Brendoncare Foundation(The)

Brendoncare Froxfield

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

Overall summary

Brendoncare Froxfield provides accommodation which includes nursing and personal care for up to 44 older people. At the time of our visit 43 people were using the service. The bedrooms are arranged over two floors. There are communal lounges with dining areas on the ground floor with a central kitchen and laundry.

A registered manager was employed by the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We looked at seven care plans and found some guidance did not always identify how care and support should be provided. There were also some parts of the care plans where we could not read what was written in terms of care and support required. This meant that people were at risk of not receiving the care and support they needed.

Summary of findings

We found the service was not meeting the requirements of the Mental Capacity Act (2005). Where people were deemed as lacking capacity assessments were not always completed correctly.

Whilst there were systems in place for monitoring the quality of the service to ensure people received a high standard of care and support they had not identified some of the areas requiring improvement.

Where one person received covert medicines these were not always managed in line with the provider's policy.

People and their relatives spoke positively about the care and support they or their relative received. People and their relatives said they felt comfortable with raising concerns and had confidence that action would be taken where appropriate.

People were supported by staff that understood how to respect people's privacy and dignity. Staff had the knowledge and skills to carry out their roles. Staff told us they had access to training that was appropriate to their role.

The service had a clear set of values which included treating people with dignity and respect and promoting independence.

Staff knew how to identify if people were at risk of abuse and what actions they needed to take should they suspect abuse was taking place. The registered manager and nurse managers dealt with and responded to all safeguarding concerns.

People were supported to eat a balanced diet. There were arrangements for people to access specialist diets where required. There were snacks and drinks available throughout the day during our inspection.

Arrangements were in place for keeping the home clean and hygienic and to ensure people were protected from the risk of infections. During our visit we observed that bedrooms, bathrooms and communal areas were clean and tidy and free from odours.

There were plans in place to respond to emergencies such as fire. Personal fire evacuation plans had been completed for people using the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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

This service was not always safe

A person receiving covert medicines did not always receive these in line with the providers policy.

Staff had received training on how to protect people from abuse and were knowledgeable in recognising signs of potential abuse.

People were protected by safe recruitment practices. The registered manager carried out checks to ensure that staff were suitable to work with people using the service.

There were systems in place to reduce the risk and spread of infection. People said their rooms were cleaned daily.

Is the service effective?

Requires improvement

This service was not always effective

The service was not meeting the requirements of the Mental Capacity Act (2005). Mental capacity assessments were in place but were not always completed correctly.

Staff said they had access to supervision to support their personal development and they felt supported. Records we reviewed did not contain up to date appraisals and records showed some staff had not received a supervision meeting for some time.

People were supported to have sufficient to eat and drink.

People's healthcare needs were regularly monitored. There was evidence of regular consultations with health care professionals where needed

Is the service caring?

Good

This service was caring

People and their relatives spoke positively about the care and support they or their relative received.

We saw people received support in a caring and sensitive manner.

Staff were knowledgeable about people's individual care and support needs. They were able to describe people as individuals.

Is the service responsive?

Requires improvement

This service was not always responsive

Summary of findings

We looked at seven care plans and found that some guidance did not always identify how care and support should be provided. Some plans contained contradictory information . This meant that people were at risk of not receiving the care and support they needed.

People and/or their relatives said they were able to speak with staff or the managers if they had any concerns or a complaint. Most people were confident their concerns would be listened to and appropriate action taken.

Is the service well-led?

This service was not always well–led

Whilst the provider had systems in place to monitor the quality of service to ensure improvements were identified these were not always effective.

There was a registered manager in post who was supported by two nurse managers.

Staff were aware of the provider's values. They were motivated and caring.

Requires improvement

Brendoncare Froxfield

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 3 and 4 November 2015 and was unannounced. Two inspectors carried out this inspection. During our last inspection in October 2013 we found the provider satisfied the legal requirements in the areas that we looked at.

