered manager told us that this bathroom was no longer in use. They had plans in place to change this into a wet room and anticipated that the work would be completed by Christmas 2016. Another shower room was being created on the first floor which was expected to be completed within one month.

In the small kitchenette in the dining room the worktop was stained and worn. In two areas we saw that bins had no lid. Slings were hung up in the corridor on the first floor; we discussed with the manager that people needed to have their own sling and she told us that more had been ordered so that people could have their own sling. Slings would then be stored in the person's bedroom. The registered manager carried out monthly checks on a selection of bedrooms to monitor cleanliness; these checks were recorded. There were cleaning schedules in place for the kitchen, and for wheelchairs, walking frames, lounge and dining chairs; these were cleaned by night staff once a week. A daily cleaning sheet was kept in each bedroom to record when beds were washed, sheets changed and the room and en-suite cleaned. Domestic staff cleaned curtains, carpets and upholstery every three months.

Good

Is the service effective?

Our findings

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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. Prior to the inspection the registered manager had informed us in statutory notifications about three DoLS applications that had been authorised by the local authority. We had no concerns about how these DoLS authorisations were being managed.

The training record showed that most staff had attended training on the MCA / DoLS, and we found staff had appropriate levels of knowledge regarding MCA for their roles. We observed that staff asked people for consent before they assisted them with any aspect of their care, such as assisting them to transfer or assisting them with meals. There were forms in care plans that recorded people's consent to confidential information being shared with other professionals and their next of kin. One member of staff said, "I talk to people throughout any tasks and if they cannot tell me whether they are happy with what I am doing I look for facial expressions or a simple yes or no."

Staff told us that they supported people to make decisions about their day to day lives. People who we spoke with confirmed they could choose what time to get up, to go to bed, where to spend the day, what to have for their meals and whether or not they wanted to take part in activities.

The induction training records we saw indicated that staff had a one day induction programme. The induction training checklist recorded that the topics covered included maintaining safety at work, safe food handling, moving and handling, accidents, health and safety and hazards, and infection control. This training was completed in one day and it was not clear how long staff had been employed before they completed more in-depth training on these topics. However, staff told us they were happy with their induction training and felt it was adequate to prepare them for their role. One member of staff told us, "I enjoyed the induction; we did a variety of training. The moving and handling was a hands on course which we did here (at the service) so we could use the same equipment that we would be using every day." They added, "I then completed a week of shadowing. [Registered manager] always makes sure people are competent and confident before including them on the rota." The registered manager confirmed that new staff shadowed experienced staff for a period of one week before they were included on the staff rota, but they acknowledged that this period of shadowing was not recorded. They told us that any shadowing shifts completed by staff would be recorded in personnel records in future.

The registered manager told us that new members of care staff would be required to undertake the Care Certificate. The Care Certificate was introduced by Skills for Care, and is a nationally recognised set of standards and training that staff new to working in care are expected to work towards. However, they added that they now usually employed people who had already achieved NVQ Level 2 or 3 in Care. We saw that 12 of the 26 care staff had completed the National Vocational Qualification (NVQ) or equivalent at Level 2, and six staff had completed this award at Level 3.

There was an overall training record in place and this evidenced that all staff had completed training on fire safety, health and safety, infection control, food hygiene, challenging behaviour, emergency first aid, safeguarding adults from abuse, moving and handling and dignity and respect. In addition to this, some staff had completed training on dementia, end of life care, skin care, pressure ulcer prevention and healthy eating. Relatives who we spoke with told us that staff appeared to be well trained. One relative said, "All of the staff appear well trained, we have no concerns there."

Staff personnel files included records of supervision and appraisal meetings. These are meetings when staff meet with a manager to discuss their performance, any training needs and any concerns they may have.

We saw that any contact with health care professionals was recorded in 'progress notes' in the person's care plan. The form recorded detailed information, including any action that had been taken following the visit or contact. A health care professional told us that staff asked for advice appropriately and then followed that advice. They added, "They have become quite skilled at assessing the level of medical attention a person needs. For example, a service user fell this morning and staff had already tested the person's urine ready for my visit." The health care professional told us they visited the service every Tuesday and they worked closely with a senior care worker at the home. They said, "They are excellent – they go above and beyond. They know everything that is going on with every patient." They said these regular visits had reduced the need for 'ad hoc' visits to the home.

