

Century Healthcare Limited

# Brimstage Manor Nursing Care Home

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

This inspection took place on the 31 May and 7 and 23 June 2017, the first day was unannounced. Brimstage Manor Nursing Care Home is a nursing care home for up to 46 people; at the time of our inspection 44 people were living at the home. The home is divided between an older Victorian style building called, 'The House' and a single storey modern wing called, 'Hesketh'. The home had well-kept grounds and was in a countryside location. There was a newly appointed home manager who was in their first month of working at the home, they had not yet registered with the Care Quality Commission.

Staff and people's relatives were positive about the new manager and their approach. Family members told us they were approachable and the manager had organised a family meeting for the week following our initial visit.

At the last inspection in April 2016, the service was rated overall Good. At this inspection we found the service was rated as Requires Improvement.

During this inspection we found that there were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were of Regulation 9; Person-centred Care and Regulation 17; Good Governance.

We completed this inspection after concerns had been raised with us relating to the quality of care planning for people nearing the end of their life. We found that the end of life care planning in place was in the form of a 'pre-palliative /holistic' plan, which was generalised and did not offer staff enough guidance that was individualised to the person. At the point of being coded as amber on the end of life register this plan replaced more individualised and person centred care planning. We saw that some people had been on a 'pre-palliative / holistic' care plan for 19 and 22 months, without it being reviewed as appropriate after a period of time had elapsed.

At the time of our inspection the clinical director along with the newly appointed manager had already been reviewing the care files of each person. We saw some people's care files where comprehensive care plans had been reinstated and updated for each aspect of a person's care and the 'pre-palliative / holistic' generic care plan approach had stopped being used.

In other areas of care planning we saw that there was not sufficient information in people's care files relating to pressure relieving mattresses and actions that had been taken to reduce the risk of falls. We also saw that in people's care files there was a 'getting to know you' document containing information about a person, their background and preferences. A one page profile was kept in each person's room which ensured that staff had to hand prompts and reminders to help them support people well. One family member we spoke with praised their relative's recent experience of care planning at the home.

After our previous inspection we gave written feedback to the registered manager highlighting that at times

care plans had not contained appropriate details to inform care staff. In these areas there had not been significant improvements. The systems that had been in place until recently had not been effective in gathering and assessing information about the quality of services provided to people and ensuring improvements were made.

Staff and visitors gave us mixed feedback about the number of staff available at the home and we saw one person waiting for care. We recommended that the manager review the numbers and deployment of staff members to ensure times of pressure on staffing levels are minimised.

People's medication was administered safely. However improvements were required in the documenting of as and when required (PRN) medication and prescribed topical creams. We recommend that the manager review these procedures.

People told us they liked living at the home. One person said, "I'm very happy here, it's quite good here." During our visit there was a friendly and relaxed atmosphere at the home. We saw that the staff made visitors feel welcome. We saw that staff were respectful towards people, stopped to talk to them and were positive in their communication. People's relatives were positive in their feedback about the staff at the home. One person's relative said about the staff, "They are lovely, experienced and really care." Staff and people's relatives told us that at certain times there was not enough staff at the home.

People told us that the food was very good and people's relatives were very positive in their feedback with regard to the dining experience at the home. We saw that people were frequently offered choices in daily living. However people's care plans did not always show that they were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible. The home's policies supported this practice but the documentation systems in place needed improving. We recommended that the registered manager review the documents used for recording a decision made in a person's best interests.

Staff members told us that they felt well supported in their role. We saw that they received annual appraisals, regular supervision meetings; appropriate training and some staff told us they had opportunities for professional development. We saw that staff had received training in safeguarding vulnerable adults and new staff had been recruited safely ensuring that they were suitable to work with vulnerable adults.

The home was clean and free of unpleasant odours. The building had a series of checks to ensure that the environment, services and any equipment used was safe. Parts of the environment were mono-tone with no distinguishing features, visual stimulation or aids for orientation for people living with dementia. The owner of the home had plans in place to make improvements as they had already done in their other homes.

We saw that people had been supported to attend health appointments and have access to their GP. We looked at documents that showed how the nurses prioritised people's health needs as part of their daily planning.

