C.T.C.H. Limited

Bredon View

Inspection report

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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

Bredon View 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. Bredon View can accommodate up to 26 older people. At the time of our inspection there were 18 older people living there of whom one had been diagnosed as having dementia. Bredon View provides family style accommodation in Cheltenham. People each have their own bedroom with en-suite facilities. They share bathrooms, a lounge, dining room and a cinema/activities room. The garden to the rear is accessible.

This inspection took place on 15 January 2019. At the last comprehensive inspection in July 2016 the service was rated as Good overall. At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection we found the service remained Good.

At the time of the inspection there was no registered manager. A new manager had been appointed in October 2018 and they were submitting applications to the Care Quality Commission to become registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's care was individualised and person centred, reflecting their life histories, likes and dislikes and needs. Staff understood them well. People's needs had been assessed and were monitored and reviewed each month or sooner if their needs had changed. Their relatives were involved in this process and kept informed about any changes. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were encouraged to be as independent as possible. Staff encouraged them to do as much as they could for themselves. Risks were assessed and strategies were in place to minimise any hazards. People's safety was promoted. They were supported to stay healthy and well. Their nutritional needs were closely monitored. Special diets were provided if needed. People had access to snacks and hot and cold drinks. People had access to their GP, optician, dentist and chiropodist. Staff liaised closely with health care professionals. People's medicines were managed safely.

People were being asked about which activities they would like to take part in. These included pet therapy, baking and cooking, trips out and gardening. People were supported individually to go out for walks, to do

puzzles and to chat with staff. Musical movement and fitness classes were held in the home. People were supported to attend a place of worship. Friends and family were able to visit whenever they wished.

People were supported by enough staff to meet their needs. Checks were completed as part of the recruitment process. Staff felt supported in their roles and had access to refresher training to keep their knowledge and skills up to date. Staff were knowledgeable about people, their backgrounds and individual needs. People were treated with respect and sensitivity. They had positive relationships with staff and enjoyed spending time in their company. Staff understood how to keep people safe and were confident any concerns they raised would be listened to and the appropriate action taken in response.

People's views and the opinions of their relatives and staff were being sought to make improvements to the service provided. The manager worked as part of the team enabling them to lead by example and to also ensure their values were embedded in people's experience of their care. People told us, "Staff are lovely", "They look after me well. Nothing is too much trouble" and "There is never a dull moment."

Quality assurance processes were carried out by the manager and provider to make sure the standard of care they wished to provide were maintained. The home had been completely refurbished and systems were in place to make sure this was maintained. The manager said, "We provide the best quality care we can and wish to be seen to provide an outstanding home."

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Bredon View

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 inspection took place on 15 January 2019 and was unannounced. This inspection was completed by one inspector.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR). This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

We spoke with eight people and observed the care and support being provided. We spoke with the manager, three representatives of the provider, the head of care, four members of staff and the chef. We looked at the care records for three people, including their medicines records. We looked at the recruitment records for three new members of staff, training records, health and safety records and quality assurance systems. We have used feedback given to the provider by people, relatives and professionals as part of their quality assurance process. We looked at an inspection carried out by commissioners in February 2018.

Good

Is the service safe?

Our findings

People's rights were upheld. A person said, "We are looked after well." Staff understood how to recognise and report abuse. They kept their knowledge and understanding of safeguarding up to date. They had access to updated policies and procedures guiding them what they should do if they suspected abuse. Staff said they were confident the appropriate action would be taken in response to any concerns they raised. No safeguarding alerts had been raised in the last 12 months.

People's risks were assessed and managed to keep them safe from harm. Strategies had been developed to prevent the risk of injury or harm whilst promoting people's independence. For example, sensor mats had also been provided in people's rooms, so they could move around, in the knowledge that if they moved or had a fall staff would be alerted and attend to them. Accident and incidents were recorded and people were observed afterwards to ensure no injuries had been sustained. The manager closely monitored accidents and incidents, so they could take the necessary action, if they thought trends were developing. There was evidence referrals had been made to GP's to check people's physical health and advice had been sought from an occupational therapist and a physiotherapist, when the risk of falls had increased. People were also provided with sensory and mobility equipment as well as specialist beds and chairs to minimise risks to their safety and wellbeing.

People who occasionally became upset or anxious were supported by staff who knew them well. They understood what might cause or increase their anxieties. Staff described how they helped people to manage these. Staff were observed supporting people by talking with them calmly and patiently; reassurance was given when needed. A person commented, "Staff all remained calm and supported me (when a person was anxious)."

