Brendoncare Foundation(The)

Brendoncare Stildon

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

Brendoncare Stildon 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, both were looked at during this inspection. The home provides care and support to people with personal care and nursing needs, several of whom were living with dementia or chronic conditions. The home was arranged over two floors and offered nursing care based on people's particular needs and requirements. The service provided care and support for up to 32 people. There were 25 people living at the home on the days of our inspections. Brendoncare Stildon belongs to a not for profit charitable organisation called Brendoncare, which provides residential and nursing care across southern England.

At our last inspection we rated the service Good. 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 ongoing 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 the service remained Good.

People felt safe at the home. There were processes in place for reporting and responding to allegations of abuse. Staff had a good understanding of their roles and responsibilities and knew how to access policies and procedures regarding protecting people from abuse.

Risks to people were assessed, monitored and updated as and when necessary. Action was taken to reduce the risk of incidents and information about risks to people were documented in their care records so that staff were aware.

People liked the layout of the building and felt it was suitably adapted to meet their needs. The building was well maintained and there were systems in place for ensuring that regular checks of the environment and equipment, including fire procedures were carried out.

Staffing levels were assessed regularly and amended if people's needs changed. There were arrangements in place for covering if staff were unable to come to work at short notice. There were out-of-hours arrangements in place to provide additional support to staff if needed. There were robust recruitment processes in place and all relevant checks such as Disclosure and Barring Service checks and the right to work in the UK were carried out.

Medicines were managed safely and staff administered them in line with recommended guidance. There was an electronic system for recording and monitoring that medicines had been administered safely.

Incidents were investigated and the provider learned from them and made changes as a result. Analysis was carried out to identify any patterns which could prevent any future incidents.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible. The policies and systems in the service support this practice.

People were supported to maintain balanced diets and have input into menu's and meal choices. People had specialist equipment to assist with maintaining independence when eating. Staff were aware of special dietary requirements and were able to cater for them.

Staff were trained and supported to obtain qualifications to enable them to assist people safely. Staff received regular supervision and were supported to develop in their roles. Staff had received training in specialist areas such as end of life care and mentoring. Clinical staff were supported to keep up their professional registrations through regular clinical updates and training.

People told us that staff were caring and kind. Staff spoke to people respectfully and encouraged people to remain independent with staff assisting when people needed them to. People were involved in their care plans and were supported to access additional services such as mental health services if they needed to.

People were kept informed about what was happening in the home on a daily basis and were able to choose what they wanted to do. People were supported to maintain their religious beliefs and participate in activities that they enjoyed.

There was an accessible complaints process in place which people knew how to use if they needed to, however, they told us hadn't needed to.

The provider respected people's wishes when they reached the end of their life. The registered manager worked with other services such as GPs and hospices to ensure that people were as pain free as possible. The service has been accredited with the Gold Standards Framework for providing end of life care.

Staff thought highly of the provider and registered manager. The vision and values of the organisation were visible within the home and staff were proud to work at the service. People and their relatives told us that they thought the service was well managed.

People and staff were asked for their opinion about the service and implemented suggestions that were put forward such as what activities were planned.

There were formal processes in place for assessing and monitoring the quality of the service provided such as audits. Where areas for improvement were identified, actions were carried out to address the issues.

The provider worked with other healthcare providers to ensure that people received care that met their needs and that they were aware of best practice and updates that were relevant to how the service was run.

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 remained good.	**Good**
Is the service effective? The service remained Good.	**Good**
Is the service caring? The service remained Good.	**Good**
Is the service responsive? The service remained Good.	**Good**
Is the service well-led? The service remained Good.	**Good**

Brendoncare Stildon

Detailed findings

Background to this inspection

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

This inspection took place on 7 March 2018 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of our planning for this inspection we used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also considered statutory notifications received by the provider and previous inspection reports.

We looked at three people's care records which included risk assessments and other associated records, four staff files, records relating to the management of the service, environment and policies and procedures.

We spoke to seven people who use the service, two relatives, two care staff, a nurse, the kitchen manager, maintenance staff, activities co-ordinator, the training manager and the registered manager. We spoke with two healthcare professionals and asked for their feedback about the service. This included speaking with a psychiatrist and a care manager who were happy for us to share their comments. We also made observations of the environment and staff interacting with people.