Before we visited we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with seven people who use the service and two relatives about their views on the quality of the care and support being provided. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included seven care and support plans, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

During our inspection we observed how staff supported and interacted with people who use the service. The registered manager was not present during our inspection. We spoke with the chief operations officer, two nurse managers, the training co-ordinator and ten staff including housekeeping staff, the physiotherapist and administration staff. Prior to our inspection we contacted health and social care professionals who work alongside Brendoncare Froxfield. Feedback we received was mainly positive about the care and support offered by the home.

Requires improvement

Is the service safe?

Our findings

One person was receiving their medicines covertly. This is when medicines are administered in a disguised form such as in food. These medicines were not always managed in line with the provider's policy. This should be undertaken in line with the Mental Capacity Act 2005, and there should be supporting information to indicate health professional input and how the person's mental capacity had been assessed. Although there was documentation in place within the person's file it did not follow the provider's policy for covert medication. The policy stated staff should complete a mental capacity assessment and document why a person was refusing their medicines. However, the documentation did not contain any information in relation to this. The documentation also informed staff to crush the medicines, but there was no documentary evidence of whether this had been discussed with a pharmacist. Crushing medicines without approval from a pharmacist can affect the way in which the medicine works and how the active ingredients are released. This meant there was a risk that prescribed medicines might not be as effective as they should be. There was conflicting information available about how frequently the need for covert administration should be reviewed. The form stated every six months, but one of the Nurse Manager's said it was reviewed annually. It was also not clear which medicines should be administered covertly. The latest review by the GP only listed one medication, but the person had been prescribed several. It was not clear if other medicines could be given normally. When we spoke to two agency nurses on duty, who were both familiar with the service and the person, one said "Are they on coverts now?" The covert policy had been in place for over a year and so this would indicate the agency staff had not been following it. The other agency nurse said "They take them normally, not covertly". The information sheet at the front of the person's medicine administration record (MAR) chart informed staff there was a covert policy in place, but did not give any detail on which medicines should be given covertly, or the method of administration, for example, on a spoon of jam. There was a lack of clear information available to permanent and agency staff who were administering medicines and this meant there was a risk that people might not receive their medicines as prescribed.

Topical creams were applied by care staff when providing personal care to people. The service had implemented topical charts during June 2015 with clear body maps in place to inform staff where the creams should be applied. However, the frequency of administration was not always recorded which meant staff might not know how often they needed to apply them. Where the frequency was recorded, there were significant gaps within the charts which indicated that the prescribed creams had not been administered. For example, one chart had 14 days in October 2015 when staff had not signed to confirm creams had been applied and another had 17 days in October 2015 with no signature. This meant there was a risk that people did not always receive topical administration of creams and lotions as prescribed.

Medication errors and incidents were reported. However, details of investigations undertaken had not been recorded, and there was no clear indication of how incidents had been shared with staff in order to learn from them and prevent recurrence.

These concerns were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received their medicines on time and as prescribed. Medicine administration record (MAR) charts were completed at the time of administration. All of the MAR charts contained signatures to indicate medicines had been administered and there were no gaps in the charts we looked at. People using the service had their medicines stored in locked cupboards in their own rooms which nurses accessed using keys. Nobody administered their own medicines.

We observed part of a medicines round. The nurse knew about the medicines people had been prescribed and the reasons why. They explained what the medicines were for, and asked people if they needed pain relief. PRN (as required) medicines protocols were in place, for example for pain relief. When people received pain relief, a pain assessment tool was used, and staff had recorded the details of when it had been given.

MAR chart audits were completed on a monthly basis. Where issues had been noted, such as missing signatures from agency staff, actions had been recorded. For example 'Contacted agency and the nurse will come in later today to sign the chart'. However, the audits did not cover the topical MAR charts, and so it was unclear how this was monitored. The service received their medicines from a

Requires improvement

Is the service safe?

local chemist who had visited on 20 August 2015. This was the first visit from the pharmacist, and advice had been given by them in relation to the storage of some medicines. We saw that this advice had been implemented.