People lived in a well-maintained home. The home had been completely refurbished and was being maintained to a good standard. There were robust systems in place to deal with day to day maintenance in a timely fashion. The maintenance team carried out health and safety checks to make sure a safe environment was maintained. This included fire systems, water checks and portable appliance checks. The servicing of equipment was completed at the appropriate intervals.

People were supported by enough staff to meet their needs. A core group of staff, who had worked together for a considerable time, provided consistency and continuity of care. New staff had been appointed when needed and adequate staff levels were maintained. Agency staff had been used when needed. The same agency staff were requested to ensure stability. Recruitment processes made sure checks were completed for new staff. These included a Disclosure and Barring Service (DBS) check. A DBS check lists spent and unspent convictions, cautions, reprimands, final warnings plus any additional information held locally by police forces that is reasonably considered relevant to the post applied for. New staff completed an induction which included health and safety training.

People's medicines were safely administered and managed. Safe practice was observed and medicines administration records were completed correctly. Medicines were stored and kept in line with

manufacturer's guidance. People's medicines were regularly reviewed with health care professionals. This was particularly important for people living with dementia or diabetes, to ensure their medicines were appropriately prescribed. Protocols were in place for the administration of medicines to be given when needed and the maximum dose to be given. A pharmacist had authorised the use of any over the counter products.

People were protected against the risks of infection. Staff had completed infection control training and followed their policies and procedures to maintain a clean environment. The home was clean and tidy at the time of the inspection. Visitors had commented to the manager how reassured they were by the cleanliness of the home. An annual report for 2018/2019, in line with the requirements of the code of practice on the prevention and control of infections, was being produced.

People's care and support was reassessed in response to lessons learnt from incidents or near misses. Their care records were amended to reflect any changes in their care. For example, a person moved into a ground floor room so that staff could quickly attend to them when they tried to move out of bed. Staff said this had significantly reduced the number of falls they were having. Learning was shared between homes owned by the provider. A representative of the provider had provided the manager with an emergency secure key safe for the medicines room after an issue in another home when staff were unable to access the medicines room.

Good

Is the service effective?

Our findings

People's needs were assessed to make sure the care and support they required could be provided. Their physical, emotional and social needs were monitored and reviewed each month to ensure their care continued to be delivered in line with their requirements and in line with national guidance. When there were concerns that people's needs had changed or they could no longer be met effectively the manager said they had discussions with the person, their family and healthcare professionals and commissioners. Any decisions were based on people's assessed needs, so they would continue to receive the appropriate levels of care and support.

People's equality and diversity was recognised and built into their care and support. Their individual needs in relation to their religious beliefs, sexuality and disability had been discussed with them and their families and incorporated into their care plans. Information technology and electronic equipment was used to improve the quality of care delivered. For example, maintaining maintenance requests electronically enabling issues to be dealt with effectively and efficiently. Sensory equipment had been installed which promoted people's independence.

People were supported by staff who had access to training and support. Staff said they were able to maintain their skills and knowledge. Individual records confirmed they had access to refresher training when needed such as first aid, food hygiene, equality and diversity and fire safety. The manager confirmed they had prioritised training for staff which needed refreshing. As a trainer they were able to deliver some of this to staff at the home. Otherwise staff had access to blended training which included on line learning, face to face and practical learning. They also had access to training specific to the needs of the people they supported such as dementia pathways, end of life care and diabetes awareness. The manager had met with all staff informally and planned to hold individual support meetings every two months to discuss their training needs and the care being provided. Some of these meetings would be observations of practice, which the head of care said they had already started carrying out.

People's nutrition and dietary needs had been assessed. People's weights were closely monitored so that preventative action could be taken if they started losing weight. People living with diabetes were provided with an appropriate diet including sugar substitutes so they could continue to enjoy puddings and cakes. A softened diet was being considered for one person. Staff were observed encouraging people to eat and drink. Cold drinks and snacks were available in communal areas and in people's rooms. Meals were ready prepared and re-heated in the kitchen. People had been invited to trial these meals in October 2018 and were still deciding their favourites. There was mixed feedback from people about the meals. If they decided they disliked the option they had chosen they were offered the alternative or the cook could provide an omelette. Some people liked to have cooked breakfasts.

