HC-One Limited

Brandon House Nursing Home

Inspection report

140 Old Church Road
Bell Green
Coventry
West Midlands
CV6 7ED

Tel: 02476638602
Website: www.hc-one.co.uk/homes/brandon-house

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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 14 February 2018 and was an unannounced visit.

At the last inspection on 31 May 2017, the service was rated as requires improvement. This was because we found there were not always enough staff to keep people safe and respond to their needs. Risk management plans and the actions taken to manage risks were not consistently recorded. We found the mealtime experience was not positive for everyone and improvements were needed in providing people with opportunities to go out into the local community. Staff did not always feel valued and sometimes lacked confidence in their role. Audit systems had not identified these concerns.

This inspection visit was a comprehensive inspection and during this inspection we checked to make sure improvements had been made. Improvements had been made to the effectiveness and responsiveness of the service and these are now rated 'Good'. However, some improvements were still needed in their audit systems because they had not identified some of the improvements we found in the safety of the service.

Brandon House Nursing Home is a care home registered to provide nursing and personal care to a maximum of 35 people. People in care homes receive accommodation and nursing and/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. At the time of our inspection visit, 32 people lived at the home. Seven of those people were living in the home on a 'discharge to assess' basis. Those people would be in the home for a short period prior to discharge to a more suitable place of care.

The home has accommodation over two floors with communal lounges on both floors and a dining room on the ground floor.

A requirement of the service's registration is that they have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and the associated Regulations about how the service is run. There was a registered manager in post.

People told us they felt safe at the home. Staff had received training so they understood what might constitute abuse and the action they should take to safeguard people if they had any concerns. Accidents and incidents that had impacted on people's safety had been referred to the local authority safeguarding team and had been investigated. The provider's recruitment policy ensured, as far as possible, that staff were safe to work in a care environment.

On the day of our visit there were enough staff to keep people safe and respond to their requests for assistance. However, staff told us they often worked without the full complement of staff which meant they could not always be so responsive. An identified staffing need between 8.00pm and 10.00pm was not being

filled at the time of our visit.

The provider used a range of recognised risk assessment tools to identify potential risks to people's health and wellbeing. Improvements were needed when staff recorded the actions they had taken to manage identified risks. Staff supported people to mobilise and transfer around the home safely and where people had fallen, appropriate action had been taken to minimise the risk of further falls.

Staff received training to meet people's needs, and effectively used their skills and knowledge to support people and build relationships. Staff understood their roles and responsibilities in relation to infection control and hygiene.

Staff were responsive to changes in people's health needs. They understood how to manage people's specific healthcare needs and when to seek professional advice and support so people's health was maintained. People received their medicines as prescribed.

Although staff found it difficult to articulate their understanding of the Mental Capacity Act 2005, overall they worked within the principles of the legislation. They sought people's consent and respected the decisions they made. Where restrictions on people's liberty had been identified, applications to deprive them of their liberty had been submitted to the authorising authority.

People were supported to eat and drink enough to maintain a balanced diet. Staff knew about people's nutritional needs and monitored their weight and appetite.

The provider assessed people's needs before they moved to the home to ensure they could provide effective support and care. The views of people and their relatives were taken into account when people's care was planned.

Staff told us they liked working at Brandon House and worked well with other staff in ensuring people received the care they required. Staff took time to understand people's needs and communicated effectively with them. Interactions between people and staff were kind and compassionate and staff respected people's privacy.

People were offered activities and social opportunities and this was being developed so it included people's areas of interest and individual hobbies.

Staff and people had opportunities to share their views about the service and felt more confident they would be listened to. The provider and registered manager were developing their focus on improvement and learning.

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 consistently safe.

Staffing levels were not consistently maintained to ensure there were always enough staff to meet people's needs safely and effectively. Risks to people's health and wellbeing were assessed, but records did not always evidence the actions staff had taken to manage identified risks. Learning was taken from accidents and incidents to minimise risks and keep people safe. Overall, medicines were managed safely and people received their medicines as prescribed. Staff understood their responsibilities to safeguard people from abuse and the provider checked they were of suitable character to work in a care environment.

Is the service effective?

Good

The service was effective.

Staff received training and support to carry out their responsibilities effectively. Staff mainly worked within the principles of the Mental Capacity Act 2005 and the registered manager understood their responsibilities under the Deprivation of Liberty Safeguards. People were supported to eat and drink enough to maintain a balanced diet and referred to other healthcare professionals when needed.

Is the service caring?

Good

The service was caring.

People received support from an understanding and caring staff team who took time to understand their needs. Staff promoted dignity by being discreet when people needed assistance with personal care and responding in a timely way. Staff encouraged people's independence and respected their privacy and personal relationships.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved in planning their care

and support. People were offered a range of activities and social opportunities and there were plans to ensure these took into account people's interests and hobbies. The service provided end of life care and listened to people's wishes about how they wanted to be supported at the end of their life. Complaints were listened to and action taken to address concerns.

Is the service well-led?

Requires Improvement

The service was mostly well-led.

Improvements had been made to ensure people received an effective and responsive service. However, challenges still remained in maintaining a full complement of staff on every shift and recording the actions taken to minimise risks to people. Staff and people had opportunities to share their views about the service and felt more confident they would be listened to. The provider and registered manager were developing their focus on improvement and learning.

