

Bamfield Lodge Limited

Bamfield Lodge

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?

Good 

Overall summary

This inspection took place on 9 and 12 October 2015 and was unannounced. The last full inspection took place in February 2015 and, at that time, four breaches of the Health and Social Care (Regulated Activities) Regulations 2014 were found in relation to safe care and treatment, staffing, good governance and person-centred care. These breaches were followed up as part of our inspection.

Bamfield Lodge is registered to provide personal and nursing care for up to 60 people. The service comprises of four units. The Crocus unit provides residential care. The

Daffodil and Bluebell Unit provides nursing care. The Snowdrop unit provides residential care for people living with dementia. At the time of our inspection there were 58 people resident in the home.

There was no registered manager in place on the day of our inspection. The acting manager had processed their registered manager's application and they were formally registered on 15 October 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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.

In February 2015 we found that that people's records were not always completed consistently or correctly to monitor and manage their long term health conditions. At this inspection the provider continued not to protect people against the risk of poor or inappropriate care as accurate records were not being maintained. Not all records were completed to manage people's on-going needs to ensure they were met.

In February 2015 we found that the care plans did not reflect people's individualised needs. At this inspection insufficient improvements had been made. The quality and content of care plans were variable. Although some were well written, with clear guidance for staff to follow, this was not consistent. Care plans were not consistently written in conjunction with people or their representative and people had not signed their care plans to indicate their agreement.

In February 2015 we found that that people were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe keeping and safe administration of some medicines. We found that improvements had been made. We observed that medicine administration rounds were more organised and uninterrupted. People's preferences of how they wanted to take their medicines were observed and noted in the front of the Medicines Administration Records (MAR) chart. People received their medicines at the time they needed them and the records were accurate so the effectiveness of the medicines could be monitored.

We found areas in the provider's medicines management which required improvement. The provider needed to work more closely with the GP to share information on peoples' medicines compliance and consumption behaviour to optimise the effectiveness of peoples' medicines.

In February 2015 we found that people were not always safe as there were not always sufficient numbers of suitably qualified and skilled staff to support their needs. Although we received mixed comments from staff and people regarding staffing levels we found improvements

had been made. The manager told us that the current staffing levels were in accordance with the assessed dependency needs of the people who used the service. We did not observe unsafe practice and people received the appropriate support at the correct times such as meal times, medicine rounds and when personal care was needed.

People's rights were not being upheld in line with the Mental Capacity Act 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. In some people's support plans we did not see information about their mental capacity and Deprivation of Liberty Safeguards (DoLS) being applied for. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty.

A range of checks had been carried out on staff to determine their suitability for the work. Staff were supported through an adequate training and supervision programme. Staff we spoke with demonstrated a good understanding of how to recognise and report abuse.

People had their physical and mental health needs monitored. All care records that we viewed showed people had access to healthcare professionals according to their specific needs.

People and relatives spoke positively about the staff and told us they were caring. One person told us; "I can't fault it really. If I ask them for help they would. I feel safe and well-supported." Staff were knowledgeable about people's needs and told us they aimed to provide personal, individual care to people.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them. One person commented; "It's lovely here and I go out with my family."

Since the appointment of the manager the overall feedback about the service had been positive and there had been a perceived notable improvement in the running of the service. Staff spoke positively about the manager. People were encouraged to provide feedback on their experience of the service and monitor the quality of service provided.

Summary of findings

We found three 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 this 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?

The service was not always safe.

The provider needed to work more closely with the GP to share information on peoples' medicines compliance and consumption behaviour to optimise the effectiveness of peoples' medicines.

Although the staffing levels were sufficient to support people safely we received mixed comments from staff and people regarding staffing levels.

Safe recruitment processes were in place that safeguarded people living in the home. Robust checks were made before people started working in the home.

Requires improvement



Is the service effective?

The service was not always effective.

The provider had not protected people against the risk of poor or inappropriate care as accurate records were not being maintained.

People's rights were not being consistently upheld in line with the Mental Capacity Act 2005. This is a legal framework to protect people who are unable to make certain decisions themselves.

People had their physical and mental health needs monitored and had access to healthcare professionals according to their specific needs.

Requires improvement



Is the service caring?