Nursing staff asked people if they were ready to take their medicines and ensured they had a drink to hand to help them to swallow them. People were not rushed and when they struggled with taking medicines, the nurse said "Don't worry, no need to rush, take your time".

People and their relatives told us they or their relative felt safe living at Brendoncare Froxfield. Comments included "I feel safe and well cared for" and "I have no worries about the care my wife receives, it's all very good".

Staff told us they had received training in how to protect people from abuse and avoidable harm. Through conversations with staff they demonstrated their knowledge and understanding of safeguarding, including how to recognise signs of abuse and report them. One staff member said "If I felt people were at risk I would always speak up. Management is very approachable". Staff also knew they could speak with outside agencies if they felt their concerns were not being taken seriously. This included the local authority and CQC. Any concerns about the safety or welfare of a person were reported to the registered manager or nurse managers who investigated the concerns and reported them to the local authority safeguarding team as required.

Assessments were undertaken to identify risks to people who used the service. When risks were identified appropriate guidance was in place to minimise potential risks. For example the provider had carried out risk assessments in relation to falls prevention, malnutrition and the moving and handling of people. There were handovers in place between shifts to ensure information regarding people's well-being was discussed with staff coming on duty. Comments from staff include "We have very good handovers here. Communication is good" and "We are always kept up to date with any changes during handover".

People were protected from the risk of being cared for by unsuitable staff. There were safe recruitment and selection processes in place to protect people receiving a service. We looked at six staff files to ensure the appropriate checks had been carried out before staff worked with people. This included seeking references from previous employers relating to the person's past work performance. Staff were subject to a Disclosure and Barring Service (DBS) check before new staff started working. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults. People using the service were also involved with the recruitment of new staff.

There were enough qualified, skilled and experienced staff to meet people's needs. We looked at the home's roster which indicated there was a consistent level of staff each day. Staff said there were sufficient staff to meet the needs of the people they were supporting. Comments from a new member of staff included "It's very well organised here. There are always enough carers to make sure people get the care they need".

One of the nurse managers was the clinical lead for infection control. They explained they were responsible for ensuring all staff received infection control training which included dealing with outbreaks and effective hand washing. Where actions had been identified we saw these had been addressed. For example, where the washing of slings wasn't adequate a new schedule had been implemented to ensure this happened on a weekly basis. They also completed infection control audits twice a year. Measures were in place to maintain standards of cleanliness and hygiene in the home. For example, there was a cleaning schedule which all housekeeping staff followed to ensure all areas of the home were appropriately cleaned. We found bedrooms and communal areas were clean and tidy. The service had adequate stocks of personal protective equipment such as gloves and aprons for staff to use to prevent the spread of infection. People and their relatives told us they were happy with the standard of cleanliness in the home.

Requires improvement

Is the service effective?

Our findings

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). Where people are unable to make decisions for themselves, the MCA sets out the actions that must be taken to protect people's rights. The Deprivation of Liberty Safeguards (DoLS) provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

During the inspection we found the service was not meeting the requirements of the Mental Capacity Act (2005). Where people were deemed as lacking capacity, assessments were not always completed correctly. For example, in some assessments we reviewed it was not clear which decision was being assessed. In one person's assessment it referred to their communication abilities but not how this impacted on their decision making. Where best interest decisions had been made, people involved where not always recorded on the providers paperwork. This meant it was unclear who had supported the decision making process.

One person's care plan contained documentation that said they had been assessed to self-administer but 'Due to not complying with safe storage X agreed to nurses administering medication'. However, there was no evidence of this discussion or details of the decision making process within the person's care plan.