Brandon House Nursing Home

Detailed findings

Background to this inspection

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

The inspection visit took place on 14 February 2018. The inspection visit was fully comprehensive and was unannounced. The inspection team consisted of two inspectors, two specialist advisors and an expert-by-experience. A specialist advisor is a qualified health professional. One specialist advisor had experience in providing nursing care to people with complex medical needs. The other was a qualified occupational therapist. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of the risk of falls. This inspection examined those risks.

Prior to our inspection visit, we reviewed the information we held about the service. We reviewed statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send us by law. We looked at information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. The local authority shared information about recent monitoring visits they had carried out at the home.

Some people living at the home were not able to tell us about their experiences of living at the home due to their complex health conditions. We spent a significant period of time observing the communal areas. This helped us judge whether people's needs were appropriately met and to identify if people experienced good standards of care.

During our inspection visit we spoke with three people and three relatives about what it was like to live at the home. We spoke with staff on duty including one nurse, an agency nurse, seven care staff, the activities co-ordinator, a member of domestic staff and a maintenance person about what it was like to work at the home. We spoke with the registered manager and the provider's quality monitoring officer about the management of the home.

We reviewed a range of records; these included three care plans in detail and specific aspects of five other care plans. We looked at daily records, food and fluid charts and 28 medicine administration records. We checked whether staff were trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in May 2017 we found the safety of the service required improvement. This was because there were periods during the day when staffing levels were insufficient to enable staff to supervise those people living with dementia to ensure their safety. Since our last visit we had received concerns that staffing levels remained an issue, especially on the unit on the first floor. At this inspection we found some improvements had been made to staffing levels, but they had not been sustained so the safety of the home still required improvement.

Following our last inspection the registered manager reassessed each person's dependency levels to ensure the home could meet their needs. The registered manager explained, "When you came last time there were seven residents who were inappropriately placed." They told us they had worked with the local clinical commissioning group to ensure people were placed in a service better equipped to meet their individual needs. The registered manager explained this had a positive impact on the home because staff had fewer incidents to manage of behaviours that caused anxiety to others. They were confident that based on the dependencies of the people currently living at Brandon House, the identified staffing levels during the day ensured people were kept as safe as possible.

During our visit we saw there were enough staff to keep people safe and care staff were available in communal areas to respond to people's needs. However, staff told us the staff numbers planned for were not always met due to unexpected absence. Staff explained this was particularly challenging because most people required the support of two staff for personal care. This meant they frequently worked below the number of staff needed to meet people's needs safely and effectively. They told us, "Today we have four up and down, but sometimes its two or three upstairs and three downstairs. When we haven't got the staff, we struggle. I would say weekends are worse than in the week, we can be short at the weekends. Today we are full so I can't say anything, but tomorrow they could be short." Another staff member also felt there were not enough staff if they worked with two or three as opposed to four on each floor. They told us, "If a staff member needs to take the trolley, we have to leave one staff member on the floor, or if we are changing someone in pairs, we are stuck. Today there is enough." Staff told us that working with less than the identified number of staff on each shift, meant they were not able to provide care and support how they would like to. One staff member explained, "Maybe the residents might not get a drink or someone will have to wait to get changed. It's not fair to them if we have not got the staff."

We shared this with the registered manager. They told us they had already recognised the need for more bank staff to cover unexpected staff absence due to illness. They had advertised and interviewed applicants the week before our visit, some of whom lived locally. They felt a larger number of bank staff would enable them to cover unplanned staff absence more effectively. Planned absence was covered by agency staff.

A senior member of staff told us staffing levels at night were three care staff and a nurse which they felt could be improved as most people required the support of two staff for personal care. The registered manager explained that following our last visit they had introduced a 'twilight shift' between the hours of 8.00pm and 10.00pm which increased the level of staffing during the evening. However, whilst permanent

and bank staff had initially been happy to cover this shift, they were no longer able to do so. This meant the registered manager had not been able to cover the 'twilight shift' during recent months. A senior member of staff told us the 'twilight shift' had "worked really well" as it provided extra cover when the nurse was giving people their medicines. The registered manager agreed they needed to recruit externally to fill the 'twilight' role so staff could be more responsive to people's immediate needs during the evening.

None of the people we spoke with during our visit raised concerns about the availability of staff to meet their needs. When we asked people if there were enough staff they responded, "I should say more than enough" and, "I haven't given it a thought so I imagine so." One person told us staff responded "quickly" if they used their bell to call for assistance. However, some people commented that there were more staff around during the week than at weekends.

At our last visit we found improvements were needed in the information available to staff to help them manage or reduce the risks to people when delivering care. At this inspection we found improvements had been made. The provider used a range of recognised risk assessment tools to identify risks to people's health and wellbeing. People's care plans were regularly reviewed and their risk assessment scores were updated when their needs and abilities changed. New 'stress and distress' plans had been introduced which guided staff on how to support people who could become anxious or distressed during care interventions.

Staff were aware and observant of risks associated with people's care. One person appeared to be slipping from their seat. A member of staff spent 10 minutes with the person, encouraging them to adjust their position and sit as upright as possible in order to prevent them falling from their chair. Staff told us any changes in risk were shared at the handover meeting between shifts.

However, we found some improvements were still needed when staff recorded the actions they had taken to manage identified risks. For example, some people were at risk of skin damage. A nurse explained how care staff routinely checked people's skin when providing personal care. If care staff identified any red areas, they informed the nurse so preventative measures could be taken to prevent the damage escalating. People at risk of skin damage were placed on a repositioning regime to alleviate pressure on vulnerable areas of their body. We looked at the records for one person who had skin damage and needed to be repositioned every four hours. Over a seven day period there were no entries on their re-positioning chart to evidence that repositioning had taken place during the night.