The service was caring.

People and relatives spoke positively about the staff and told us they were caring.

Staff were knowledgeable about people's needs and told us they aimed to provide personal, individual care to people.

Good



Is the service responsive?

The service was not always responsive.

The service did not consistently take into account the person's capacity and ability to consent.

Care plans did not always reflect the ways in which people wanted to receive their care.

A complaints procedure was in place and the manager responded to people's complaints in line with the organisation's policy.

Requires improvement



Is the service well-led?

The service was well-led.

Good



Summary of findings

Systems were being operated effectively to assess and monitor the quality and safety of the service provided.

Where risks were identified, the provider introduced measures to reduce or remove the risks to minimise the impact on people who use the service within a reasonable time scale. It was acknowledged by the manager that improvements were still required in the maintenance and accuracy of records.

People were encouraged to provide feedback on their experience of the service.

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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 9 and 12 October 2015 and was unannounced. The inspection was undertaken by three inspectors, a specialist pharmacist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people who used the service were able to tell us of their experience of living in the home. For those who were unable we made detailed observations of their interactions with staff in communal areas. 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 to us.

We spoke with 12 people that used the service, nine relatives and nine members of staff. We also spoke with the clinical lead, the deputy manager, the manager and regional manager. We also spoke with the local GP who was visiting the service on their weekly round.

We reviewed the care plans and associated records of eight people who used the service. We also reviewed the medicines administration records (MAR's) of the people who lived at the home. We also reviewed documents in relation to the quality and safety of the service, staff recruitment, training and supervision.

Is the service safe?

Our findings

At our last inspection in February 2015 we found that that people were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe keeping and safe administration of some medicines. The provider sent us an action plan telling us what they were going to do to become compliant.

During this inspection we found that improvements had been made. We observed that medicine administration rounds were more organised and uninterrupted. Peoples' preferences of how they wanted to take their medicines were observed and noted in the front of the Medicines Administration Records (MAR) chart. People received their medicines at the time they needed them and the records were accurate so the effectiveness of the medicines could be monitored.

People were treated with respect in reference to how medicines were administered. Covert administration procedures were in place and observed for two residents. This meant that if the person declined their medicines, staff could disguise them in food or drink to make sure they were taken. Staff checked with the GP to ensure that it was safe to give the medicines using the covert method. Suggestions made subsequent to the last inspection, e.g. certain medicines should be taken on an empty stomach 30 minutes before food, have been implemented.

Suitable storage arrangements were in place for medicines. Following a recent pharmacist audit the provider had taken the appropriate actions forward and ensured only medicines that required refrigeration were stored in the refrigerator. They also ensured 'opened on' dates were consistently recorded on appropriate items, such as ointments and creams. The medicines awaiting disposal were stored securely and only designated persons were authorised to hold keys to the medicine cupboards and trolley.

We found areas in the provider's medicines management which required improvement. The provider needed to work more closely with the GP to share information on peoples' medicines compliance and consumption behaviour to optimise the effectiveness of peoples' medicines. This is central to the effective management of medicines in a care home. We reviewed residents on long-term Proton Pump

Inhibitors (PPI's). PPI's are a group of drugs whose main action is a pronounced and long lasting reduction of gastric acid production. This type of medicine when used long-term will impair absorption of calcium and vitamin B12. Over 30% of the residents received PPI's. The clinical lead should discuss with the GP to review this sort of medicine because of their high risk of side effects especially in frail elderly people. Working more closely with the GP will ensure the person gets the right choice of medicine at the right time.

Staff observed (on all three floors) needed further training from pharmacy professionals on inhaler techniques for different types of inhalers and the necessary oral hygiene measures after the use of steroid inhalers.

At our last inspection in February 2015 we found that that people were not always safe, as there were not always sufficient numbers of suitably qualified and skilled staff to support their needs. The provider sent us an action plan telling us what they were going to do to become compliant. Although we received mixed views on staffing levels we found improvements had been made.

The staffing levels were sufficient to support people safely. The manager told us that staffing levels were assessed by following the Care Home Equation for Safe Staffing (CHESS) dependency tool. The tool determines the level of staffing required whilst taking into account the dependency needs of the people who resided at home.