People told us they could see their GP whenever they needed to. One person told us, "I see the GP when I need to. A lady GP came in the other day." A relative said, "They have regular visits from the chiropodist, district nurses and the GP when needed." Any communication from NHS departments was retained with people's care records so that it was available for staff.

We saw that people's nutritional needs were recorded in their care plan; this included any special dietary requirements to meet health care needs and their likes and dislikes. Charts were used to record people's food and fluid intake when this was identified as an area of concern so that their nutritional intake could be monitored. The chef and care staff who we spoke with displayed a good understanding of people's nutritional needs. The chef told us, "If anybody is at risk of losing weight, then the seniors inform me. I update the board so all kitchen staff are aware and we will make sure that their meals are supplemented with additional calories by adding cream, butter and also making up milkshakes." Meals were served to people individually by the chef and this enabled each person to request what size portion they wanted and specify their choice of vegetables. This also enabled the chef to monitor people's intake and assess their response to the food they were served.

We observed the serving of lunch in the dining room. Tables were set with tablecloths, tablemats, napkins, flowers, cutlery, glasses and a cup and saucer for tea or coffee. Most people chose to eat their meal in the dining room whilst others chose to have their lunch in their bedroom. We noted that staff created a pleasant atmosphere; they encouraged people to chat to each other and enjoy a 'sing song' before the meal was served.

We saw that people were asked what meal they would like during the morning and this enabled the chef to prepare any alternative dishes in advance. People were offered a choice of hot and cold drinks. A relative told us, "They always offer a good choice of meals; if they want an alternative then they can request one." We saw that when people needed assistance to eat their meal this was provided in a dignified manner. Staff sat alongside people and offered appropriate prompts, reassurance and encouragement to ensure people had enough to eat and drink.

One visitor told us they were invited to stay for lunch with their relative. They told us the meals were very good. Another relative told us their family member "Loves the food – it is spot on." A person who lived at the home told us, "The food is one of the best things about living here."

Although the home was well-decorated and furnished, we found that some aspects of the environment were not dementia friendly. We saw that the dining room, lounge and toilets had signs on the doors to help people orientate themselves within the home. However, bedrooms and bathroom doors were painted the same colour which could have made it more difficult for people living with dementia to identify where their bedroom and bathrooms were located. There was a lack of contrasting colours on toilet seats, handrails and the surrounding fixtures. Contrasting colours can help people living with dementia to identify particular areas of the home and handrails can reduce the incidence of falls.

We recommend that the registered provider seeks advice on providing environments that are suitable for people who are living with dementia.

Good

Is the service caring?

Our findings

People told us they were happy living at the home and that they felt staff really cared about them. One person said, "I'm very happy here. I've got a lovely room and the staff are lovely" and another person told us, "Staff are extremely kind and helpful. They are all a good bunch of lasses." One person gave a member of staff a special mention. They said they were, "Lovely, cheery, polite and obliging. I cannot fault [name]." This was supported by all of the relatives we spoke with. Comments included, "Staff are very kind. I see them helping other people to eat their meal. They genuinely care", "Staff genuinely care. They are excellent. I don't have a bad word to say about any of them" and "Staff genuinely care. [Name of relative] has been to hospital a couple of times recently and staff have taken them and stayed with them." One relative added, "[Name of manager] doesn't work weekends, but she still pops in to check everything is OK."

People who lived at the home and relatives told us that staff were, "The right kind of people to do the job." We saw positive interactions between people who lived at the home and staff on the day of the inspection. We noted that people were comfortable in the presence of staff, and that staff were polite and sensitive to people's needs.

We saw that confidential information relating to people who lived at the home and staff was stored securely, Staff were required to sign a statement to demonstrate they understood the home's confidentiality statement when they were new in post.

