Maria Mallaband 11 Limited

Brunel House

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

At the last inspection dated 30 June 2015 we found breaches of fundamental standards in relation to person centred care and for consent to care. The provider developed an action plan detailing how they would take steps to meet the requirements of the legislation. While we found that some improvements had been made these were insufficient in all areas and we have repeated these breaches.

This inspection was over two days which took place on 19 April and 2 May 2017. The visit on the 19 April was unannounced and the manager was aware of the second visit on 2 May 2017.

Brunel House provides a service for up to 65 people. The staff provide care and treatment to people with nursing needs and to people living with dementia.

A registered manager was not in post. The current manager will be making an application to register with us. 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.

Risks were not managed appropriately. Risks assessments on how staff were to minimise risk were not always in place and staff had not recognised when people were at risk of harm. For example, risk assessments were not in place for people at risk of choking. Where risk assessments were in place they lacked detail on how staff were to minimise the risk. For example, how staff were to support people when they became anxious.

Waterlow assessments were completed by the staff to identify the potential of people developing pressure ulcers. Action plans were not developed on how to minimise the potential of skin breakdown. Body maps were used to locate the position of injures but reviews had not taken place to monitor the healing progress of the wounds.

Incidents and accidents were not always reported by the staff. We saw where people had sustained injuries managers were unaware of them having occurred. This meant accidents and incidents were not fully analysed to prevent any reoccurrence. The manager said where accidents and incidents were reported the quality assurance team shared learning from an analysis of trends and patterns.

Medicine systems needed improving. Protocols for when required medicines (PRN) were not in place for all PRN medicines and where they were in place they lacked detail. Protocols lacked detail on the signs which identified to staff that PRN medicines were needed. Care plans were not in place for the administration of covert (disguised) medicines. Guidance on the best method of disguising the medicine was not sought from the pharmacist.

Staff's opinion on the quality of training was mixed. Some staff said the online training provided did not provide an opportunity for the staff team to share learning. Other staff said the quality of the training was poor for example, Mental Capacity Act 2005 (MCA) training and other staff said higher level of dementia training was needed for staff working on units where people were experiencing dementia .

The staff were knowledgeable about how to enable people to make day to day decisions such as menu choices, activities and what people would like to wear. We saw good examples of staff supporting people to make choices. However, staff lacked knowledge of the MCA and were not working within the principles of the act. Guidance from healthcare professionals was consistently disregarded for one person. MCA assessments were not undertaken to ensure where people had cognitive impairments they had the ability to understand the consequences of the decision taken.

People were not involved in the planning of their care. Care plans were inconsistent and lacked detail on how staff were to deliver care and treatment in people's preferred manner. Care plans on how staff were to manage difficult behaviours when people living with dementia expressed their frustration in an aggressive manner were not clear and did not provide sufficient guidance to staff. While care plans were reviewed the care plans were not updated with people's changing needs.

Moving and handling risk assessments were in place for people that needed assistance with moving around the home. Within the risk assessments were the equipment needed for each movement and the number of staff to assist the person with transfers.

Malnutrition Universal Screening Tool (MUST) were used to assess the potential of people developing malnutrition. Action plans were developed on how to support people to maintain their weight, for example, monitoring people's food and fluid intake, serving fortified drinks and enriched meals.

There was a variety of opinions about staffing levels. Some staff said the staffing levels were appropriate while other said there were shortages of staff. Agency staff were used to maintain staffing levels for existing staff vacancies.

People told us they felt safe living at the home and the staff made them feel secure. Members of staff were knowledgeable about the safeguarding of vulnerable adults from abuse procedures. They were able to identify the types of abuse and expectations they report abuse.

People told us the staff were kind and caring. The staff understood the importance of developing relationships with people. We saw staff communicating with people in a way they understood. When people needed support from staff we observed a discreet approach being used to offer assistance.

Quality assurance systems that assess and monitor systems were in place. A programme of audits had taken place and a developmental plan introduced on the improvement needed. Visits on behalf of the provider were monthly to monitor that improvements were taking place. Action plans on the areas for improvements were in place and where actions were ongoing the timescale was amended.

You can see what action we told the provider to take at the back of the full version of the report.'

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

There were sufficient staff to meet people's basic care needs. The same agency staff were used to maintain staffing levels.

Risk assessments were not always developed on how to minimise risk. Staff had not recognised risk and taken action on how to minimise risk.