On the day of our inspection the occupancy level for each area; 14 people resided in Crocus; 16 people resided in Daffodil; 12 people resided in Bluebell; and 16 people resided in Snowdrop.

Before our inspection, concerns had been raised about staffing levels on Snowdrop, particularly at night time. The night time staffing level across the home equated to one nurse, one senior health care assistant and four health care assistants. The staffing rota for September 2015 demonstrated that owing to sickness the staffing level was not achieved for two days of the month. On each occasion they were missing one member of the care staff. During the night time shift one health care assistant covered Snowdrop. This was considered by the manager as an adequate night time staffing level for the dependency level of the people who used the service. Our inspection observed night time staffing on Snowdrop. Members of staff thought staffing levels could be improved but if

Is the service safe?

needed they could call on senior members of staff to assist. On Snowdrop the re-positioning charts recorded that two people were available to provide the appropriate support when needed. We were told by a care assistant; “We get help when we need it. Sometimes it’s fine, sometimes it would help if there was an extra pair of hands.”

During the day we were told by the manager the preferred level of staffing would be two nurses and 13 care staff. On the day of our inspection the staffing levels was one nurse and 12 care staff. Cover was not provided for the absent staff. The manager told us that the absences were not covered for as their roster is always set 15% above the indicative minimum levels of staffing.

Although at times, it was not easy to locate a member of staff, all of the staff we spoke with said they felt there was “usually” enough staff on duty to meet people’s needs. Staff said “They’ve taken on some new staff. On this unit, there is usually four staff, but I think the minimum is three. We need four though, it’s hard with three, and the extra person means we have time to help people with drinks” and “We’ve got quite a few new staff. The problem is when staff go off sick, and you can feel a bit rushed then”. One member of staff told us they were supposed to have a floater care assistant on two floors but that this didn’t often happen. Whenever a carer went sick the floater was pulled to cover the staff shortfall. This was evident on the day of our inspection. Relatives said “We were told there was always three staff on duty on Bluebell, but there is often only two” and “I don’t think there is always enough staff available to help with drinks, but I do feel that people are safe here”. One relative said that they felt the home was short staffed 50% of the time and that when they came in to visit people were still being got up at lunchtime. Our observations saw that staff were responding to call bells in a timely manner. A member of staff was available during the day in the communal areas.

The manager told us that the current staffing levels were in accordance with the assessed dependency needs of the people who used the service. We received mixed comments from staff and people regarding staffing levels. We did not observe unsafe practice and people received the appropriate support at the correct times such as meal times, medicine rounds and when personal care was needed.

The manager told us they were in the process of recruiting new nursing and care staff. They told us staffing allocation

and staffing levels are reviewed on an on-going basis and they consulted with staff to update them and sought their views. Where the service was experiencing difficulties with a staff member’s attendance appropriate action was taken. They senior management team told us that they were also reviewing their processes on how to manage short-term absenteeism as it’s proving disruptive to managing the day-to-day level of operation.

Staff we spoke with demonstrated a good understanding of how to recognise and report abuse. All staff gave good examples of what they needed to report and how they would report concerns. Staff told us they felt confident to speak directly with a senior member of staff and that they would be taken seriously and listened to. They also advised that they would be prepared to take it further if concerns were unresolved and would report their concerns to external authorities, such as the Commission.

Staff understood the term ‘whistleblowing’. This is a process for staff to raise concerns about potential malpractice in the workplace. The provider had a policy in place to support people who wished to raise concerns in this way.

Records showed a range of checks had been carried out on staff to determine their suitability for the work. For example, references had been obtained and information received from the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person’s criminal record and whether they were barred from working with vulnerable adults. Other checks had been made in order to confirm an applicant’s identity and their employment history.

The provider had appropriate arrangements for reporting and reviewing incidents and accidents. The manager audited all incidents to identify any particular trends or lessons to be learnt. Records showed these were clearly audited and any actions were followed up.

The care plans we looked at contained risk assessments to identify when people might be at risk of avoidable harm. Risk assessments covered areas such as falls and moving and handling. For example, in one plan, staff had assessed the person as being at high risk of falling. The plan was easy to read and guidance for staff was clear to follow. There was information regarding the type of hoist staff should use, the sling size that was required and detailed

Is the service safe?

instructions on how staff should move the person safely. When the person had fallen, there were completed forms within the file detailing where the person fell, any contributing factors if known, and details of any actions taken by staff following the fall.