People's health and wellbeing was promoted. Their health care needs were clearly identified in their care records and any health care appointments were recorded. People living with diabetes had access to regular blood tests and the services of a chiropodist and optician to monitor the status of their diabetes. Staff worked closely with social and health care professionals to share information to ensure they received co-

ordinated and timely services when needed. For example, there was close co-operation with community nurses. Staff liaised with health care professionals when people needed to attend hospital for outpatient or inpatient services. People had regular access to their GP, a dentist, optician, chiropodist and community nurses.

People benefited from renovations to their home. On-going improvements had taken place since our last inspection in 2016. This was nearly completed, although the manager said they had plans to replace some en-suite baths with wet rooms. Signage around the home helped people living with dementia to find their way around. For example, toilets and bathrooms had visual displays illustrating the room's use. Subtle lighting in corridors prevented shadows which might confuse people.

People made choices about their day to day lives. They were observed choosing how to spend time, what to eat and drink and who to sit with. People's capacity to consent had been assessed in line with the Mental Capacity Act (MCA) 2005. 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. Any decisions made in people's best interests, for example for finances and medicines were recorded. These confirmed those involved in making these decisions such as their relatives and health care professionals.

People's liberty and any restrictions had been assessed. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). An application had been made to restrict a person of their liberty. The person was observed being supported by staff to go out for frequent walks during the day.

Good

Is the service caring?

Our findings

People had positive relationships with staff. They were observed enjoying the company of staff. They chatted with them, shared jokes and were relaxed in their company. People said, "Staff are lovely", "They look after me well. Nothing is too much trouble" and "There is never a dull moment." Relatives told the manager staff were really friendly and they had seen a massive improvement in their relative since moving into the home. A healthcare professional said, "Excellent care from staff." Staff were aware of people's backgrounds and personal histories. Staff reacted quickly to people's wellbeing offering reassurance when needed. One person told us, "They're very good; they know your likes and dislikes."

People's wellbeing was promoted. Staff monitored people closely and shared concerns with the manager to ensure they could respond in a caring way. For example, they had concerns about a person who had recently moved in and chose to sit in their chair all night. By working together and with other professionals they introduced a special bed to give support to the person similar to the chair but it which they were able to get a comfortable and peaceful night's sleep.

People's equality and diversity were recognised in line with their protected characteristics under the Equality Act. People's rights with respect to their spirituality, disability, age and sexuality were respected. People were supported to maintain relationships with those important to them and were able to meet them in privacy if they wished. People had been asked if they had any preference about the gender of staff providing their personal care and this was respected wherever possible. People's cultural and spiritual needs had been discussed with them and their relatives. People were supported to attend local places of worship and had visitors from a local church.

People were involved in the planning of their care and support. People's care needs were reviewed monthly. Their relatives were kept informed of any changes in people's wellbeing and were involved in making decisions about people's care and support. People had access to information about advocates should they need their services. Staff were given the time to attend and complete training which did not impact on the quality of care they could provide to people.

People were supported to keep in touch with those important to them. Relatives and friends were able to visit whenever they wished. People said their relatives and friends took them out for trips and visits. The Provider Information Return stated, "Relatives and visitors are welcomed and supported in visits at any point during a day. The home has no restricted visiting times."

People's privacy and dignity was respected. A person said, "They tap the door and wait to enter before I give them permission." Staff were observed treating people with dignity and sensitivity. People decided when they wanted to spend time alone and staff respected this. People were encouraged to be as independent as possible. Staff were observed respecting this, giving people time and space to do things for themselves.

Good

Is the service responsive?

Our findings

People's care was individualised. Their personal needs, routines, wishes, likes and dislikes were explored. People told us, "We do what we like" and "Staff know us well." People's care records provided comprehensive information about their care and support. These were based on their strengths and needs promoting their independence and quality of life. Their care records stated what they could do for themselves and what they needed help with. For example, getting dressed and walking around the garden without staff support. Staff understood people's diversity and individual preferences. The manager said they wished to "ensure care is personalised" and was reviewing care plans to ensure the individual personal touches and care delivered by staff were all captured.

People were being consulted about the provision of activities. The range of activities had declined and the manager had identified shorter activities they wished to offer to people to encourage their participation. These included pet therapy, a salon providing a nail bar and foot spa, trips out, a coffee morning, baking and cooking. They planned to build a greenhouse in the garden so people could grow fruit, vegetables and herbs. A local school had offered to visit each week so that children could read with people. People enjoyed a fitness class and musical movement class held at Bredon View. Staff were observed encouraging people to take part in board games. The cinema/activities room was used to show films whilst providing a glass of sherry and popcorn to viewers. One person had a table dedicated to a large puzzle which they enjoyed doing.