Medicines were not always managed safely.

Staff recognised the signs of potential abuse and knew what to do when safeguarding concerns were raised.

Is the service effective?

Requires Improvement

The service was not effective in some areas.

The service did not always follow the requirements of the Mental Capacity Act when people lacked the capacity to give consent to care and treatment.

Staff were supported with their personal development and to carry out their roles and responsibilities. Staff said the quality of the training needed to improve.

People had access to food and drink throughout the day and were provided with support to eat and drink where necessary.

Is the service caring?

Good

This service was caring.

People said the staff were kind. Staff used people's preferred method of communication to interact.

Staff had developed good relationships with people and their families.

Is the service responsive?

Requires Improvement

This service was not always responsive.

People were not part of the care planning process. Care plans were not developed on people's preferences on how to deliver care and treatment. Care plans were reviewed but care plans were not updated on people's changing needs.

People knew who to approach with concerns.

People were encouraged and supported to follow their interests or to go out in the community.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Staff gave positive feedback about the manager and that the quality of the service was improving.

There were systems to check and monitor the quality of care and service people received.

Brunel House

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 the 19 April and 2 May 2017. The visit undertaken on the 19 April was unannounced and the manager was aware of the second visit which took place on the 2 May 2017.

Before the inspection, we asked the provider to complete a 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 reviewed all of the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

The inspection was carried out by one inspector and an Expert by Experience. Experts by experience are people who have had a personal experience of care, either because they use (or have used) services themselves or because they care (or have cared) for someone using services.

We spoke to nine people and four relatives about their views on the quality of the care. We spoke with the manager, deputy manager, quality assurance manager, seven staff including registered nurses and agency staff. We also spoke with the chef and activities coordinator.

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 six care and support plans, staff training records, staff duty rosters, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection of June 2015 we found improvements were needed as staffing levels were not adequate to meet people's needs. While staffing levels had improved we found improvements were needed in medicine systems and risk management.

Protocols for when required (PRN) medicines were not always in place. PRN protocols did not always include guidance to staff on when to administer these medicines. For example, Lorazepam was prescribed for agitation when needed. The protocol did not give staff guidance on the signs of agitation and at what point the medicine should be given.

For another person there was no cross reference with PRN protocols for paracetamol and codeine which lacked guidance on how to stagger the administration of two types of pain relief. This left a risk that the person would be given too much paracetamol based medication.

Protocols were not in place for all topical cream to be applied as needed. Where protocols were in place the action plans lacked guidance on how staff were to maintain people's dignity during intimate applications of cream.

Medicines were out of stock for one people. We noted that for one person pain relief was prescribed to be administered before personal care as pain may be the cause of this person resisting person care. However, this pain relief medicine was out of stock. Staff told us they had made attempts to get the medicine but it had not been delivered. This meant the person may experience pain and be resistive to staff intervention during personal care.

Where appropriate, for some people, the GP had agreed for staff to administer covert medicines. For one person the staff had documented the GP's agreement for medicines to be disguised. However, the pharmacist was not contacted on the best method of disguising the medicine which ensured the integrity of the medicine was not compromised. An action plan that detailed how the medicines were to be disguised was not developed for people on covert medicines. A registered nurse told us for one specific person the medicine was no longer administered covertly.

This was a breach of Regulation 12 (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicine procedures were in place and kept in the medicine file which also included staff's specimen signatures. The person's photograph were at the front of their Medicine Administration Record (MAR) chart to ensure their identification and personal information regarding medical history, name of GP and if Do not attempt resuscitation (DNAR) were in place.

Homely remedies, including cough medicines, anti-sickness and pain relief were administered from a stock

supply. The GP had agreed on the homely remedies that could be administered to people . A separate record where staff recorded the name of the person having the homely remedy and the running balance was maintained. On the reverse of the MAR chart staff recorded the purpose of the homely remedy and the reason for administering this medicine.

Medicine training was attended by staff that administered medicines. A member of staff said training was online with workbooks to complete. They said their competency was assessed by the deputy manager.