Fire risk assessments had been completed for people, and there were personal emergency evacuation procedures for individuals in place. This meant that staff had the information they needed to keep people safe in the event of a fire. We did note that the Portable Appliance Testing (PAT) required up-dating.

Staff knew their responsibilities in relation to the prevention and control of infection. Personal protective equipment (PPE) such as gloves and aprons were readily available and we observed staff using it prior to assisting people with personal care. Staff also wore aprons when assisting people to eat. Wearing PPE reduces the risk of cross infection. We found the home was clean and free of odours. One person described their room as “beautiful”.

Is the service effective?

Our findings

At our last inspection in February 2015 we found that people's records were not always completed consistently or correctly to monitor and manage their long term health conditions. The provider sent us an action plan telling us what they were going to do to become compliant.

The provider had not protected people against the risk of poor or inappropriate care as accurate records were not being maintained. Not all records were completed to manage and ensure that people's on-going needs were met. Where people had been identified as being at risk of malnutrition or dehydration, they were having their food and fluid intake monitored. However, the charts where staff recorded this were not always completed correctly. For example, one person's chart stated they had an intake of 600mls of "urine" at 6am on the day of our inspection. Although staff said this was a documentation error, it meant there was no accurate record of the person's intake so far that day. Where people's food intake was being monitored, staff had documented the amount of food eaten as "All portion" or "1/2 lunchtime meal". There was not enough detail recorded to assist staff to recognise if the person's intake was adequate or not.

Staff said they would escalate any concerns about food or fluid intake to the nurse in charge but it was not clear how they would know when to raise concerns. For example, another person's plan stated they needed assistance to eat. The action within the plan was for the person "To have a balanced diet and adequate fluid intake", but it did not define what an adequate fluid intake was. Although another person's plan did contain the required detail to guide staff, the entries on the chart did not reflect the plan. Although the plan informed staff the person should drink 2100mls per day, staff had documented an intake of 1400mls on 07/08/2015 and 1550mls on 08/10/2015. There was no evidence of whether the reduced intake was escalated, or if it had been assessed by a nurse as adequate. This lack of detail and guidance meant there was risk that people might not receive enough to eat or drink.

When people had been assessed as being at high risk of pressure area breakdown, care plans indicated how staff should prevent this occurring. For example, people were cared for on pressure relieving mattresses and staff were informed to ensure that the person's position was changed

regularly. However, position charts, although in place were not always completed in full, and did not always indicate the frequency of position changes. One chart we looked at did not state the frequency and had not been completed for seven hours.

There continues to be a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's rights were not being upheld in line with the Mental Capacity Act 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. In some people's support plans we did not see information about their mental capacity and Deprivation of Liberty Safeguards (DoLS) being applied for. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely. The manager confirmed that some DoLS applications had been made and they are in the process of completing the remaining applications. The records viewed confirmed this position.

The staff we spoke with told us they had received training on the Mental Capacity Act. They understood that informed decision making and ability to consent was dependant on people's mental capacity. They said "I always ask people first before I do anything" and "It's important to get to know people so that you know how to encourage people".

Despite staff training and their understanding of the principles of the Act care plans did not consistently demonstrate that people's capacity had been fully assessed in line with guidance. For example, although some care plans showed that people's capacity to consent to care had been assessed, others did not. We looked at three care plans for people who had been assessed as needing bed rails. In two plans staff had documented "Bed rails are the most appropriate solution". Although one person's capacity had been assessed as "fluctuating", there was no evidence within the plan of how this decision had been reached. Another person's plan stated that bed rails were in place because they had been "Requested by family". The person's mental capacity assessment stated "Doesn't have capacity" and "Staff to assist her and make the right decision for her". There was no evidence of a capacity assessment within the plan. There was also no evidence of alternatives to bed rails being considered or

Is the service effective?