Some people were on fluid charts because they were at risk of not drinking enough. We looked at three people's fluid charts. We found the charts had not been consistently completed so we could gain an accurate picture of how much fluids people had taken. For example, one person had no charts to evidence what they had to drink on two days in the week prior to our visit.

Whilst the registered manager assured us people were receiving appropriate care, the inconsistency in record keeping meant there was a lack of written evidence to assure us that the risks to people's health were always managed in accordance with their risk management plans.

Prior to our visit we had received concerns about how staff supported people to mobilise and transfer within the home. Our specialist occupational therapist observed manual handling closely. Where people needed support to stand from sitting, this was carried out appropriately with the correct techniques. People were supported from the side and not under the arm which can cause injury. One person was transferred from a chair to a wheelchair with the use of a hoist, and this was carried out in accordance with good practice. Particular attention was paid to ensuring the person's feet were on the foot plates before the wheelchair was moved.

Our specialist occupational therapist looked at the records of four people who were at high risk of falls because we had received concerns that falls were not being managed appropriately. People identified as being at high risk of falls had clear risk management plans to reduce the risks. The plans were reviewed after a fall to identify whether further measures were required to reduce the risks further. Where people were at risk of falling out of bed and bed rails had been assessed as not suitable, 'hi-low' beds and crash mats were in place. This reduced the risk of injury to people who may be restless at night and attempt to climb over the bed rails and fall from a greater height. Sensor mats were used for some people to alert staff when they attempted to move without support.

We looked at the records of one person who had fallen nine times since August 2017 and was assessed as being at high risk of falls. The person was able to move around the home independently without equipment, although they used the hand rails along the walls to steady themselves. This had been risk assessed by senior staff who had documented the person's needs clearly in their care plan. During our visit we saw the person was constantly observed by staff during the day and offered a helping hand when required. It appeared the person had the interventions required to keep them safe, as the number of falls had decreased in the last four months.

Another person had fallen three times. They had alert mats in their room and the registered manager had ordered an infra-red beam which would alert staff when the person left their bedroom. This meant staff could immediately provide the person with the support they required to reduce the risk of them falling. One person told us they felt safe because, "I am supervised with my frame, I have to take somebody with me in case I fall."

The provider had a procedure for recording, monitoring and analysing accidents and incidents and staff said they were supported and encouraged to follow it. Records demonstrated there was clear evidence of learning taken from individual accidents, both for individuals and at service level. For example, one person had sustained bruising and on investigation it was felt this could have been caused by their body movements when being supported to transfer using a hoist. The person's care plan clearly indicated what action staff should take to keep the person safe when being hoisted.

A nursing specialist advisor looked at how medicines were managed by checking the Medicine Administration Record (MAR) charts for 28 people, speaking to staff and observing how medicines were given to people. We found the MARs were completed accurately and demonstrated that people received their medicines at the times they needed them. A member of the nursing staff supported people to take their medicines in line with safe administration procedures. People told us they received their medicines when they needed them.

All medicines were stored securely and at the correct temperature to ensure their effectiveness. Medicines that required extra checks and special storage arrangements because of their potential for misuse, were stored correctly. The administration of these medicines was recorded accurately and showed they were being given as prescribed.

Where people were on medicines which were prescribed on an 'as required' basis for anxiety, agitation or pain for example, there were clear guidelines in place as to when these medicines should be given. This information helped to enable care staff to make a decision as to when to give these medicines safely and consistently. Limited use of medicines for anxiety or agitation indicated staff followed the guidelines to ensure they were not given unnecessarily. One relative told us their family member's medicines had been reviewed since they moved to the home and they were now a lot calmer and less agitated.

Some people received their pain relieving medicines via a trans-dermal patch applied directly to their skin. It is important the patches are rotated around the body to avoid people experiencing unnecessary side effects. Rotation charts were in place showing the site and removal of the patches, but these had not always been completed. There was no record of daily checks to ensure the patches were still in place. Daily checks are important as patches can fall off or be removed by people, which could result in them experiencing unnecessary pain. The deputy manager assured us these checks would be implemented.

We found where people had to have their medicines given to them disguised in food or drink, the GP had agreed and signed the appropriate documentation. The provider had also sought the advice of a pharmacist about the suitability of crushing medicines into people's food or drinks so they could be safely prepared and administered. However, the care plans for giving medicines in this way did not state the safeguards to ensure all the medicine was taken, and only taken, by the person it was prescribed for. This is essential for people living with dementia as they can easily become distracted and leave their food or drink unfinished which could then be picked up by another person. It is good practice for a copy of the plan to be attached to the MAR.

People told us they felt safe and well supported by staff. Comments included: "Oh yes, you feel safe because you're enclosed and in charge of everything" and, "I'm pretty sure about the security."

The provider took action to minimise risks of abuse, harm or neglect. Staff completed training on safeguarding people from the risks associated with abuse. Staff were aware of what signs to look for that could suggest people were at risk and told us they would report any concerns to their manager which demonstrated they were aware of their responsibilities. For example, one staff member explained how they would respond to unexplained bruising. They told us, "We would report it to the nurse in charge and we have to document it. At the moment there is nobody with any bruising." Another staff member told us, "When we check people if they have bruises, we tell the nurse and they will normally come and check it and take pictures. If the nurse is not available, we tell the manager."