A range of activities were organised and facilitated by the activities co-ordinator, visitors from outside the home and occasional trips out into people's local community. We saw that people who were receiving care from their bed were supported to participate in relaxation sessions.

Most people's relatives we spoke with told us they had been happy with the communication they received from the managers and staff at the home. People living at the home, their relatives and staff members spoke positively about the new manager. Many people commented that they had found them approachable,

positive and very visible at the home. We spoke with the new manager and saw that they already had plans in place to make improvements to the service people received.

## 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 was not always safe.

There were enough staff at the home. However the use of staff had not always ensured that people's needs were met in a timely manner.

Medication was administered safely. However improvements were required in the records of as and when required (PRN) medication and prescribed creams.

New staff had been safely recruited to work with vulnerable people. All staff had received safeguarding vulnerable adults training.

Accidents and incidents were recorded and reviewed by the manager for any learning and possible improvements to the service provided.

The environment was clean and checks had been made to ensure that the building was safe for use as a care home.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

Large parts of the building had not been adapted for people living with dementia.

Records in people's care files did not demonstrate that the service had consistently operated within the principles of the Mental Capacity Act 2005.

Staff told us they received support in their role. We saw evidence of supervision meetings, training and other development opportunities for staff.

People told us the food was very good.

People were supported with their health needs from outside professionals as required.

**Requires Improvement** ●

**Is the service caring?**

The service was caring.

People and their relatives told us the staff were caring in their approach.

We saw there was a welcoming, friendly and relaxed atmosphere at the home. At times staff stopped and asked people questions and waited for their reply.

People who received care from their bed were included in relaxation activities.

People were provided with information and their private information was kept secure.

**Is the service responsive?**

The service was not always responsive.

End of life care planning had not always been personalised. A new care plan had not been completed in the required timeframe. There were omissions from people's care files; such as guidance on the use of pressure relieving equipment and measures in place to reduce falls.

We saw one page profiles in people's bedrooms which offered prompts and reminders for staff on important aspects of people's care.

A range of activities were available inside and occasionally outside the home in people's community.

**Requires Improvement ●****Is the service well-led?**

The service was not always well-led.

Some of the systems at the home to ensure quality had not prompted action in the areas that required improvement.

Other checks and audits had ensured that the environment and equipment used was safe. Information was gathered with regard to safeguarding and any incidents and accidents. These were reviewed by the manager.

There was a new manager in place who was consulting with people's family members. Staff told us they found the new manager approachable.

**Requires Improvement ●**

We saw that the previous inspection rating was displayed.

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# Brimstage Manor Nursing Care 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.

This inspection took place on 31 May and 7 and 23 June 2017, the first day was unannounced. The inspection team included an adult social care inspector and a specialist professional advisor with a nursing background.

Before our inspection we reviewed the information we held about the service, this included some concerns that had been raised with us by health professionals about care planning during end of life care. We also reviewed the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the local authority quality assurance team to gain their views.

During the inspection we spoke with the provider, the clinical director of the organisation, the new home manager, assistant manager and five other members of the staff team, including the chef. We also spoke with eight people living at the home and five people's relatives.

We looked at the care files of nine people receiving support from the service, four staff recruitment files, documents relating to the administration of ten people's medication and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various points during the inspection.

# Is the service safe?

## Our findings

People we spoke with and their relatives told us that they felt safe living at Brimstage Manor. One person told us, "I'm very happy here, it's quite good here." One person's relative told us, "They are very friendly. The staff are helpful, [name] is happy here." Another said, "It's very good, excellent. [Name] is well cared for and happy in himself."

The manager told us that they had sufficient staff at the home. They did not use a lot of agency staff and if they did it was mostly to cover sickness. We looked at the daytime staffing rota and saw a pattern of the home having two nurses and nine care staff on duty during the day.

Staff and visitors gave us mixed feedback about the number of staff available at the home. Some staff told us they thought there was very rarely a problem, others told us that there usually was enough staff, but sickness and finding staff cover was a problem and there were also pressure points during the day. We looked at staffing rotas for the past week, these showed that one day over the weekend the number of care staff was six compared to the regular number of nine. The manager told us that this was due to last minute sickness and they had tried to obtain additional agency staff. One staff member told us, "I love my role." Then told us about stress points with regards to staffing levels; "There can be difficult times, during breaks and dinner time. Often I have no dinner."