tried before reaching the decision to fit the bed rails. Other plans we looked at contained mental capacity assessments for all aspects of people's care. These assessments had been fully completed and showed that a clear process had been followed in line with legislation. However, this was not consistent across the service. The current arrangements showed that the staff had not been involving the necessary people such as relative's, representative's and health professionals or followed a procedure to ensure they had a robust agreement to restrict people's rights. The provider's training statistics also demonstrated that a number of staff had yet to receive Mental Capacity Act training. The manager told us that training was on-going and had been booked for staff as part of a rolling programme.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were supported through an adequate training and supervision programme. Staff told us they had received supervisions recently. We reviewed staff records which demonstrated that recent staff supervisions and appraisals had been conducted. This meant that staff received effective support on an on-going basis and development needs could be acted upon

New staff undertook a three day induction and mandatory training programme before starting to care for people on their own. Staff told us about the training they had received; this covered a variety of subjects such as health and safety, safeguarding, moving and handling, food hygiene, dementia awareness and infection control. The remaining induction training period was over 12 weeks and included training specific to the new staff member's role and to the people they would be supporting. The manager told us the induction included essential training such as person centred planning, pressure ulcer management and nutrition. The manager told us that they are going to implement a four day induction programme which will

include specialist training from the outset of the training programme, such as positive behaviour management. The training matrix demonstrated that some staff training needed to be conducted as some modules needed to be up-dated, such as fire safety and accredited food hygiene training for the kitchen.

People spoke positively about the meals; one person said "the meals are nice." Staff encouraged people to eat independently whilst continuing to monitor people's food intake and prompting them where required. At lunchtime we saw the meals being served to people in the dining room and portion sizes were varied and people choose their drinks. People were offered napkins and whilst we were there we saw people hold conversations with each other and staff. People ate their food at their own pace and enjoyed their food. One person got more food as soon as she asked for a second helping. Our observations confirmed that lunchtime was mainly a positive and social experience for the people. We did note one exception where a staff member did not speak to the person they were helping with their lunch. When another person called out, the staff member got up and left the table to help the other person. They did not tell the first person where they were going, or how long they would be. The person was left alone at the table with their food in front of them.

People had their physical and mental health needs monitored. All care records that we viewed showed people had access to healthcare professionals according to their specific needs. We saw written entries made from visiting health professionals. On the second day of our inspection, a GP was visiting some of the people living in the home. They discussed with the nurse each individual person's needs and changing circumstances. This information of the visit was documented in the person's care plan and recorded in the handover notes. We also viewed referrals being made to the Falls Clinic, the Mental Health Team and the Community Hospital.

Is the service caring?

Our findings

People and relatives spoke positively about the staff and told us they were caring. One person told us; "I can't fault it really. If I ask them for help they would. I feel safe and well-supported." One relative told us; "The staff are welcoming and caring. When x had a GP visit they phoned me to let me know to see if I wanted to attend." Another relative told us "We have the code to let ourselves in. All the staff are friendly."

We observed staff moving a person using a hoist. They informed the person what they were doing, ensured their dignity was maintained by making sure they were not exposed in any way, and spoke to the person throughout the procedure. Staff knew the procedure they needed to follow, and did so in order to move the person from a wheelchair to an armchair in a safe way.

Staff spoke to and about people in a respectful way. We regularly observed staff knocking on the door before entering people's bedrooms. Staff were heard asking people to make choices and holding everyday conversations about things they had in common. Any terms of endearment were used appropriately. The staff member serving morning tea and coffee was courteous, friendly, polite and treated people as special. We observed positive interactions between staff and people at the home. For example, when one person became upset they were comforted by staff and the person responded positively and was soon smiling with staff. At various times, staff complimented people on their appearance and took an interest in what they were doing. One staff said to a person "You look pretty today". This approach by the staff made people feel valued and enhanced their wellbeing.

We observed at lunch after pudding everyone was offered a hot drink and some people wanted to sit in the garden. The door to the garden was unlocked and three people went and sat out there. A member of staff went to sit with them for a few minutes before leaving them on their own. The three people enjoyed some time sitting in the sun in the

garden enjoying both the warmth of the sun and the sounds of the garden. They were all sitting together having a giggle. The atmosphere in the home appeared relaxed and staff members enabled people to engage in activities of their choice. One person said; "It's lovely here. I go out with my family. I lock my door if I want my privacy and this is respected." Another person who lived at the home went out on their own to have fish and chips and told us they were "Very happy."