People's independence was promoted. One person's care plan recorded, 'I like to pick out myself what I want to wear and only want help when needed.' A member of staff told us, "We promote independence whenever we can. For example, if somebody is capable of washing their own face and body I fill the sink and let them get on with it." Another told us, "Some of the ladies like to help us wash up and the kitchen gives them the opportunity." We saw there was a small kitchen in the dining room where people who used the service and their relatives could make themselves a hot drink. A member of staff explained, "Relatives can make their own drinks and this frees the staff up to do their job."

Although family and friends were invited to visit the home at any time, the home operated 'protected' mealtimes. This is when family, friends and care professionals are asked not to visit over meal times to allow people to have their meals undisturbed.

We saw that staff respected privacy by knocking on doors and asking if they could enter the room. We noted that any treatment by district nurses was carried out in people's own room, and that there were areas of the home where people could see their visitors in private. We saw that people were asked discreetly if they would like their pain relief medication.

Discussion with staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that those diverse needs were adequately provided for within the service; the care records we saw evidenced this and the staff who

we spoke with displayed empathy in respect of people's needs. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Some staff at the home had undertaken training on end of life care. Over a period of 18 months, they had produced a portfolio of work to gain an award on this topic. The home's 'end of life' folder stated, 'This is a short care plan for all residents when they reach their last days of life. This care plan will cover and document everything that is done to ensure that the resident's last days of life are peaceful and comfortable and that all their wishes and the wishes of their family and next of kin are respected. We hope by putting this in place the person's actual needs and wishes are concisely detailed to help us deliver excellent personal care and TLC'. The care plan included food and fluid charts, mouth care charts, a communication sheet to record discussions with family and health care professionals, a positional change chart and a record of whether the person's spiritual needs were being met.

The home had appointed 'end of life' champions. These members of staff had a role in promoting good end of life care within the home, and in sharing information about this topic with their colleagues.

We saw that people's care plans recorded their wishes about care at the end of their life. This included whether people had an advanced directive, a living will or a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) record in place.

Good

Is the service responsive?

Our findings

The care records we saw included care needs assessments, risk assessments and care plans. We saw that assessment and risk assessment information had been incorporated into an individual plan of care that was entitled 'Residents choices and preferences'. Topics covered in care plans included safety, senses / communication, a typical day, cultural / spiritual needs, promoting a healthy lifestyle, eating and drinking, elimination, personal hygiene , mobility, mental health and future wishes. Assessment tools had been used to identify if people had any level of risk, for example, in respect of pressure area care, nutrition or moving and handling. When risks had been identified, there were appropriate assessments in place that detailed the action that needed to be taken to minimise the risk.

Each person's care records included a photograph, their preferred name, information about their GP, their medical conditions, their current prescribed medication (including the route, dose and frequency), a body map and any current physical or mental health care concerns. We saw that care plans included person-centred information recorded in a document called 'This is Me'. This recorded information about the person's life history, their current routines and their wishes, anxieties and needs. Another document called 'My memory folder' included personal information such as names of family members, their childhood, favourite meals and singer / actor, hobbies, their wedding day, best friend, interests, likes and dislikes and their preferred hairstyle / makeup. This information helped care staff to get to know the person and to provide more individualised care. A relative told us, "The staff are aware of each person's specific needs, requirements and character, so they know how to best respond."

Some care plans were written in the first person and recorded information such as, 'I love to chat' and 'I want to do all my own personal care; I don't need help at the moment'. Other care plans had been written by staff and included information such as, '[Name] now has a hospital bed with bedrails'. We saw a letter that had been sent to a GP to ask if the medication for three people could be administered earlier in the evening, as they were in bed by 9.00 pm. There was a note to record that the GP had agreed to this. This showed that people's individual needs were taken into consideration.

We were told by staff that one person who used the service experienced periods of distress, which caused them to display both verbal and physical behaviour that could challenge the service. Staff consistently described how they managed this behaviour. However, when we viewed the person's care plan we found that, although the behaviours were referred to, there was no specific detail about the type of behaviours displayed or guidance to advise staff on how to support the person during these periods of distress. In another instance, we saw that there was written advice for staff to follow should conflict arise between two named people who lived at the home. All staff had signed to record that they had read this information. The registered manager assured us that additional information would be included in care plans to make this recording more robust.