Records showed accidents and incidents that had impacted on people's safety had been referred to the local authority safeguarding team and had been investigated. For example, unexplained bruising to one person's head had been referred as a safeguarding incident and a full investigation had been conducted to identify the cause.

People were cared for by staff who were suitable to work in a caring environment. Before staff were employed, the provider carried out checks to determine if staff were of good character. These included criminal record checks through the Disclosure and Barring Service (DBS) and obtaining references from previous employers. This showed the provider followed recruitment procedures which minimised risks to people's safety.

Prior to our visit we had received concerns about the cleanliness of the home. We found the provider's policy and procedures protected people from the risks of infection. The provider had appointed a champion for infection prevention and control, in line with the Department of Health guidance. We saw the home was clean and tidy during our inspection visit, and the senior housekeeper confirmed there were sufficient domestic staff to ensure the cleanliness of the home was maintained. The provider had created a schedule of cleaning tasks to make sure every part of the home was regularly cleaned. We did identify an unpleasant odour in the upstairs lounge. The registered manager told us they had already identified this, and had plans for the carpet and some of the furniture to be changed. This was confirmed by people we spoke with.

There was no cleaning schedule for clinical equipment such as the suction machine. The deputy manager

told us a new suction machine was on order and assured us they would implement a cleaning schedule once it had arrived.

Staff understood their role and responsibilities in relation to infection control and hygiene. Staff were seen to wear gloves and aprons when completing their duties and supporting people. During the morning of our visit, we saw a person was sitting on a pressure cushion placed on their specialist chair. We could see the chair underneath the cushion was dirty. When the person was supported with personal care later during the morning, staff took the opportunity to clean the chair.

The provider minimised risks related to the premises by contracting with specialist suppliers to test, service and maintain essential supplies and equipment. Records showed, for example, the electrical supply and equipment had been checked within the last 12 months, and that the lift and hoists were regularly serviced.

The provider had procedures to manage risks in the event of an emergency. People's care plans included personal emergency evacuation plans (PEEPS), which described the support they would need to evacuate the building in the event of an emergency. There was a condensed version of PEEPs in the emergency evacuation bag located near the entrance to the home. The bag also contained clear information about who staff should contact in the event of a disruption to essential services to the home such as gas, electricity or water. The provider had obtained an external risk assessment of the premises to ensure their plans for managing the service in the event of a fire were adequate and minimised risks to people's safety.

Good

Is the service effective?

Our findings

At our last inspection in May 2017 we rated the effectiveness of the service as 'Requires improvement'. This was because some staff demonstrated a lack of confidence in their role and the meal experience for some people needed to be improved. At this inspection visit we found improvements had been made and the rating is now 'Good'.

Pre-admission assessments in people's care plans showed the provider assessed people's needs before they moved to the home to ensure they could provide effective support and care. The registered manager told us the assessment process had been refined since our last inspection as previously people had been discharged from hospital to Brandon House with complex needs the staff team could not always support. They explained that during the assessment process they now considered the skill sets and experience of staff, and also the needs and personalities of those people who already lived in the home. The registered manager felt this had improved outcomes for people because staff now had much more confidence in their abilities to meet people's needs effectively.

Staff received an induction when they started work at the home which took into account their qualifications and previous experience of working in care. Induction was tailored to the different roles each staff member performed and meant new staff received training in line with the Care Certificate. The Care Certificate assesses staff against a specific set of standards. Staff have to demonstrate they have the skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support.

Staff told us their training was kept up to date, and their skills were refreshed so they continued to be competent in their role. Staff training was relevant to people's needs and included safer people handling, dementia awareness and nutrition. We particularly spoke with staff about their safer people handling training as we had received concerns this was not always put into practice effectively. Staff told us they had received this training in the last six months and because the course covered all aspects of supporting people to mobilise and transfer, they felt confident to do this safely. The registered manager and two other staff members were accredited trainers and regularly observed staff to ensure they were able to transfer their knowledge into practice. The registered manager explained, "Between the three of us we would see if any staff were taking shortcuts and we would also see the signs, such as bruising and skin tears." During our visit we saw staff used their training and skills effectively to support people when assisting them to move around the home safely.

Clinical nursing staff felt access to training and the opportunity to gain further qualifications was good. A member of the clinical nursing team told us they had been supported by the registered manager to undertake all the training and reflective practice necessary to revalidate their nursing qualification. Another nurse had been supported to attend an advanced university course in caring for people living with dementia.

Staff were given opportunities to discuss their role and developmental needs at supervision meetings and annual appraisals.

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. 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Where people lacked the capacity to make their own decisions, mental capacity assessments had been undertaken, to establish what support was needed to make specific decisions. Where people needed support to make decisions, family members and health professionals had been involved in best interests meetings.

Staff had received training in the MCA, but we found some staff would benefit from more training as they found it difficult to articulate their understanding of the legislation. Overall staff worked within the principles of the MCA as we heard and observed staff to seek consent from people who needed support with personal care. One staff member told us how they watched people's body language and facial expressions to ensure they were consenting to care and support if they were unable to do so verbally. They told us, "We speak to them and explain what we are doing, some of them may not understand what we are trying to say so it can be quite difficult. Some move their hand or arm so we know it's okay." They went on to explain how other people would give a 'high five' or do a 'thumbs up' to communicate they were happy with the care provided. However, we did observe a couple of occasions when staff did not explain to people what they were going to do. For example, one person was assisted to eat a yoghurt. The staff member wiped the person's mouth without telling them first.