The chef said they normally tried to imitate takeaway food on Saturday to create a homely environment which they thought many people might eat with their family, if they still lived at home. One person loved sweet-and-sour chicken and so they kept portions of this specifically for them.

Staff were knowledgeable about people's needs and told us they aimed to provide personal, individual care to people. Staff told us how people preferred to be cared for and demonstrated they understood the people they cared for. Staff gave examples of how they gave people choice and encouraged independence such as; "enabling them to make choices of food, clothes and drinks." One member of staff told us about a person who was able to make their own decisions refusing personal care on a particular day and how they respected their decision.

Within people's care plans there was a section for end of life planning. This planning enables people's preferences and choices to be taken into consideration while they are still able to communicate them and for those that matter to them to be involved. However, none of the plans we looked at had been completed. Although resuscitation decisions had been recorded, there was no other detail available. This lack of information meant that staff may not know how to manage, respect and follow people's choices when the time arose. The manager told us that the care plans were in the process of being transferred into a new care planning paperwork system. The new paperwork will incorporate the appropriate recording of end of life planning.

Is the service responsive?

Our findings

At our last inspection in February 2015 we found that the care plans did not reflect people's individualised needs. The provider sent us an action plan telling us what they were going to do to become compliant. Insufficient improvements had been made.

The quality and content of care plans was variable. Although some were well written, with clear guidance for staff to follow, this was not consistent. Care plans were not consistently written in conjunction with people or their representative and people had not signed their care plans to indicate their agreement.

Where a person lacked the mental capacity to make specific decisions about their care and treatment, and no lawful representative had been appointed, their best interests were not established and acted upon in accordance with the Mental Capacity Act 2005. This includes the duty to consult with others such as health professionals, carers, families, and/or advocates where appropriate.

Some of the language used within the care plans was not professional and demonstrated a lack of respect for the person. For example, we saw phrases such as "X is toileted on the bed", "Can sometimes talk nonsense because of confusion" and "Supposed to be assisted with feeding, though takes a long time to eat". Some of the plans did not provide detail for staff to follow on how to assist and support people. For example, one person's plan informed staff they experienced episodes of agitation and aggression, but the guidance for staff was documented as "Nurse to give Lorazepam PRN (as required medication) as prescribed to calm X down when agitated and aggressive". There was no detail of what might cause the person to become agitated or aggressive and there was no guidance for staff on how they should support the person or ways of helping to relieve any distress.

Other plans were person centred and contained lots of detail for staff, such as how one person preferred to take their medicines "X puts their tablets on a small tray in their room, and then picks them up themselves and takes with a glass of water". In another person's mobility plan, staff had documented that because the person wore lined skirts, there was a risk of them slipping in the chair if not positioned correctly. Wound care plans were clear and

contained details of dressing requirements, including frequency of wound dressing changes. In one plan we looked at staff had liaised with the GP when the wound had become infected. They had documented their concerns, had swabbed the wound to confirm the infection and had documented when the person had commenced a course of antibiotics. Although the staff had documented the wound's deterioration and subsequent improvement, there was no photographic evidence available to assist staff. On one occasion staff had documented "Wound is yellow and sloughy, it's not getting any better. Photo not taken as camera not found". A photograph, although not essential, would assist staff from a continuity of care perspective.

Staff on the dementia unit told us they worked in other parts of the home where more general or nursing care was provided. In the last fortnight staff had only spent an average of 55% of their time on the Snowbell dementia unit. People with dementia benefit from continuity of recognising the same staff and building a rapport and trust with them. The manager told us they are currently working with the Bristol Dementia Partnership team to review their practices on the dementia unit.

My life, my preferences documents had been completed in some of the plans we looked at, but not all. This meant that care plans might not always reflect the ways in which people wanted to receive their care. Although some staff said they had read people's care plans, others said they hadn't.