These concerns were a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff demonstrated a good understanding of supporting people to make choices. Staff were aware some people who used the service lacked mental capacity to consent to their care and treatment. They showed an understanding that people should still be encouraged to make decisions and choices about their daily living. Comments from staff included "For those people who may struggle to make choices we still offer but not too much in one go. I will offer them a choice of two tops and if they don't like either I will then offer another two. I try not to overload people" and "People have rights and choices. I will always ask before I do anything".

During the inspection, the nurse manager told us that where needed they had made applications for DoLS authorisations. Applications had been submitted by the provider to the local authority and they were awaiting a response.

Staff told us regular meetings were held between them and their line manager. They said these meetings were used to discuss progress in their work; training and development opportunities and other matters relating to the provision of care for people living in the home. However records we reviewed did not reflect this. Some records did not contain any annual appraisals and some staff had not received supervision in the last year. Staff said they felt supported by both the registered manager and nurse managers. They said they could approach them at any time to seek guidance and support. They also said they could seek support and advice from other staff members. The provider had stated in their PIR that the company was reviewing its supervision and appraisal systems. Therefore whilst some staff had not received an appraisal for some time, the PIR stated that all appraisals would be completed by the end of the year.

Newly appointed care staff went through an induction period which included shadowing an experienced member of staff. Care staff had the skills and knowledge to support people effectively and this was supported by core training they had completed, such as mental capacity, health and safety, safeguarding, moving and handling and more condition specific training such as dementia awareness. Once completed training was recorded on a matrix and this was monitored to ensure training was completed as required by the training co-ordinator. The training co-ordinator explained the matrix identified when staff needed updating with core training. Staff would be written to and non-attendance of training could result in the staff member being suspended from duty until the training had been completed. The nurse managers had received training relevant to their role and had access to continuing professional development opportunities. One Nurse Manager said "I am the tissue viability link nurse and go to

Requires improvement

Is the service effective?

refresher training every six months". All staff we spoke with and observed demonstrated they had the necessary knowledge and skills to meet the needs of the people using the service.

People told us they enjoyed the food. Comments included "The food is very good here", "Food is excellent. I've never had something I didn't like" and "Staff offer him the foods he prefers like sandwiches and cake. They always make sure he has enough to eat and drink".

Care plans included an assessment of the person's nutritional needs. Where risks had been identified, we saw people had been referred to specialists such as speech and language therapists (SALT) or dieticians. Staff followed the advice provided to minimise the risks. For example, to minimise the risk of choking, staff used thickeners in drinks or ensured people had access to 'soft' diets.

The chef was not available during our inspection. The administration officer explained they compiled a list of information of people's dietary requirements and allergies. This also included people's likes and dislikes. This was made available to the chef each day. They explained people had a choice of meals. Staff would go round with the menu and ask people what they wanted for lunch. Where people did not want the options available an alternative had been recorded such as scrambled egg on toast or cheese on toast. They said if people did not like what was on the menu then they were always able to request an alternative. One person who liked to eat their meal slowly was offered their meal in two small portions. This ensured they were not eating food that had gone cold. People's cultural preferences for food they wished to eat were also taken into account.

There were regular hot and cold drinks offered throughout the day and snacks were available in-between meals. We observed people during lunchtime. Staff supported people if they needed assistance to ensure they had enough to eat and drink to maintain good health. We observed staff supporting people at a pace appropriate to them. Staff asked if people were "Ready" before offering any more food. On the first day of our inspection we observed people being reminded of the meal they had chosen. However during lunch on the second day staff did not always inform people of the meal they were having. Instead the food was placed on the table in front of them with no comment, other than "Here you are". As some of the people using the service had some dementia symptoms, this meant there was a risk that people may not remember or may not know what they were eating.

People told us the staff supported them to see a health professional such as a doctor or optician when they needed to. One person said "The GP visits once a week. If I want to see her I just ask". A GP visited once a week and there was also evidence to show care staff would act appropriately when a person's health condition changed. Contact with health professional was recorded in people's daily records which showed people's day-to-day health needs were met. It was also evident from care files that people were referred to relevant professionals such as speech and language therapy and physiotherapy for mobility.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about the care and support they or their relative received. Comments included "It is so lovely and friendly here. If I ring my bell and apologise for doing so they always say you mustn't apologise", "Staff are always very helpful and kind", "It's obvious the carers all get on as there's such a lovely atmosphere here" and "They treat her very well. She gets all the care she needs".