Good

Is the service safe?

Our findings

People and their relatives said that Brendoncare Stildon was a safe place to live. They liked the open layout of the building and the gardens and told us the staff team were well trained and extremely friendly. People said that they thought there were enough staff to meet their needs.

People said they felt safe at the home. One person said, "It's safe and my things are safe". Staff members were able to confidently define their duty within safeguarding procedures, including how to raise concerns and ensure the safety of people at the care home. Staff were also able to confidently define and describe whistle blowing. Staff we spoke with told us they had received annual safeguarding training. They also told us they felt supported by the registered manager and senior management team with regard to raising concerns, and were confident that any such concerns would be dealt with appropriately. The local authority policies and procedures were available for staff and information about where to report concerns was displayed in staff areas.

People were provided with care that had been assessed to meet their specific needs. We found that there were a number of risk assessments in people's care records, covering their level of dependency, risk of malnutrition, choking, falls, and breakdown of pressure areas. The assessments were all personalised, detailed and were reviewed monthly, and the measures taken to reduce any identified risks were reflected in both the care plan and in observed care.
The registered manager reviewed people's needs on a monthly basis to identify how many staff were needed to support people. This was also reviewed if people's needs changed or new people were admitted to the service. There was one nurse allocated to each floor and eight healthcare assistants who provided support over both floors as needed. At night, there was one nurse and three carers across the whole home. There was also a management on call rota in place for additional support for staff out-of-hours. People told us they thought there were enough staff to meet their needs.

Staff were recruited robustly and all relevant checks were carried out before they began working at the service. Four recruitment files were reviewed and all four contained appropriate checks such as disclosure and barring checks, and obtaining references. The service also checked the registrations of nursing staff prior to them commencing at the service and then had a process in place for monitoring registrations.

People liked the environment of the home and relatives said "It's quite a good layout here, they can circulate and there are good vantage points for staff because the layout is so open". The home's physical environment was well maintained, and records seen showed that equipment and facilities were serviced regularly, including the lift, hoists, assisted baths, and the nurse call system. All safety equipment, including fire alarms, emergency lighting, fire extinguishers, and automatic fire doors, were regularly serviced. All wheelchairs and walking aids were checked by the maintenance person regularly, and records maintained of any issues identified and addressed.

Fire extinguishers and fire blankets were situated throughout the home, with the extinguishers having been serviced within the previous 12 months. Fire escape routes were clearly marked, and the procedure for safe

evacuation to the fire assembly point in case of a fire was displayed throughout the home. Staff told us about the fire escape procedures, including the use of fire doors to maintain a safe and protected space. A fire drill occurred during the inspection, and the automatic fire doors were observed to close as part of the home's fire safety procedure. There were personal emergency evacuation plans within each person's care record. These were detailed and showed the number of staff and type of equipment required for safe evacuation, as well as the person's level of cognitive awareness and ability to understand and process instructions.

Medicines were managed safely, and records showed that staff adhered to the organisation's policy and procedure. Staff were able to confidently describe the home's policy with regard to the administration of medicines and the use of "as required" (PRN) medicines, including the rationale for their use, record keeping and when to discontinue the medicines (under medical supervision). The home used an electronic medicines administration record system (eMAR), which showed that medicines were administered as prescribed, with signature entries for each administered medicine, and appropriate omission codes used when a person did not receive their prescribed medicines. Staff told us that they checked all the eMARs each day to ensure all medicines had been administered as prescribed, and there was an audit section within the eMAR system to support this.

There were processes in place for reducing the risk of infection. All products subject to the Control of Substances Hazardous to Health regulations were stored appropriately and securely. Domestic staff were seen at work during the inspection, and all areas were found to be clean and tidy. Staff told us that they were provided with sufficient personal protective equipment (PPE) such as gloves and aprons for use when providing personal care, and also had received training in infection control procedures. People and their relatives told us that they always found the home clean and tidy.