People's communication needs had been considered. Their care records guided staff about how to interpret their behaviour and body language as an expression of how they were feeling. They also guided staff about how to interact with them, for example, using short sentences and speaking slowly. One person had a document 'Top 10 tips for communicating with people with Dementia.' The manager was aware of the need to make information accessible to people. The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. Documents and information had been produced in easy to read formats using pictures and photographs to illustrate the text.

People knew how to raise a complaint. They said, "I have no worries" and "If you're not happy all you can do is complain." One person said, "I feel confident she (Manager) will listen to me and do something about it." The complaints procedure was displayed in communal areas and people were encouraged to talk about any issues they had on a day to day basis. The Provider Information Return stated, "Concern forms are implemented by service users, staff, and visitors on any issue to prevent complaints. All concern forms are completed and reviewed to ensure immediate resolution of the issue raised." One complaint had been received by the provider. A full record had been kept and a response had been given to the complainant.

People and their families had discussed their preferences for end of life care. Advanced care plans described how they would like to be supported, their choice of service and memorial as well as what they would like to happen to their possessions. Staff worked closely with relatives and health care professionals to ensure people's treatment and medicines at end of life were well managed. Relatives who had been supported to

make decisions about the end of life care of a family member said, "Your experience and knowledge have helped me (through this period)." People's care records were clear when they had a do not attempt cardiopulmonary resuscitation agreement (DNACR) in place. These been reviewed with people, their relatives and their GP.

Good

Is the service well-led?

Our findings

People experienced person centred care which promoted positive outcomes for them. The manager told us, "Residents are in my heart. We provide the best quality care we can and wish to be seen to provide an outstanding home." Relatives told the manager they were really impressed with the staff and it was a "really homely home". The provider had told the staff team, "An excellent home providing excellent care and I am sure it will continue in this way." The manager worked alongside staff monitoring the day to day delivery of care and ensuring high standards were maintained. Staff commented, "I am proud to be part of a wonderful team" and "It's brilliant. I love working here."

The manager was submitting applications to the Care Quality Commission to become registered with us. 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. The manager said they felt supported by the provider. They had regular contact with a representative of the provider during their induction and were working together to make improvements to the service. Staff told us, "The manager is brilliant" and "She is on the ball. She has been really supportive." Staff said there was good communication between the staff and the manager. The manager recognised the importance of valuing staff and nurturing them in their roles. They said, "The confidence of staff is amazing. I make sure they know how good they are and I am appreciative of their work."

The manager understood their responsibilities to meet the Care Quality Commission's (CQC) requirements and to adhere to health and safety legislation and keep up to date with changes in legislation and best practice. Adjustments had been made to policies and procedures reflecting the General Data Protection Regulation. People's personal information was kept confidentially and securely in line with national guidance. Staff were confident raising concerns under the whistle blowing procedures.

There were effective systems in place to monitor the quality of services and care provided to people. Policies, procedures and guidance were kept up to date and available to staff. The manager had a range of quality assurance checks which were completed to ensure compliance with national regulations. These showed areas such as health and safety, fire systems, food hygiene, infection control and medicines were managed effectively. When actions had been identified for improvement these had been implemented in a timely fashion.

The provider monitored people's experience of their care and support through weekly reports from the manager and by monitoring quality assurance audits. The provider had reviewed how they monitored the service over the past twelve months, trialling visits by other registered managers, employing a quality assurance manager and self-assessment by managers. A representative of the provider confirmed they were working closely with the manager.

People, their relatives, social and health care professionals and staff were asked for their opinions of the service. The manager confirmed they would be invited to complete an annual survey in early 2019 to give

their views about people's experience of their care and support. The outcomes of these surveys would be used to make improvements. People talked with staff on a daily basis and any issues or feedback had been dealt with as they arose. People were able to make good practice comments anonymously in a box situated in the entrance hall. An inspection had been carried out by commissioners in February 2018. This was satisfactory.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The manager said, "It's important we learn from mistakes and make improvements". They ensured they met CQC's registration requirements by continuing to meet all necessary regulations, by displaying the home's current inspection rating and were aware of the need to submit notifications to support our on-going monitoring of the service.

The manager worked closely in partnership with other agencies, social and health care professionals. Records confirmed information was shared with them when needed to ensure people's health and wellbeing was promoted. The manager kept up to date with changes in legislation and best practice through meetings with other local providers and meetings with other registered managers working for the provider.