Staff were respectful and caring in their approach to supporting people. Where people needed assistance staff sought their permission before assisting them, explained what they were doing and offered reassurance throughout the task. We observed one member of staff supporting a person to eat their lunch. They offered reassurance by stroking their hand and asked if they were going "To try a bit more" after each mouthful. They checked the person had eaten enough before taking the plate away.

Throughout the inspection we saw people being treated with kindness and compassion. For example one person, who was sitting in the entrance lobby, was not enjoying the musical entertainer who was playing in the main lounge. Staff explained this person liked to listen to classical music. They asked the person if they would like some headphones and IPad to listen to their music instead. This way the person could remain sitting in the communal area and could listen to the music of their choice. One person using the service told us "I can tell staff what support I need. I feel I have control over my life". Another person said "Someone very kindly gave me some books to read, the staff must have a second sense".

On one occasion a person was becoming upset, we observed a member of staff talking gently with them, and assisting them back to their room. They stayed with the person for some time providing reassurance. Another member of staff stopped one person as they were walking along the corridor and asked them how they were feeling. They said "You seemed a bit sad when I spoke to you earlier. How are you feeling now?" They stayed and spoke with the person for some time.

We saw staff promoted people's privacy and dignity. Staff knocked on people's doors before entering. Any care and support was conducted behind closed doors. Staff told us when supporting people with any personal care they would always ensure this was done with the person's door closed and the curtains drawn. They would always explain what was happening and encourage the person to do as much for themselves as they could. They said they would always ensure that they had everything they needed so the person didn't have to wait too long. They would also ensure people were covered when supporting with intimate tasks. One staff member told us "I treat people how I would want my most loved person to be treated".

People were supported to be independent and were encouraged to do as much for themselves as possible. Some people used equipment, such as walking frames, to maintain their independence. Staff ensured people had the equipment when they needed it and encouraged people to use it. We spoke with one person using the service who said they liked to bake. Although they could not use the main kitchen as meal preparation was taking place, they said staff had set up a table in the dining area where they could "measure and mix" the ingredients for a cake. This would be cooked in the main kitchen and then shared with people during afternoon tea.

People were supported to make choices and decisions about their daily living. Staff were knowledgeable about the care and support people required. For example if people preferred a bath or shower or what food they liked to eat. Staff were also able to tell us about people's histories and family life. People and their families we spoke with confirmed they were involved in the planning and review of care. One relative told us "Staff know her very well. Anything they don't know they will always ask me".

People told us their relatives were able to visit whenever they wanted. Relatives told us staff were friendly and welcoming when they visited. One relative said "I am always made to feel welcome, you couldn't get better staff".

Health and social care professionals were complimentary about the care people received. Comments included ". I felt very warmly welcomed on each visit, by health care assistants and nursing staff and received very useful information from staff to assist my assessments" and "It has been evident from my observations of the interactions between staff and the residents I visited that staff knew their residents well and were striving to maximise their comfort and dignity".

Requires improvement

Is the service responsive?

Our findings

We reviewed seven care plans and found they were of an inconsistent quality and in some instances impossible to decipher what was written. Some were handwritten and some were typed, and some were a combination of the two. Some also contained conflicting information and guidance. This meant there was a risk people would not always receive the care they required because the information needed by care staff was not readily available, or clear and easy to understand. For example, one person had been assessed as being at risk of choking,. The Speech and Language Therapist (SALT) had reviewed the person and had recommended stage 1 thickened fluids. The person had a fluid chart in place which also informed staff they required Stage 1. However, the supplementary feed chart that was also in place, adjacent in the file to the fluid chart informed staff Stage 2. This meant there was a risk staff would not know which stage of thickened fluids the person required.