Staff told us they respected people's right to refuse their assistance with personal care, but balanced that right with the need to ensure people's health and wellbeing was maintained. One staff member told us how they worked with one person's family to ensure the person received the care they needed. They explained that when this person was visited by a family member their mood changed and they were more willing to accept care and support. Staff told us they used these opportunities to carry out care the person had previously refused, such as showers and the application of creams. Another staff member told us, "If I apply cream in the morning, but they are refusing in the afternoon, it's alright if their skin is okay. If the skin is worse I explain nicely it is needed and very important, and if they are still refusing we tell the nurse."

The manager had a good understanding of the MCA legislation and reviewed each person's care needs to assess whether they were being deprived of their liberty, or their care involved any restrictions. Several people at the home had an authorised DoLS and additional applications had been made to the local authority and were awaiting a decision. The registered manager was aware of those people who had conditions on their authorisations, and was liaising with one person's family to ensure their cultural needs were met in accordance with a condition within their DoLS authorisation.

People were supported to eat and drink enough to maintain a balanced diet. During the morning we saw staff offered people snacks such as biscuits and crisps, because they recognised some people needed extra calories to maintain their health and weight. Staff knew to show people what food they were offering to them rather than just asking them. For example, one staff member asked a person if they would like some crisps and opened the bag and put them into a bowl so the person could see them. They held one up to the person's mouth to encourage them to take them. Some people were on soft diets and were unable to eat some of the snacks offered. These people were offered yoghurts and staff supported people to eat them. Staff regularly offered people drinks and also provided them as and when requested.

At our last inspection we received some concerns about the choice of food available. At this visit people indicated they were happy with the quality and choice of food provided. One person told us, "The food is nice, it's improved a lot." A relative commented, "The food is very good, the chef tries to be versatile and [name of person] has a fantastic appetite."

We observed lunchtime on both floors. There was a menu on display which included pictures and staff showed people sample meals on plates which enabled them to see and smell the food before they made a choice. During lunch staff checked who had a meal and who had eaten and who had not. Staff offered people the second choice of meal if they did not eat their first choice.

In the dining room on the ground floor, there was a nice relaxed atmosphere and people were asked what music they would like. One person requested a specific singer and this was put on quietly as background music. On the first floor, the atmosphere was much busier as most people stayed in their lounge chairs to eat. This meant staff were walking in and out of the lounge to deliver meals to people. A lot of people needed encouragement to eat and staff did not have the time to sit with them until they had finished serving all the meals.

Where staff assisted people to eat, this was done in an unhurried manner. Staff waited for people to finish their mouthful before offering the next and encouraged people to finish their meals.

People's care plans included a nutritional assessment and an appropriate care plan for those identified as at risk. Staff monitored people's weight and appetites and sought the advice from healthcare professionals, such as speech and language therapists or dieticians, if there were any concerns about their nutrition. Staff knew about people's nutritional needs and who needed a soft or pureed diet. They also knew who needed to have a thickening agent added to their drinks to prevent them from choking when swallowing. Records we checked showed most people's weight was stable as a result of actions taken to ensure they maintained a good food and fluid intake.

The home was supported by two GP practices. A GP or 'modern matron' visited weekly to review people's care so they had a good working knowledge of people's individual medical needs, and could identify any improvement or deterioration in people's conditions. The home had also developed their relationship with the tissue viability nurse, who was now able to review people's notes electronically if they did not have capacity to visit immediately a need was identified.

Care records demonstrated that staff were responsive to changes in people's health needs. Staff understood how to manage people's specific healthcare needs and when to seek professional advice and support so people's health was maintained. A visiting healthcare professional confirmed, "The staff are very good at identifying when something is not right with a resident so I know that if they request additional visits it is needed." Detailed records were maintained of healthcare professional visits to ensure treatment was delivered in accordance with any medical advice given.

The home was on two different levels and there was a lift to enable those people with limited mobility to move around between the two floors. There was a lounge and a dining room on the ground floor and a quieter area where people could meet with family and friends. On the first floor there was a lounge with two dining tables at the end of the room. The layout of the furniture in the lounge resulted in some restrictions in space which meant staff had to frequently move items around the lounge to move people in and out safely. There was a second communal lounge on the first floor but this was not being used to its full potential and at the time of our visit was being used as a storage area for equipment. There was picture signage around the home to help people find their way around.

Communal areas of the home were being redecorated at the time of our inspection visit and people had been involved in choosing the colour scheme. People had personalised their bedrooms with items that depicted their past and present lives.

Work had been done over the last six months to improve the garden space to make it a more pleasant area for people to sit and spend time. The garden was accessible to people and there were brightly coloured benches where people could sit in the warmer weather. A wooden hut provided a versatile place for different activities such as a tea room or an ice cream parlour in the summer and festively decorated at Christmas.

Good

Is the service caring?

Our findings

At our last inspection we rated caring as 'Good'. At this inspection we found people continued to receive care and support from an understanding and caring staff team. One visiting healthcare professional told us, "The staff are exceptionally good with the residents and really know them well." The rating continues to be 'Good'.

The provider displayed the names and photos of all the staff who worked at the home, to support people and visitors to understand staff's responsibilities and to help develop relationships with them. Staff told us they liked working at Brandon House and worked well with other staff in ensuring people received the care they required. One staff member told us, "Residents need us to be caring. As a human being, they are all suffering with dementia and they don't know what they are doing. If they are hitting us they don't understand, so we try to make it safe for them. We tell them in a friendly way with nice words to try and look after them properly."