One person's relative told us there was not enough staff at times. They said, "The home is lovely and they will all help; but no there is not enough staff." We saw that their relative asked a passing staff member to help their family member to use the bathroom after lunch. On two occasions a staff member said they would go and get a second staff member as the person required support from two people; the staff members never returned. The family member had to ask a third member of staff for help; this took some time. At other times during our inspection we also observed staff having plenty of time for people and we also saw that people were supported in an unhurried manner at mealtimes. We recommended that the manager review the numbers and deployment of staff members to ensure times of pressure on staffing levels are minimised.

We saw that individuals care needs were assessed as low, medium or high. However this information was not being gathered across the home as a tool to work out if the care needs of the people were increasing, possibly having an impact on staffing levels. The manager told us that they are currently recruiting more care staff and that the home has an on-call service for staff where they can contact the manager or deputy manager out of office hours.

We saw that staff had been recruited safely. Applicants completed an application form providing details of their experience and previous employment. They attended an interview and provided the details of previous employers who the manager sought references from. Successful applicants had a criminal record check completed by the disclosure and barring service (DBS) before they commenced employment. This all contributed to ensuring that staff employed were suitable to work with vulnerable people.

We saw that staff received training in safeguarding vulnerable adults and longer serving staff received periodic refreshers of this training. Staff we spoke with knew how to raise a concern if they suspected a person was at risk of abuse.

Accident and incident records were kept in people's individual care files after being reviewed by the manager. We saw recent accident reports in the manager's office that were being reviewed. The manager told us they look for any learning and improvements that could be made to the person's care plan to prevent future accidents.

Medication was administered by the two nurses on duty. We looked at the ordering, storage, administration and recording of a sample of ten people's medication. Medication was safely stored and controlled drugs were stored in a second locked cupboard. We checked the register of controlled drugs and found it had been correctly completed with two signatures for all entries. There was a monthly stock check of all controlled drugs; we found these stocks to be correct.

We saw that there were guidelines in place for as and when required medication (PRN), for example to relieve pain, agitation or other symptoms. This meant that staff knew when to administer this medication to help people and this had been recorded. However for four people's medication for pain relief the nurses were administering as if it was PRN medication; but the administration records gave specific instructions as to when it should be administered.

We looked at the records of the application of people's emollient creams and the guidelines available for staff. These records had not been kept up to date. For example one person's instructions for their emollient was to, 'use daily to keep shin and foot areas intact'. There was no record of any application during personal care on the day of our inspection or for the previous two days. Another person's emollient had changed and the name of the emollient on the records had not been changed. There was no record of any application on the day of our inspection or for the previous two days. A third person had guidelines for staff on the application of a cream that a staff member told us was, "not used now" and they removed the document. The staff member told us that staff, "Copy the ones [records] before. It's not good, we need to improve. Medication can change brand names; we should take details from the MAR (medication administration record) or prescription." We recommend that the manager review the procedure for recording as and when required medication (PRN) and the application of topical creams.

People's relatives were positive about the home's environment. One relative told us, "The building is in reasonably good shape, ninety nine percent of the time it smells nice and feels clean." Another said, "It's a lovely building." We saw that the home was clean and free of any unpleasant odours. Toilets and bathing facilities were clean and well equipped. People's rooms that we visited smelt fresh, looked clean and were bright and airy. The kitchen was clean and food was stored safely. We saw that the kitchen had again been awarded the highest score of five stars by the local authority in September 2016. We also saw that the cleaning room store / sluice was clean and appropriately equipped. There was secure storage of cleaning chemicals.

We looked at record that showed regular checks of the safety of the building and services had taken place. There had been recent investment made to replace the heating boilers and we saw the certificates from their safe installation. The electrical installation, passenger lift and equipment used to help people move safely had been checked by competent persons. There had been checks on aspects of the plumbing to reduce the risk of legionella.