Accidents and incidents were documented clearly, along with any actions taken to ensure the person's safety. For example, falls were recorded and noted the time and place of the fall, any behavioural changes associated with the fall, and any pain or injury. Staff told us that they also used body maps to chart any wounds, and records seen confirmed this. Reviews of incidents were held monthly to identify patterns and action taken was reviewed as well as further actions being taken such as following up with other services or the local authority.

Good

Is the service effective?

Our findings

People and their relatives were happy that staff were able to competently and confidently care for their individual needs. People were able to furnish their rooms as they wished. People were happy with the food on offer at Brendoncare Stildon, and that they were able to choose something different if they didn't like what was on the menu. They also were happy that they could have their meal where they chose. Apart from the usual mealtimes people were offered drinks throughout the day. Each room also had a jug of fresh water that was replaced daily.

People's needs were assessed and care was delivered in line with best practice guidance. We noted that air mattresses used to protect pressure areas on the skin were used in conjunction with a risk assessment. This included a Waterlow score, which was reviewed monthly. We observed that people cared for in bed had call bells within reach, as well as drinks, and staff were seen refreshing and replacing drinks throughout the inspection. Where a person had been assessed as being incapable of using the call bell, staff had completed a risk assessment to identify potential risks to the person's condition as a result. We found that control measures put in place were carried out by staff and documented; for example hourly checks on the person by staff.

Staff received training and support which allowed them to carry out their roles competently. Staff told us there was a varied programme of mandatory and developmental training available at the care home. Training topics included dementia awareness, dignity, safeguarding, health and safety, moving and handling, care planning, and fire safety. The maintenance person had also received training in the inspection and testing of electrical equipment, to enable the testing of portable electrical appliances. Staff completed mandatory training as part of their induction which also included spending two weeks shadowing other staff and learning about the home and the people they support. New staff also completed the care certificate during their probationary period.

Staff told us that they were aware of the expectations of their roles, as they have regular supervision and appraisal with their line manager. "I feel very supported in my role, and if there were any problems the manager would sort it out straight away". Staff told us that their appraisal and supervisions were used to discuss what they were doing well and what they needed more support with, which they found helpful and constructive. One staff member said "We are supported well with training here". Further developmental training was also available, and three nurses had recently completed a mentor training course in conjunction with a local university, with a view to supporting student nurses during placements at the care home.
We observed staff reminding people to remain hydrated and offering alternatives to liquids such as jelly if people were at risk of dehydration which staff said they had learned through the hydrate project. One staff member told us that they had requested specific dementia awareness training, and this had been approved. Once they had completed their course, the staff member was then able to train other staff members, thus further disseminating the knowledge.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that staff understood the requirements of the Mental Capacity Act, and documents seen demonstrated that the appropriate procedures had been followed.

People were encouraged to make their own choices of meals. Staff were seen asking people which menu option they wanted, and staff told us that if people did not want any of the offered options, then alternatives would be offered. There were menus displayed in the dining room, and the food served was as displayed on the menu. People were encouraged to eat and drink independently, and specific aids such as dual-handled beakers were in use to support this. People who were unable to eat their meal independently were supported by staff, and this was done with care and dignity. Staff were seen sitting next to the people they were supporting, and chatted easily with them throughout the meal. All staff seen serving food were wearing aprons. Care was taken to ensure that people had a safe and pleasant dining experience. Drinks and snacks were made available throughout the day.

People were able to access external healthcare professionals as required, and any changes to their care as a result were incorporated into their care plans. For example, one person required input from the anticoagulation clinic to maintain their health. The person was noted to have regular blood tests to monitor their blood clotting times, and their anticoagulant medication was adjusted accordingly, as evidenced by their eMAR. All healthcare professional visits or interactions were clearly recorded within the person's care plan, including screening programmes for diabetes, and chiropody visits. We spoke with a visiting professional who told us that the staff were quick to put any advice into action and regularly contacted them for advice.

Good

Is the service caring?

Our findings

People told us staff were kind and caring and treated them with respect. People and their relatives said they were asked to participate in care reviews and relatives said staff informed them quickly of any incidents or problems.