Interactions between staff and people were kind and compassionate. Staff knew people's names and took opportunities to engage with them when providing assistance and guidance. When staff offered people a supportive arm, they talked with them as they walked along and engaged them in conversation. One person told us, "Staff are pretty good actually. You can make contact with them and discuss things and they are available." Another said, "Staff are very nice and very friendly. On the whole they are very, very good."

Staff communicated effectively with people and used different ways of enhancing that communication. For example, by touch, ensuring they were at eye level with those people who were seated, and altering the tone of their voice appropriately. They reassured people who were anxious and distressed and responded promptly, calmly and sensitively.

Staff took time to understand people's needs. One person was struggling to communicate with staff and kept repeating the word 'wet'. The person was becoming frustrated at not being able to get staff to understand them. However, staff gave the person the time they needed to communicate what they wanted. One staff member continued to speak with the person until they understood the person was talking about their hair being wet which meant they wanted to know when the hairdresser was visiting. The staff member shared this with other staff so they all understood what the person wanted so they could respond appropriately if asked again.

Prior to our inspection visit we had received some information that people were not always supported with their personal care in a timely way which compromised their dignity. On the day of our visit staff promoted dignity by being discreet when people needed assistance with personal care and responding promptly.

The provider understood the importance of promoting dignity and respect in care. They had appointed three members of staff as 'dignity champions' who had attended a 12 week dignity training programme. Their role was to encourage other staff to always consider people's dignity when supporting them. Staff told us dignity issues were discussed in staff meetings. They explained they had recently discussed how some

staff referred to the clothes protectors people wore when eating as "bibs" which was not respectful. Staff had been told to always refer to them as protectors and that once people had finished eating, they should be promptly removed.

People's independence was encouraged because care plans were clear what people could do for themselves and when they needed support. Staff understood some people needed time to maintain their independence. One staff member explained, "Some people we assist with food, and some eat by themselves and we give them time." A relative confirmed, "I think they encourage them to eat on their own as long as possible."

Staff respected people's privacy. Staff did not disturb people unnecessarily if they chose to spend time in their own room. For example, when people were asleep or had visitors in their room, domestic staff gave them privacy, and returned later to carry out their cleaning tasks. When staff did go to people's rooms, they knocked first and called out to let them know who was at the door, before entering. Doors were closed when staff delivered personal care.

The provider was committed to equal opportunities and diversity. Staff had received training in equality and diversity to support them in meeting people's individual needs and preferences. This included cultural and religious backgrounds as well as people's gender and sexual orientation. One person's first language was not English. A member of staff told us they were this person's keyworker because they spoke the same language which had helped them build up a relationship together. This staff member clearly knew the person well and was able to tell us in detail about how they worked in accordance with the person's routines to ensure they had enough to eat.

People's spiritual needs were supported. A minister visited the home regularly to support people who chose to follow their religious beliefs. The registered manager was working with a relative to ensure another person's spiritual needs could be met.

People were encouraged to maintain links with family and friends. Visitors were encouraged to visit when they wished to. Staff welcomed people's relatives and took time to share information and engage with them. One relative told us, "Any time you want to come you can, mornings, afternoons or evenings. As soon as you walk in they ask you if you want a drink." On the day of our visit, the chef had prepared a special menu to celebrate Valentine's Day. Relatives were invited to enjoy a special meal with their family member in a quieter area of the home.

Good

Is the service responsive?

Our findings

At our last inspection visit we found the responsiveness of the service required improvement. This was because due to the complex demands of some people on short term placements, staff had limited time to respond to the needs of others in the home. People were given the opportunity to engage in social activities, but had limited opportunities to go outside the home and maintain links with the community. At this inspection we found improvements had been made and plans were in place for further developments. The rating is now Good.

At this visit we found staff had more opportunities to engage with people and were able to be more responsive to people's immediate needs. People's requests for assistance were responded to in a timely manner. The registered manager explained that whilst they still had the 'discharge to assess' short term placements, their more stringent pre-assessment process meant they no longer accepted people with complex high dependency care needs that were so demanding of staff time. They had also reduced the amount of paperwork staff had to complete which took them away from spending time with people. For example, people were now only on food and fluid charts where a need had been identified. During our visit we saw staff sat by people when completing paperwork so they could still continue to engage with them. However, staff said they found it more difficult to be responsive and engaged when they were working below the identified staffing levels due to unexpected absence.

We found the size of the room and the layout of the furniture in the first floor lounge continued to be a challenge to staff's ability to respond to people's needs. For example, one person's chair was in a position where staff were initially unable to see when the person became upset. Staff told us it was more difficult when everyone chose to go into the first floor lounge, although they did encourage them to go to the larger communal areas on the ground floor. The registered manager told us they would look at the accessibility of a smaller 'quiet lounge' on the first floor to alleviate pressures on the main lounge.

The views of people and their relatives were taken into account when people's care was planned. Care plans were personalised stating how people liked to dress, the food they liked and preferences for bathing or showering and sleep. This information was taken from the detailed profile completed on admission to the home either with the person or their family members. People's care plans were regularly reviewed and updated when their needs and abilities changed. Daily care notes gave a good sense of how the person was on any day, and the care they had received.

Relatives told us they continued to feel involved in people's care with one commenting, "I get a document every month telling us what's going on, when the hairdressers coming in or chiropodists, outings and relatives meetings."