There continued to be a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A dedicated activities coordinator was employed by the service. They arranged a structured weekly activities programme on each floor. People could join activities on the floor of their choice and were not restricted to the floor they lived on. We observed the activities coordinator on the second floor conducting an 'Oomph' exercise class. The principle of 'Oomph' is to enhance the health and quality of life of older people through inclusive exercise and activity classed that improve physical mobility, social interaction and mental stimulation. Great fun was had by most singing along to some of the songs and even those that didn't sing, tapping their feet in time with the music. In the afternoon on the ground floor people were offered a choice of movies and had popcorn. People visiting the home also attended the movie activity. We received mostly a positive response

Is the service responsive?

from people about the activities provided in the service and people joined in if they wanted to. We received lots of praise from people about the lead activities coordinator and observed their enthusiasm for their role in trying to get people involved, but respected people's decision not to.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them. One person commented; "It's lovely here and I go out with my family."

The provider had systems in place to receive and monitor any complaints that were made. We reviewed the

complaints file. Where issues of concern were identified they were taken forward and actioned. People said they would speak to the manager if they had a complaint. One relative told us; "I know who the manager is. I've had no need to speak to them as I have no concerns. People and relatives we spoke with said they would feel comfortable making a complaint if they needed to. One person told us; "I would tell them if I had any concerns." One person did express concern about the outcome of their complaint and told us that they been advised if they continued not to be satisfied with the level of service it was suggested they look elsewhere.

Is the service well-led?

Our findings

Since the appointment of the manager the overall feedback from staff, people and their relatives had been positive and they had perceived a notable improvement in the running of the service. Staff spoke positively about the manager. One member of staff told us; “the manager is very approachable. Staff morale has improved and it has definitely picked up since the manager’s arrival.”

The manager communicated with staff about the service to involve them in decisions and improvements that could be made; we found recent staff meeting minute’s demonstrated evidence of good management and leadership of staff within the service. Agenda items identified action items which needed to be taken forward with immediate effect such as training. Other agenda items included recruitment and staffing levels were discussed and the problems of short term absenteeism. In order to deal with the latter issue the manager has set up a staff forum. The forum includes a representative staff group and they're working together to focus on and take forward the issues of staffing levels, sickness, absence, recruitment and retention of new starters. One member of staff told us; “Staff are brought into the decision making. We all help each other. We have manageable staffing levels and try not to use agency staff.”

The regional manager visited the home regularly. The visits were used as an opportunity for the regional manager and manager to discuss issues related to the quality of the service and welfare of people that used the service. The manager’s recent audits had identified a number of failing issues that needed to be taken forward by the service. They were similar to concerns that we had identified during our inspection such as omission of mental capacity assessments and best interest decision meetings. The manager acknowledged that improvements were still

required regarding their record-keeping and accuracy of records. To ensure improvement continues to be made they had incorporated a care plan audit system. They reviewed each section of a number of resident’s care plans each month. They made recommendations and then reviewed the actions had been completed. We saw records that confirmed these audits and recommendations were being taken forward.

The manager also undertook regular night time spot checks. They reviewed issues such as the environment, staff uniforms, medication trolley storage, staffing level and charts. Any issues were reported back to the team such as reporting to the housekeeper that debris was found on the stairwell due to the refurbishment programme. They also found that the staffing level was not according to the level set on the staffing rota. The night time team tried to obtain an agency member of staff but no-one was available. It was evident that the manager was addressing the issue through a recruitment drive and implementing more stringent measures to deal with short term staff absenteeism.

People were encouraged to provide feedback on their experience of the service to monitor the quality of service provided. Annual customer surveys were conducted with people and their relatives or representatives. Relatives and relatives meetings also took place to gain people’s views. The minutes were available in the foyer for all to access and how the service was responding to the issues raised. Items discussed included activities, staff changes, recruiting and the accuracy of the food and fluid charts. Overall positive feedback was received about the leadership from people and their relatives. Comments included; “The management seemed good and genuine”; “The manager is working hard with the staff. The staff love the job but that sometimes they could do with more of them”; and “The manager gives strong leadership and that the home responds to change as far as is possible.”

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

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider had not protected people against the risk of poor or inappropriate care as accurate records were not being maintained.

Regulated activity

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

People's rights were not being consistently upheld in line with the Mental Capacity Act 2005.

Regulated activity

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Care plans were not consistently written in conjunction with people or their representative and people had not signed their care plans to indicate their agreement.