The staff team were kind and caring towards both people and their relatives and visitors. When people were required to make decisions staff never rushed them but were very patient. Their stance, positioning, level, loudness and tone of voice were appropriate for each situation and they communicated with people in line with guidance in their care plans. We observed that staff were always smiling and singing and spoke to people as they passed them in the corridors. We observed that when entering people's rooms, staff always knocked and waited for a response before entering.

Visiting was not restricted at Brendoncare Stildon, and regular visitors were given the access code for the entrance doors, but for security they were still required to sign in the visitors' book. Relatives told us they were always made to feel welcome and we observed staff greeting people warmly when they arrived.

Staff members spoke with confidence, compassion and respect about the people who lived in the care home, and understood the necessity of equality and inclusion in their work. One staff member said, "I treat each person equally." All staff members told us that they read the person's care plan to ensure they have the appropriate information to support them. Staff told us they always carry out personal or intimate care in a closed environment to protect the person's privacy. Staff were observed to knock on bedroom doors, and awaited a response before entering.

Staff were aware of the person's rights with regard to personal choice. Staff encouraged people to make their own choices where possible, especially for decisions such as meal options or which clothes to wear. Staff members said they always gave people a choice where possible, and spoke with the person and their family where appropriate to determine their history, likes, dislikes, and preferences and to involve them in care planning. Each care plan had a "This is me" section, which had been completed with the involvement of the person or their family. This section provided key information about the person's life, hobbies, preferences and cultural or social needs.

There was evidence that people's relatives and advocates were involved in care. For example, we found that care plans were signed by the person' next of kin or family where the person had been assessed as not having the mental capacity to make independent decisions about their care. Care records included details of the person's preferred routine, for example when they wanted to get up or go to bed, and where they preferred to have their meals.

People and their relatives said that they had been involved in completing feedback forms and questionnaires during their involvement with Brendoncare Stildon. Everyone was aware of the Residents and Relatives meetings and said that they were very inclusive and a place to share ideas and viewpoints. People said they were used very well to disseminate information and discuss future plans.

Good

Is the service responsive?

Our findings

People that we spoke to said that they were all treated as individuals, and their care needs reflected their individual care needs. People and their relatives agreed that staff were helpful and encouraged them to pursue their own interests and hobbies. They also said that staff knew them by name and were genuinely friendly and welcomed them when they visited.

People said that staff were very responsive when they needed them. Call bells were answered in a timely manner when people needed help. People said "They come very quickly when you ring the bell". Healthcare professionals told us that they had observed staff being very responsive to people's needs whenever they had visited people at the service.

There were many photographs and examples of arts and crafts that had been produced by the people at the care home. There were many photographs depicting many of the activities and entertainment that occurred at Brendoncare Stildon that the staff group, including the manager participated in. People and their relatives told us that they enjoyed the activities that were offered and were able to choose what they wanted to do and put forward suggestions for new activities and outings such as trips to local historical places of interest.

People's individual and spiritual needs were supported and a monthly church service was held at the care home which people who wanted to could attend. One person also went to church with their family every Sunday. People were asked whether they had any religious, spiritual or cultural needs when they arrived at the service so that this could be incorporated into their care plans.

Information was provided for people in ways they could understand in line with the principles of the Accessible Information Standards. Documents such as the complaints process were available in large print for those with a visual impairment and staff told us that they went through information verbally with people who were unable to read. The registered manager told us that they had access to an interpreter if they needed to provide information to people whose first language was not English.

Care records were person-centred, and provided specific information on how to support the person. The care records contained an initial assessment of needs prior to admission, followed by a care plan. The initial assessment included a detailed medical history and current medical needs. The care record was individualised, and had been written with the person's usual routines in mind, including when they preferred to go to bed, or if they usually had a hot drink at night.

The care plan provided staff with further details of how to support the person, and included their current needs and abilities. For example, one person had been assessed as requiring end of life care, and had advance care plans and end of life care plans which were comprehensive, person-centred and written from a multi-disciplinary perspective. The person and their family had been involved in the care plan, and information about the person's preferences with regard to their care was highlighted, as well as their status with regard to cardiopulmonary resuscitation. There was information on anticipatory medications to ensure

the person remained comfortable. The care home had links with a local hospice, and staff told us that the hospice staff provided good support, including reviewing the care needs of the person, and liaising with medical professionals.