We saw people were dressed and groomed in their chosen style. Men were clean shaven if this was their choice and some women were wearing makeup and jewellery.

We saw some care plans had been reviewed each month but were not always a true reflection of the person's care needs in respect of the risk of falls, behaviour that could challenge the service, wound care and a percutaneous endoscopic gastrostomy (PEG) regime. This is when a tube is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. Although staff were able to explain people's latest care needs, the information in care plans was not recorded in enough depth to ensure that every member of staff was aware of every detail. The registered manager explained to us on the day of the inspection how they would include this more specific information in people's care plans.

We did not see any records of formal reviews of people's care. One relative told us, "The manager has said we can have a review whenever we want, they have an open door policy. We have no issues so have not requested a review yet."

Relatives confirmed there was good communication between themselves and staff at the home. They said they were always kept informed about any issues or events that involved their family member. One relative told us they always received a telephone call to inform them of any concerns or changes in the person's care needs. Another relative told us they received a regular newsletter and that they found it very informative. A person who lived at the home showed us the same newsletter. We saw the newsletter for August 2016 and noted it included information about birthdays celebrated in July and August, photographs of activities that people had taken part in during July, an introduction to new staff, entertainment booked for August (such as singers, pet therapy and a church service) and details of a planned Caribbean Day (to include fruit sculptures, steel drum music and a coconut shy). The newsletter also encouraged people to nominate the 'employee of the month', and included a form for people to fill in and hand to the administrator.

One relative told us, "We can visit whenever we want and can stay and have lunch. One person's husband comes most days and has his lunch with his wife." Another relative told us that they were always made welcome and added, "Staff are really friendly." One person who lived at the home told us, "I have lots of friends and family visiting."

We saw that any activities people took part in were recorded in their care plan. These evidenced that people took part in activities such as pamper days, one to one time, exercise sessions, watching entertainers, watching the TV and church services. There was a weekly activities plan on display and this included arts and crafts, visits from the hairdresser, sing-a-longs, 'movie and popcorn', entertainers, nail care, bingo and exercises. We saw that although there was a baby doll located in one lounge there were no 'twiddle muffs' for people to engage with. Twiddle muffs are a knitted muff with items attached so people with dementia can twiddle in their hands. They provide a source of visual, tactile and sensory stimulation.

On the day of the inspection the activities coordinator organised an activity; this was singing along to a CD that had been specially recorded for people who lived at the home by a visiting entertainer. Ten people took part in the activity. The activity coordinator stopped the CD at intervals to include people in discussion about topics they had been singing about, for example, the seaside. Relatives commented, "People really come to life when the entertainers come in. [Name of relative] is singing a new song that she must have heard yesterday; she loves singing", "We were involved in the care planning stage, and provided lots of information about [name of person's] like and dislikes. We mentioned that she liked arts and crafts and the activity coordinator was so pleased. They really encourage her to join in with the activities." The relative also told us, "They can also have individual one to one time and have their hair and nails done" and "They can go out if they want and they sit outside on nice days. Not a lot of them want to go out but the ones who do can."

People who lived at the home were happy with the activities provided. One person told us they had a daily newspaper delivered and they enjoyed knitting and watching TV. They said that they also joined in the church service and the keep fit sessions. They also said they had been on three outings organised by a voluntary group. Another person told us that a member of staff took them out for a walk most days.

The home had a policy on comments, suggestions and complaints and this was displayed within the home, although we noted this was in small print and may have been difficult for some people to read. The policy was also referred to in the home's service user guide. Complaints were recorded in the complaints log and we saw there had been two complaints during 2015 and 2016. Records evidenced that these complaints had been investigated and resolved.

People who lived at the home told us that they felt able to express their concerns, and they told us who they would speak to. One person said, "I could talk to any of the staff if I had any worries – they are all very good." Relatives told us they had not needed to raise any concerns, but they were confident they would be listened to if they raised any issues. They said that one of the senior care workers or the registered manager would try to 'put things right'. One relative said, "[Name] gets good care. If I felt she didn't, I would speak to someone." We noted that the newsletter included the statement from the home's administrator, "If any relatives have any concerns or queries please do not hesitate to drop me an email and I will do whatever I can to help."