Fire safety equipment had been checked and serviced appropriately. This included emergency exit lighting,

the fire alarm system and firefighting equipment. There was a fire risk assessment in place that had been recently reviewed.

## Is the service effective?

### Our findings

People told us that they felt comfortable with the staff at the home. One person told us about the staff, "They are very pleasant." Another person described the home as, "Quite good and friendly." Relatives we spoke with praised the skills of the staff and their approach.

We saw that people had been supported to personalise their rooms with pictures and personal items. We saw that some people used their room during the day. One person who was watching their television with the window open told us, "I feel well this morning, they are looking after me. I do go downstairs now and again but I like my room." There were three lounge areas in the home, a conservatory, a large lounge in a sitting room style and a smaller TV room. We also saw people relaxing in other areas of the home, for example the reception area. One person told us, "This is a nice sitting room."

On our previous inspection in April 2016 we saw that communal areas and corridors of the newer 'wing' area of the home had not been adapted for people living with dementia. During this inspection we found this to still be the case. The environment was mono-tone with no distinguishing features, visual stimulation or aids for orientation for people living with dementia. We saw on three occasions during our visit people were moving around asking; "Where is the toilet?", "Where can I sit down?" and "I don't know where to go." The owner of the home told us they had plans in place to change this and showed us pictures of improvements that had been made to other homes they also owned.

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. For some people a DoLS had been granted or an application was in place with the local authority for people who were unable to consent to their care and were unable to safely leave the home.

We saw that people were frequently offered choices in daily living and people's preferences were recorded in their care file. At times with reference to specific decisions it was not clear from the documents used if the principles of the MCA were being applied. We saw a mental capacity assessment form which was being used to determine if a person had capacity to make a decision. In the MCA a person's capacity refers specifically to their ability to make a particular decision at the time it needs to be made. The form entitled 'mental capacity assessment' did not state the particular decision on which the person's capacity was being

assessed. We saw one form that documented a decision made by staff, the person's family and their GP in a person's best interest. However it had not been recorded on this form or in person's care files how this decision was the least restrictive option for the person. The documents in place did not clearly demonstrate that all the principles of the MCA had been considered even though they may have been during the discussions at the best interest meeting. We recommended that the documents used for recording a decision made in a person's best interests included clearly recording all the options considered including ensuring the decision taken was the least restrictive option.

Staff members told us that they felt well supported and were happy in their roles. One staff member told us, "I love my job." Another staff member told us, "I like helping people. I hope my work benefits people and they like me caring for them." A third staff member told us, "I love working here, I like the atmosphere."

We saw evidence that staff received regular supervision meetings and an annual appraisal. One staff member told us they found the supervision meetings useful and told us, "We can raise any issues as necessary."

Some staff told us that they had been supported to attend study days to update and refresh their skills. We saw that some staff were had enrolled as 'dignity champions' with the National Dignity Council. A dignity champion is someone who had signed up to the standards of the National Dignity Council which state, 'A dignity champion is someone who believes passionately that being treated with dignity is a basic human right, not an optional extra'.

The home also made use of agency staff to support people with increased needs under the guidance of a nurse. We spoke with one agency staff member on their first day at the home. They had received an induction from a nurse, knew the needs of the three people they were supporting and understood their role. Permanent staff that we spent time with knew people well and were knowledgeable about their needs.

Training was organised centrally by head office. We saw the training matrix for staff which showed that staff received refresher training every two or three years according to the home's policy. The training provided met the requirements of the care certificate. A lot of refresher training had been provided from March to May 2017. Staff members National Vocational Qualifications (NVQ) were documented and any training due was highlighted in red or amber on the matrix helping to ensure that training deadlines were met. We saw certificates of training in staff member's files. For example training in; fire safety, safeguarding, first aid, health and safety, food safety, safer handling of people and infection control. Nurses received training in medication handling.

People told us they thought the food was very good. One person said, "The food is superb, too good really. The meat melts in your mouth; there are good portions and homemade puddings." One person's relative told us, "The food is excellent, the chef is superb and the portions are great." Another relative said, "Their attitude shows that dinner is a very important part of the day, mum eats better than she did before coming to the home. Little things make all the difference, like an extra dollop of cream." Other relatives told us that people were offered drinks and biscuits regularly throughout the day.