Another person's care plan stated they had difficulty swallowing. However, the eating, drinking and swallowing assessment that had been completed had not raised any concerns. The care plan informed staff the person should receive a fortified diet. However, of the two agency staff on duty, one said they were receiving a pureed diet, and the other said they having a normal diet. This conflicting information meant care plans could provide staff and in particular agency staff with the incorrect information in relation to people's dietary needs. The same person's assessment from 27/07/2015 informed staff they could feed themselves when sitting in a chair. However, in the daily home life summary, it was documented the person required the assistance of a member of care staff to eat. Again, the conflicting information would make it difficult for staff to know which guidance should be followed.

As well as conflicting information, many of the care plans lacked the detail required in order to provide person centred care. For example in one person's falls care plan, there were no actions listed to indicate how staff should assist the person to minimise the risk of falls. Despite the lack of listed actions, the care plan had been reviewed and staff had documented 'Continue with care plan'. In another person's care plan it stated they liked coffee as their morning drink at breakfast. We observed them being given tea. When we asked staff about this they said the person "Loved a mug of tea". We saw the person drinking the tea. However this was not what was written in their care plan. We also saw this person liked to eat finger foods and was given a cooked meal at lunchtime. Whilst again they ate this, this was not reflected in their preferences in their care plan.

Daily personal care records were in place but these were not always filled in and it was difficult to assess if this was due to documentation errors or if personal care had not always been provided. For example, one person's record indicated they had not been assisted with any oral care (teeth cleaning) for seven days, but within the daily record staff had documented 'All personal care given'. Daily records did not also contain information on what other things had been done or tried when someone had refused personal care. For example, if the person had been offered a bath in the morning and refused, there was no record that had staff then offered the person a bath later in the day or had offered an alternative. Some entries in daily care records were also unreadable which meant we were unable to decipher what care and support had actually taken place. We asked staff to help us understand the entries but they were also unable to decipher the writing.

Position charts did not always provide enough detail to assess whether people were being assisted to change their position regularly enough in order to prevent skin breakdown. For example, one chart stated the person was 'Sat up' at 08.40, 'Sat up' at 09.50 and 'Personal care' at 11.00. Where position changes had taken place, not all of the charts indicated which position the person had been moved to, such as left side or right side.

Where sections of care plans had been hand writing some of the records were unreadable. This meant it was hard to decipher what care and support someone required and if there had been any changes in the person's care needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Some of the plans did contain the information that would be needed by care staff in order to meet the needs of people. For example, one person's plan stated 'X is frail and vulnerable to getting cold, please ensure appropriate clothing' and 'Prefers loose stretchy clothes'. Another person's plan provided detail for staff, about the person's difficulties with eating and drinking. There was clear guidance for staff in relation to the support they required,

Requires improvement

Is the service responsive?

and dietary requirements including details of when this had been reviewed. For example staff had noted the person required a texture C diet. This had been reviewed recently and had changed from a Texture D to Texture C. The person's weight was being monitored monthly, and their weight chart showed their weight had increased.

Plans showed where external support or specialist advice had been sought. This included referrals to Tissue Viability Nurses, physiotherapists, GP's and opticians.

Three of the plans we looked at, showed people's relatives had been involved in care plan reviews. In one review, a relative had written 'Great care plan, including all Mum's needs and wishes'.

The home had an activity co-ordinator who organised activities throughout the week. They also offered people activities on an individual basis. Activities included arts and crafts, quizzes and day trips out. They also invited outside entertainment to come in to the home to perform. People told us it was their choice if they wished to join in. One person said "Any hobbies and they try to encourage you to keep them up. I felt useless when I first came here. X asked what I'd like to do and they sorted it". They told us they liked gardening and pots for them to fill had been organised. Another person said they liked to take a walk around the gardens each morning before breakfast, which we saw them doing.