The home had achieved the Gold Standards Framework for end of life care which meant that staff had been trained to support people when they were nearing the end of their life which included early identification and advanced planning. There were regular reviews from the staff at the local hospice and the person's doctor. All care records were reviewed monthly to ensure that the care plans remained relevant.

People were provided with information about how to make a complaint if they needed to. There was a complaints process displayed around the home and people and their relatives were also made aware of it at meetings. The complaints process included details of where people could refer their complaint to if they were not happy with the outcome such as the local government ombudsman. Compliments were also recorded and people and their relatives had made comments such as "I would like to say a heartfelt thank you for all the excellent care given to my mum". There had been no complaints made within the last 12 months.

Good

Is the service well-led?

Our findings

People, relatives and healthcare professionals told us that they thought the service was well managed. One healthcare professional said, "I can't fault the clinical management and they have the overall management of the service which supports that."

There was a registered manager in post. 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. The registered manager was aware of their responsibilities in ensuring that they adhered to relevant legislation and guidance and completed notifications to the Commission when required. They were aware of their responsibilities under the duty of candour and how they had been open and honest with people when anything went wrong.

Staff told us they felt the service was supportive and had a positive culture. One staff member told us, "The service is managed well; no improvement is needed". Another staff member told us "The deputy manager is very supportive." Staff told us that the senior team were approachable and open to discussion about the service and suggestions from staff. Staff told us they were confident to raise concerns and felt sure they would be appropriately addressed. There was a Brendoncare staff award scheme in place which recognised staff who had performed over and above the expected level which was advertised for nominations from other staff, people who used the service, relatives and healthcare professionals. Staff were also given lead roles in areas that they could develop such as Mental Capacity Act lead where they were given additional training to be able to support other staff.

The registered manager said that they had a good support network facilitated by the provider which included meetings with other registered managers, regular supervision and support from other managers and directors within the organisation. Regular meetings were held to discuss clinical governance as well as operational issues and developments. Staff meetings were held every two to three months and were broken down into staff groups so that they could discuss topics relevant to their roles such as nurses discussing nursing tasks. Senior carers attended both nurse and carer meetings to enable continuity between the groups of staff. Staff were able to ask questions and make suggestions at meetings such as requesting that information about safeguarding was discussed at handovers to ensure that staff knew their responsibilities.

People and their relatives were asked for feedback and kept informed about the running of the service. Relatives meetings were held every three months which relatives told us were well run. Minutes of the meetings showed that people's relatives were informed about any changes to the service such as staffing and discussions about upcoming activities such as children from the local primary school visiting. People's relatives were also encouraged to make comments and suggestions and we saw that they had suggested purchasing new sun umbrellas for the garden which had been arranged. An annual residents survey was carried out, the most recent was sent in July 2017. The results of the survey were compared with the previous year to show improvement or look at if any areas had deteriorated. There had been improvement in 2017 and 100% of people had responded positively in areas such as feeling safe, staff knowing them well

and being treated with dignity. People had made additional comments such as "I love it all".

The service worked with other organisations to enable them to develop their links with the local community and keep up to date with changes and best practice. Nursing staff attended a mentor training course in conjunction with a local university to enable the service to provide placements to student nurses at the care home. The service had also participated in a hydration project with local NHS services and the registered manager was currently involved in a project with Skills for Care which was looking at putting standards together for new managers and nurses in social care.

There was a programme of audits in place to monitor the quality of the service and make improvements where necessary. Monthly audits included medication, infection control, care plans and incidents. Areas for improvement were identified such as in the care plan audit in February 2018 it was picked up that that there was no Do Not Attempt Resuscitation (DNAR) form however the action taken clarified that the person did not want a DNAR and this had been made clearer in their care plan. Medication audits were carried out weekly, and records seen demonstrated this. Stock checks on both regular and controlled drugs showed that balances tallied with those recorded in the eMARs. Provider visits were carried out on a monthly basis and spot audits were undertaken to address areas of improvement such as gaps in monitoring charts.