People ate where they chose to, either in one of the dining rooms, in their bedrooms or using an over the chair tray. We observed one lunch time. The dining room was bright and well presented with placemats, condiments on the tables and background music. We sampled the food during one lunch time. It was well presented in a home cooked style, it smelt appealing and was hot and tasty. For lunch people were offered lamb hotpot with potatoes, cabbage and carrots, with the option of beetroot. There were alternatives available if people didn't like the main option. People who required their food preparing in a way that

helped them eat had this support provided and were individually helped to eat.

We saw that a meal chart was used by staff; this highlighted who needed assistance with their breakfast and who had provided this assistance. The document showed that all people had been offered food with the right support and ensured that nobody was missed out. We saw that one person who didn't eat much of their meal was offered an alternative and additional pudding.

We saw in nursing handover notes that identified health needs were documented and followed up with investigation and referrals to relevant health professionals. The home had close relationships with local GP's and we saw that people were supported to access their GP and to attend health appointments as necessary.

## Is the service caring?

### Our findings

People living at the home and their relatives told us that the staff were caring. One person's relative told us, "From the word go staff have been amazing. When it's all too much they give you a cuddle and a cuppa." Another relative said, "I've not seen anybody being treated anything but nicely."

We saw that staff were respectful towards people, stopped to talk to them and were positive in their communication. We saw one staff member stop and tell a person, "Oh you look lovely." We also saw that staff asked people questions, stopped and waited for their reply. For example we saw different people being asked, "Are you comfortable?" and "Did you enjoy your lunch?"

One person's relative told us, "The staff sit and take the time to talk to people." Another relative when talking about a staff member told us, "They are lovely, experienced and really care. They have a nice approach and are always calm."

During our visit there was a friendly and relaxed atmosphere at the home. We saw that the staff made visitors feel welcome during lunchtime. We also saw that one person's relative stayed for lunch and a table for two was set up for them. When we spoke with them they told us that they regularly had lunch with their family member and found the staff, "Very, very friendly and helpful." Another person's relative told us, "They are always welcoming."

We saw that people who received care from their bed due to frailty were included in the homes activities aimed at relaxation from their bed. Care staff were helped by the activities co-ordinator so that two staff were able to support people to bathe and receive hair and eye care in a relaxing fashion with background music and scents along with a massage of their hands and feet. The clinical director showed us an article in a care journal which stated that this was an evidence based approach that had benefitted people. The activities co-ordinator told us that joining up with care staff meant that two staff were able to safely help and they both had more time to spend with people. The aim was that bathing for people who were unable to leave their bed became more of an experience and not viewed as a task.

The activities co-ordinator told us and we saw photographs that showed people were supported to celebrate significant events such as their birthdays and anniversaries. The kitchen staff make a cake and prepare an afternoon tea to celebrate. One person told us they had recently been supported to hold a party for an important wedding anniversary.

We saw that people's private information and other care records were kept secure in offices with locked doors. There was information available for people including a menu planner, activities and notices of upcoming events.

## Is the service responsive?

### Our findings

During our previous inspection we had recommended that the manager review how people's care plans, risk assessments and care records were updated and reviewed. Before this inspection we had received concerns regarding care planning at the home for people nearing the end of their life. The service identified itself as following the National End of Life Care Programme as set out in the End of Life Care Strategy (Department of Health 2008). This comprises of six steps and was developed to help anyone providing health and social care to people nearing the end of their life.

Until recently the practice at the home had been to remove the organisations usual care planning process and put in place a 'pre-palliative / holistic' care plan. This happened when it had been determined by the nurse at the home, at times along with the person's GP that a person had been coded as 'amber' on the end of life register.

The 'pre-palliative / holistic' care plan was largely pre-populated with guidance for staff which was generalised and not individualised to the person. At this stage it had been practise at the home to stop certain observations, for example; weighing the person, recording their pulse and recording blood pressure.