People's communication needs were assessed and guidance for staff explained how they should support the person to understand information. Records showed the registered manager ensured people's sensory needs were assessed to support their communication and understanding with visits by opticians, audiology and dentists.

When people moved to Brandon House, people and their relatives were asked to complete a "Remembering Together – Your Life Story". This covered information about family, friendships, working and family life, skills and interests and personal attributes. This enabled staff to get to know people well and to understand what was important to them. The registered manager explained how they were beginning to develop this information to support people with their particular interests. For example, one person had been to school with a nationally known singer. The registered manager had arranged for the singer to call the person on the telephone and then supported them to attend a concert when the singer was performing locally. Another person had a particular interest in giraffes and staff supported them to visit a local zoo. The registered manager had bought a large picture of a giraffe which was placed in the corridor opposite their room. The registered manager explained, "It's the first thing he sees when he leaves his room and it usually brings a smile."

There were two designated members of staff to support people's engagement in activities between 10.00am and 3.30pm, seven days a week. People were offered the opportunity to join in group activities such as dancing and pet therapy, and also individual activities such as doing jigsaws, playing chess and hand massages. There was also entertainment including singers, magicians and a Christmas fete. Many activities were planned around events in the calendar such as St David's Day, Valentine's Day and Bonfire Night. These gave events a theme and also reminded people of different times of the years and the changing seasons.

At our last visit, people did not have many opportunities to go out into the local community. At this visit we found improvements had been made. The registered manager now had a staff member who could drive the home's minibus and people had already been on several trips including a recent trip to Skegness. Further trips were being planned. One member of staff told us how important it was for people to be given these opportunities. "Most of them have spent their time working, not stuck in the house. Taking them to a zoo or garden centre is things they probably used to do, it is keeping their life as normal as possible."

During the morning on the first floor, most people were seated in the lounge with very little stimulation and activity aside from when staff were supporting them. During the afternoon staff encouraged people to go down to the ground floor where there was a singer entertaining people. Some people chose to go, but others chose to stay where they were. The activities co-ordinator showed us an activities involvement sheet the provider had recently introduced. Each person had a sheet in their file which evaluated the activities and entertainments they had been involved with, and identified areas of interest which would support their well-being. The registered manager explained this would enable them to offer more activities and social opportunities around people's individual interests which would encourage their involvement. For example, based on people's past interests and life experiences, four people had been taken out for a pub lunch the week before our visit. Also because some people liked football, goal posts had been put in the garden so they could still enjoy kicking a ball around once the weather improved. Another person had joined in painting the communal areas because it was something they had done in the past. Photographs showed how much they had enjoyed the opportunity to join in with the decorating.

We found there were limited activities for improving core muscle strength. We discussed this with the activities co-ordinator who explained these had been tried, but people had chosen not to join in. However, one member of staff had qualifications in personal fitness and had submitted a plan for two people to have a bespoke and tailor made fitness programme to support improvement in their mobility. This has been accepted by the registered manager and this was due to start once any medical needs had been identified.

One relative had recently complimented the provider on the social engagement in the home. They had written, "We love that [person] is taken out on day trips and there are regular events/activities for them to

take part in if they wish to."

Some people had always enjoyed owning pets and looking after them. There were fish and two birds in the downstairs lounge and doves in the garden. Many people enjoyed the company of a small dog that came to work with one of the members of staff. The animals gave people interest and generated topics of conversation with their visitors.

The service provided end of life care for those people whose preference it was to stay in the home. People's care plans contained the appropriate documentation that confirmed the person or their representative had been consulted about their wishes in the event of them having a cardiac arrest in the future. Where people had chosen to express their wishes, they also contained an advanced plan stating how people wished to be supported at the end of their life. The registered manager explained the importance of, "Making sure people are where they want to be. It is about making the care plan as detailed as possible and having good communication with the GP and nurse to make sure they are pain free and comfortable." They told us about one person who had recently died at the home. The family had been given the use of an empty bedroom so they could stay with their family member during their final days.

The provider's complaints policy was available to people, relatives and staff. There were comments cards in the entrance to the home and a suggestions box so people could leave feedback about the service.

There had been two formal complaints since our last inspection visit. One was about fees and the other was an anonymous complaint about care standards. The registered manager had fully investigated the concerns raised and conducted an unannounced observation visit at 4.30am. Learning from the visit had been shared with staff at a staff meeting. This demonstrated that concerns were used to improve the quality of care people received.

One relative told us they had raised a concern about their family member's personal hygiene. They told us staff had taken immediate action and they no longer had any issues. Another person said they would share any worries with a family member who they said would raise them with the registered manager. They went on to say, "They are always put right."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found the leadership of the home required improvement. This was because audits and checks were not always effective and we received mixed feedback regarding the leadership of the home. At this inspection we found improvements had been made in the management of the home, but further improvements were required to ensure people consistently received a safe and quality service.

At our last inspection we found the key areas of safe, effective and responsive required improvement. At this inspection we found improvement had been made in the effectiveness and the responsiveness of the service. Following our last visit, the registered manager had taken action and reviewed the needs of people who lived in the home. They had worked with the local clinical commissioning group and social workers to ensure people had the appropriate support they needed to maintain their physical and mental health, and promote their emotional and social wellbeing. This had resulted in some people being moved to more suitable placements which meant staff had more time to respond to the needs of the other people who lived at Brandon House. Staff were more effective because they had the skills to meet people's needs.