A satisfaction survey had been distributed to people who lived at the home and relatives in May and June 2016. The responses had been collated and we noted that one negative response about meals had been resolved by offering people a choice of meals. A relative said, "There are no relatives meetings as such, but the manager is always available and we are free to discuss any issues at any time."

Requires Improvement

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. At the time of this inspection the manager was registered with the Care Quality Commission (CQC), meaning the registered provider was complying with the conditions of their registration.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had not always informed CQC of significant events in a timely way by submitting the required 'notifications'. CQC had received notifications about deaths, safeguarding concerns and DoLS applications, but no notifications had been submitted over a two year period in respect of serious incidents such as falls. We saw information on the day of the inspection about an accident that had resulted in the person having a fractured wrist and CQC had not received a notification about this incident as required. The registered manager explained to us that they submitted a return to the local authority each month about any accidents or incidents at the home, and the local authority used this to determine which incidents required investigation under safeguarding vulnerable adults from abuse protocols. The registered manager told us they had not realised that they also needed to submit information about accidents and incidents to CQC.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009: Notifications of other incidents.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, were stored securely and that most were easily accessible. However, we saw that some care records had not been updated and were not a true reflection of the person's current care needs.

Audits were carried out by the registered manager to monitor whether staff were following the policies, procedures and systems in place at the home. They included audits of infection control, care plans and medication. We saw the medication audits recorded any errors that had been identified and any improvements that needed to be made to practice. We noted there was a record of when action had been taken.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, were stored securely and that most were easily accessible.

Staff spoke positively about the registered manager and the service. Comments included, "[Registered manager] is lovely. She is really approachable and any issues that I have discussed with her have all been addressed. She makes sure the place is running properly", "She's a good manager, fair, approachable but can also have a bit of banter. If there is anything that needs addressing she will deal with it, but then we move on so there is no lingering atmosphere" and "She's really approachable; firm but fair." One member of staff added, "It's lovely here, I don't go home stressed and the girls [colleagues] have been really good to

me." We observed that the registered manager interacted with people who lived at the home and relatives throughout the day and that these interactions were positive and friendly.

The home's welcome pack described the aims of the home to be, 'To promote dignity and privacy and freedom of choice', 'To work as a team and respect each other' and 'To provide person-centred care in a safe, sound and supportive living environment'. One relative told us, "Walking through the door, it felt homely, not clinical and it was in a good location."

Staff meetings were held on a regular basis; there were meetings for all staff, night staff, senior staff and ancillary staff (domestic assistants, laundry assistants and the maintenance person). We saw the minutes of the staff meeting held in July 2016. The topics discussed included timekeeping, mobile phones, annual leave, breaks, day care, locking doors and completing the records in people's bedrooms. A member of staff told us, "We have regular staff meetings. We discuss anything that needs addressing; we all have the chance to have our say. We raise concerns if we have any and I think people are comfortable raising any issues. The meetings always finish on a positive note." The minutes of these meetings showed that staff were able to raise issues and make suggestions.

A staff survey was carried out in July 2016 although we noted that the responses had not yet been collated and analysed. The outcome of a recent professional survey recorded that all professionals had rated the service as 'excellent'.

We received a complimentary letter from the family of a person who lived at the home prior to this inspection. This family told us that since moving to Brabyns House their relative had "A growing sense of happiness, greater engagement with people around her and a renewed desire and ability to communicate with people." They added their relative's speech was improving in small ways and they were clearly relaxed at the home. They described the positive characteristics of Brabyns House. These were that the registered manager was a strong, warm, guiding, approachable, innovative professional presence who demonstrates the values of the home. There had been a positive transition from their relative's previous home. There was detailed care planning that involved the family and responsiveness to any requests. There was a great range of activities and good healthcare, including tissue viability.

We noted the home had achieved the Investors in People award in May 2016. Investors in People is the standard for people management that defines what it takes to lead, support and manage people for sustained success.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures had been established but these were not being operated effectively by the registered provider. Regulation 19 (2).