Some people had a 'pre-palliative / holistic' care plan that had been in place for a long time. One person's plan had been in place for 19 months and another person's for 22 months. People's care had been reviewed monthly by the care staff, nurses and manager at the home, recording observations on people's wellbeing since the previous month. However there was no evidence that this care planning process had been reviewed as being appropriate for an individual after a certain period of time. In order to check that it was the most appropriate care plan for this length of time, to ensure people's needs are met.

People had individualised risk assessments in place, for example for moving people safely, skin integrity, falls and their mental health. However the removal of individualised care planning at this stage was inappropriate and may expose the person to potential problems; an example of which is not knowing a person's weight in relation to pressure care. We asked one senior staff member about the rationale for this end of life care planning and they told us, "This is the way we do it."

At the time of our inspection the clinical director along with the newly appointed manager had already been reviewing the care files of each person. We saw some people's care files where comprehensive care plans had been reinstated and updated for each aspect of a person's care and the 'pre-palliative / holistic' generic care plan approach had stopped being used. The owner of the home met with us and told us that the last twelve months has been a period of change at the home, including a change of management and the care planning at Brimstage was being brought in line with that of their other care homes which have all been rated by the CQC as good.

We looked at the care records for one person who had been in the home for just over one week. The person had been identified as being at high risk of falls and of losing weight; however the full care plans had not yet been completed. We spoke with the manager about this and they were completed on the first day of our

visit. The clinical director told us that company policy was that care plans should be written within 48 hours of a person arriving at the home. They told us they would identify why these had not been completed.

During our previous inspection we had found a lack of guidance in people's care plans in how pressure relief mattresses should be used; in particular what the correct settings should be to provide the best pressure relief. On this inspection we had similar concerns regarding the use of pressure relief mattresses. In one person's care file it was written, 'Airflow mattress in situ, check settings'; without documenting what the correct setting for the person should be. When we visited the person their mattress pump was set to 90Kg, the person's weight was not being monitored so nobody was able to ascertain if this was correct. However the manager and clinical director agreed with us that from the person's appearance it was clear that the setting for the mattress was incorrect. Another person's mattress was set on '3', care and nursing staff were unable to tell us what this meant. The person was last weighed in April 2015 and had been identified at high risk of pressure sores. They had not experienced any pressure sores, but their care planning in preventing them was not robust.

These are breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Because care planning had not been consistent in identifying, effectively documenting and planning for people's individualised needs.

We saw that that the language in people's care files did not always follow best practice guidance. For example people were described as, 'suffering with dementia', rather than living with dementia. This could place negative connotations on the way their care is planned.

Some people who had been identified at high risk of falling chose to use their rooms during the day so they could not be continually observed by care staff. Staff had been using sensors and alarms to alert them if a person who was at high risk of falls was moving independently so they could offer support. Some of these were motion sensors and others were door sensors. We saw that people with higher support needs used the rooms that were closer to the nurse's office. Any falls experienced by people were recorded and we spoke with the nurse about referrals that had been made to the falls team. When looking at one person's care plan we saw that it had not been updated with information about the preventative measures in place. We recommended that the language used in care planning and information regarding to falls prevention is reviewed in people's care plans, to clearly show what preventative measures are in place.

People's relatives gave mixed feedback about being involved in people's care planning. Feedback about more recent care planning was positive. One person had told us, "I don't feel let in on what they are doing for [name]." Another relative praised the care planning process telling us, "It is amazing, the matron came to hospital and assessed mum. They had a can do attitude and she has an individualised care plan. It's reviewed and people come up with ideas, it's continually improving. They keep us up to date."

In each person's bedroom there was a 'one page profile' which kept to hand brief prompts and reminders that staff may need to support a person well. For example there was information about a person's mobility, personal care needs, food and preferred position of their bed. One person's relative showed us their family member's one page profile and told us they thought it was a "good idea". We saw in some people's care files a 'getting to know you' document which contained information about a person's social history, personality and preferences such as sleep and waking times as part of their pre admission assessment.

We asked one of the nursing staff how they prioritised people's care. They told us that they used the information in the verbal and written handover from the night nurse, notes in the diary and in reviewing people's care files. We looked at the handover information for the day and found it to be clear and detailed.