However, there were some areas where we had identified the need for improvements at our last inspection and these were still required. Staffing numbers had not been consistently maintained to ensure people always received safe care. For example, the 'twilight shift' between 8.00pm and 10.00pm was no longer on the rota even though we had been told this was an identified staffing need. Unexpected absence due to illness was another issue raised by staff. The challenge of ensuring the home had a full complement of staff at all times was recognised by the registered manager.

One area of concern at our last visit was that fluid charts were not always completed correctly. We found this was still an issue which meant the records that supported people's intake could not be relied upon to provide an accurate picture of what fluids people had consumed and any potential cause for concern. Other records had not been completed to evidence the management of risks to people's skin.

The issues around fluid and turning charts had been identified during a visit from the local clinical commissioning group in October 2017 and the issues still remained when we visited.

At our last visit we identified that the lounge on the first floor did not always meet people's needs because it could become very noisy due to the number of people in the room. At this visit we identified the same issues. The lounge was over full with people who sat there all morning. Consequently, the room appeared cluttered and uncomfortable. Although staff were responsive to people's needs, a great deal of time was spent moving furniture and chairs around to transfer people in and out safely. Where people remained in their lounge chairs to eat lunch, there were insufficient numbers of 'over chair' tables which meant it was challenging for some people to eat their lunch properly. The provider's checks had not identified that this compromised the quality of care some people received. When we last visited, a smaller 'quiet room', also on the first floor, was not accessible because it had a coded lock fitted to the door. At this visit we found the room was still not being used and no consideration had been given as to how it might be staffed to provide a quieter, more relaxing environment for some people and relieve the pressures on the main lounge.

When we visited in May 2017 some people and their relatives did not always feel listened to and that action would be taken in response to their feedback. Since then the registered manager told us they had worked hard to develop a better understanding so people felt engaged and involved in the running of the home. This had involved the establishment of a 'residents committee' to take ownership of some aspects of the home. This was reflected in the community approach to the redecoration of some of the communal areas.

People and relatives were also invited to provide feedback at regular meetings and through annual surveys and questionnaires. Meetings were planned around social events such as Burns Night and a Bingo Night to encourage people to come along, have their say and then enjoy socialising together. At the last meeting we saw people had discussed activities and one person had particularly commented on how there were more choices available at mealtimes. Responses from the last survey were mostly positive. Where issues had been raised, action had been taken. For example, comments about the quality of the outside spaces had resulted in a refurbishment of the garden. Comments from the survey included: "Friendly, caring staff and excellent food" and, "The staff are always courteous and polite."

At our last visit some staff said they did not always feel valued. At this inspection we found staff were more positive in their responses. They told us they felt able to talk to their managers about any concerns, but also felt communication could sometimes be improved. Typical comments were, "If I have a problem I will go to [registered manager] or [deputy manager] and I don't feel I couldn't" and, "I can speak to the manager but sometimes when you feel you need to speak to someone, you don't feel you get the answer you need." The registered manager told us it had been a challenging time encouraging staff to follow the provider's policy and procedures, but felt they now had a better understanding of staff as individuals. They went on to say, "I think it is better now. Staff will come and be open with me and be honest with me. A year ago there were things going on I didn't know about it, but I know them better now." During our visit we found the shift was well organised and staff appeared clear about their duties and responsibilities.

Staff told us they attended regular meetings where information was shared with them to improve practice and outcomes for people. One staff member told us they could write on the agenda if they wanted to raise anything and went on to say they felt safe to raise issues and knew they would be listened to.

Staff told us they had "flash" meetings each day where any concerns identified by management staff were discussed with the care staff who could attend, and then cascaded to other staff. One staff member told us, "There is a flash meeting every day and the care staff member who attends will tell us what was said."

The provider had an initiative where people could nominate a member of staff for a 'kindness in care' award. If a staff member was selected they received a certificate and money voucher and a letter of thanks. Staff who had worked for the provider for a number of years received a long service award.

When we asked the registered manager what they were most proud of in their achievements in the last six months, they responded, "The relationship with the relatives. I think that has improved. I'm proud of the staff team now because they are here for the residents and I am proud of the care because we see the residents as people and not just a name."

The registered manager was developing their focus on improvement and learning. Where they had identified some people had lost weight in the home, they had carried out a 'root cause analysis'. This identified that there had been a couple of menu changes which had not suited people's needs. Work had been done to develop the menu changes and people had now put on weight again.

We spoke with the provider's Quality Monitoring Officer who told us their role was to identify areas for

improvement across 12 local homes for which they had responsibility, and to put strategies in place to improve quality and reduce risks. Recent pieces of work they had carried out included a falls management programme involving postural management techniques, and a weight management programme to identify nutritional needs. Although the programmes had taken place in another of the provider's home, they were to be rolled out in Brandon House in the near future. The registered managers of the 12 homes met monthly to share knowledge, good practice and new learning.

The provider carried out a full internal audit of the home twice a year. This together with the checks and audits carried out by the registered manager were fed into a home improvement plan. The registered manager explained this was a new working document and showed actions that needed to be completed and timescales for completion of the work. The registered manager told us this would be monitored by the provider to check the quality of the service was continually tested, to drive improvements and ensure people experienced positive outcomes.

The registered manager understood their regulatory responsibilities. They had notified us of important events in the service and the ratings poster from our last inspection visit was displayed in the communal entrance, which they have a legal duty to do.