The home also had a league of friends. This is a group of volunteers who support the home with fundraising and organising trips out. We spoke with the chair person who explained how they worked with the activity co-ordinator to support people to be able to go on outings each month.

There was a procedure in place which outlined how the provider would respond to complaints. People and their relatives told us they knew what to do if they were unhappy with any aspects of care they or their relative was receiving. They said they felt comfortable speaking with the manager or a member of staff. We looked at the complaints, compliments and comments book which was available for people to fill in. We saw that the provider had responded to comments left and noted any actions they had taken. The chief operating officer explained that all complaints were analysed and reported to the board of trustees. We saw a recent complaint where the provider had responded in a timely manner and had also raised a safeguarding with the local authority as a result of the concern raised.

Requires improvement

Is the service well-led?

Our findings

Whilst the provider had systems in place to monitor the quality of service to ensure improvements were identified these were not always effective. For example whilst care plans had been audited the contradictions in information, as documented in the responsive section , had not been identified. The audits had also not picked up that information and guidance in some care plans was unreadable. They had also not identified that mental capacity assessments were not correctly completed and the issues regarding the administration of covert medicines. We have spoken with the provider about addressing this area.

Audits were carried out periodically throughout the year which included infection control, training and health and safety. For each area where improvements were required an action plan was in place. This detailed actions to be taken, who was responsible and when actions had been completed.

There was a registered manager in post who was supported by two nurse managers. People and their relatives knew the management team and told us they felt comfortable speaking with them. Staff told us their managers were approachable and they felt part of a team. They said they could raise concerns with their managers and were confident any issues would be addressed appropriately. Staff told us they felt well supported in their role and that they did not have any concerns. One staff member said "The managers are really nice and approachable. We all work as a team which gives me confidence".

Staff felt supported by the management team and there were resources available for staff development. Staff members' training was monitored by the training officer to make sure their knowledge and skills were up to date. There was a training record of when staff had received training and when they should receive refresher training. Staff told us they received the correct training to assist them to carry out their roles.

Staff were aware of the provider's values which they said included promoting people's safety and independence and to "treating people as individuals". Staff said they were supportive of each other and shared information in-between shifts so they were aware of people's care needs and any concerns or changes. Comments from staff included "I really enjoy working here and spending time with people" and "I feel we do a really good job here".

Team meetings were in place where staff said they could share their ideas for improving the service or discuss any concerns they had. Staff were supported to question the practice of other staff members. Staff had access to the company's Whistleblowing policy and procedure. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. All the staff confirmed they understood how they could share concerns about the care people received. Staff knew and understood what was expected of their roles and responsibilities.

People and their relatives were encouraged to give their feedback on the service and this was acted upon. There was a suggestion box available in the main entrance for both people using the service and their relatives to make suggestions. There was also a complaint, comments and compliments book available at reception. We saw that one person had written about 'their thoughts' after having been living at the home for three months. Their thoughts included 'I now know that if I cannot live my old life, then Brendoncare is the best place to be. There is a wonderful, cheerful and happy atmosphere'.

The chief operations manager told us the registered manager had a clear understanding of the changes and improvements that were required within the service. The registered manager had an action plan for improvements they wished to make in the coming year.They told us that the challenges for the coming year were to ensure that the recruitment of new staff was completed, the provision of improved activities, to source dementia training and to improve people's dining experience.

We recommend the provider ensure that quality monitoring systems in place are used correctly to ensure areas for improvement are clearly identified and acted upon.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Where people required covert medicines this was not always managed safely by the provider. (1) (2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The service was not meeting the requirements of the Mental Capacity Act (2005). Mental capacity assessments were not completed around a person's ability to make decisions. (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care plans did not always contain guidance that identified how care and support should be provided. Some information also contradicted other information in plans. This meant that people were at risk of not receiving the care and support they needed. (1)(a)(b) (3)(b)