We also saw that some people who received care from their bed had charts showing what support they have received to reposition. The charts we looked at had been completed.

We spoke with the activities co-ordinator for the home who kept a record of the activities each person participated in. They told us that they had at least eight activities provided by people outside of the home each month. These included entertainers, for example a pianist, a variety of singers and guide dogs. A reverend also visits the home to offer spiritual support for people and sing. There were also activities provided by the staff at Brimstage Manor, on one afternoon we visited people were preparing food for baking and using a foot spa machine. The activities co-ordinator told us they also make use of a mini bus and recently some people had been out for an afternoon tea. They also told us they used celebrations as an occasion for people to get together, on Valentine's day they held an afternoon tea for couples. One person's relative told us that last summer they went to a summer fair at the home, which was well attended and most people got together in the garden.

## Is the service well-led?

### Our findings

Since our previous inspection of the home, a long standing registered manager had retired and there had been an interim period when an acting manager was in post. There was now a new manager at the home who was in their first month of the role.

After our previous inspection we gave written feedback to the registered manager with regard to care plans not being robust and providing appropriate details for care staff to follow. Some of the examples given were; not providing adequate information in end of life care plans and use of equipment such as pressure relieving mattresses. At this inspection we found these areas still required improvement.

Since then people's care plans had been reviewed twice by the registered manager without significant improvements.

The systems that had been in place until recently had not been effective in gathering and assessing information about the quality of services provided to people and ensuring improvements were made. This meant that the registered manager and the provider could not effectively assess and monitor the care provided to people in order to know the quality and make any necessary improvements.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The systems in place had not always been effective in assessing, monitoring and improving the quality of the service provided.

Other checks and audits had been done at the home which had been effective in ensuring the safety of the environment and any equipment at the home. There was also information gathered and assessed relating to safeguarding and any accidents and incidents at the home such as falls people may have had. We saw that the clinical director had been auditing the medication every eight weeks; we looked at some of these audits and found them to have been thorough and highlighted any actions needed in areas that could be improved.

Most of the relatives we spoke with told us they had been happy with the communication they received from the managers and staff at the home. They made comments such as, "They keep us up to date" and, "If there are any problems they get in touch."

There was now a new manager in place at the home. They had not yet registered with the Care Quality Commission as they were in their first month of the role. As part of this inspection we also spoke with the organisations clinical director and the owner of the home.

People living at the home, their relatives and staff members spoke positively about the new manager. Many people commented that they had found them approachable. One person's relative told us, "They have been very reassuring and very positive. I was very well supported during an emotional time." Staff we spoke with were positive about the new manager. One staff member told us that the new manager was very positive

and very visible.

We spoke with the new manager and saw that they already had plans in place to make improvements to the service people received. They had plans in place to store and update people's care plans electronically with a view to reviewing and updating them on a more frequent basis. They told us they were at a time of stabilising the staff team after recent changes and working on staff morale.

The manager told us that they had been impressed with the quality of care at the home and most staff had been at the home a long time and knew people well and people had benefitted from a long standing staff team. The manager was going through a program of ensuring that staff were familiar with the Mental Capacity Act and how it was relevant to their roles through training.

We noted during our inspection that the new manager had already made changes to the office location. They had moved the office from an out building to a more central location within the home. They told us that this was to ensure they were more visible and accessible to people and staff. During our inspection we noted that the manager had also arranged for a glass panel to be fitted into the office door. They told us this was to make the office more open, so people felt more comfortable.

People's relatives told us that the new manager had arranged a relatives meeting for the following week. They were positive about this and looked forward to spending time with the new manager. One relative told us, "[Name's] daughter had got questions. We are coming to the coffee morning next week, it's the first one."

The owner of the home told us that since our last inspection there had been a time of change and now they have a stable leadership team at the home. As a provider they have six other homes rated as good by the Care Quality Commission and they are working with the new manager on the areas of this home that require improving.

We saw that the previous inspection rating was displayed at the home and on the provider's website.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care  Because care planning had not been consistent in identifying, effectively documenting and planning for people's individualised needs.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  The systems in place had not always been effective in assessing, monitoring and improving the quality of the service provided.