Incidents and accidents were not always reported. We found in the care record of one person where staff had photographed extensive bruising on the forearm and recorded on the 23 March that a large bruise was noted on their right forearm. It was recorded the person had a "tendency to lash out and has sustained bruising." The staff had reviewed the tissue viability care plan and stated there were "issues with sustaining bruising during transfers and intervention." A record of the healing of the bruise was not in place. The deputy manager was unaware of the incident and therefore the incident was not investigated. The manager agreed that there were issues with staff reporting accidents and incidents. They said previous staff had taken on more responsibility than their role and had made decisions on the reporting of accidents and incidents.

Risks were not always recognised by staff and where risks were identified they were not always assessed. For example, the guidance from the Speech and Language Therapist (SaLT) included the texture of meals and for high calorie diets to be served as one person had difficulties in swallowing and was losing weight. However, textured meals had been refused and a normal diet was being served. We saw that on two consecutive visits the correspondence from the SaLT team had raised concerns about this. Mental capacity assessments were not undertaken to ensure the person had capacity to take this decision and had understood the consequences of refusing textured meals. The reviews of the care plan indicated the person's ability to eat was deteriorating. A member of staff told us the person was accepting fork mashable meals and high risk foods were avoided. The risk of this person not having textured meals was not assessed and action plans on minimising the potential of this person choking was not undertaken. A member of staff confirmed a risk assessment for choking was not in place. The manager raised a safeguarding alert for this person when we raised concerns regarding as this person had cognitive impairments and capacity assessments had not taken place. This meant where people had difficulties with swallowing they were not fully protected from the risk of choking.

The waterlow assessment had identified one person at high risk of pressure ulcers because of their medical condition. The reports of incidents showed the person had sustained injuries which were difficult to heal because of their medical conditions. The desired outcome of the care plan was to reduce the potential for pressure ulcers and the action plan was for staff to check for signs of pressure sores. The signs of pressure sores were not included in the action plan. This meant staff were not given the guidance needed to identify signs of pressure sores.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's potential of developing malnutrition was assessed. For one person the Malnutrition Universal Screening Tool (MUST) showed they were at high risk of malnutrition. The action plan from the assessment was for staff to monitor the person's weight and food and fluid intake. We saw recorded where staff were reminding people to maintain good fluid intake as on the previous day their intake was poor. A member of staff said risk assessments were devised on how to minimise the risk which included fortified for people losing weight

Falls risk assessments were in place for people with a history of falls. One person was assessed at high risks of falls due to poor balance and unsteady gait. The action plan stated was for bed rails to be used and we saw that these were in place. For another person "general" risk assessments were in place for the use of sensors in the bed as the person was at increased risk of falls particularly from bed.

Moving and handling risk assessments were in place for people that needed assistance with their mobility needs. The risk assessment included information to staff that at times this person resisted assistance. The action plan was for staff to give the person time and explain the task. For another person the moving and handling risk assessment included the number of staff needed and the techniques and the equipment needed for each movement.

Staff said risk assessments were used to identify the actions needed to minimise risks. A registered nurse told us the policy for managing risk was the "least or simplest way to resolve and reduce the potential for restrictions. For example, there are hourly checks by the staff for people not able to use the call bells". This staff member also stated once risks were identified measures were put in place and staff were made aware of the actions needed. For example, sensor mats were used for people that needed assistance with mobility. Another member of staff said falls risks assessments were undertaken for people with a history of falls and where appropriate crash mats were used to prevent injury if the person were to fall in their bedroom. One person was supported to take risks safely. A member of staff said that this person was living with dementia was supported to use the kettle and make their own refreshments.

A member of staff told us there was an expectation they report accident and incident. They said deputy manager followed up the reported events with the staff involved. However, not all incidents and accidents were reported. Body maps were used to indicate the locations of injuries sustained. For one person falls were documented and body maps were used to indicate the location of the injuries. Observations for signs of head injuries were conducted by the staff for 72 hours following an accident.

Fire procedures were on display telling staff and people the actions needed in the event of fire. Personal emergency evacuation plans were in place which gave staff instructions on the equipment and number of staff needed for the safe evacuation of the property. It was also included the behaviours that people may exhibited when staff attempted evacuation of the property in the event of an emergency.

People and relativities said that Brunel House was a safe place to live because there were enough staff to support them and the homely atmosphere made people feel secure. Comments made included "Feel safe, very much so. Lots of people [staff] around you. They look, see and do without you needing to ask," "Gosh I feel very safe. Very nice and you do get to meet people [staff and residents]", "I feel very safe here. Good security, things don't go missing, very good place," "Think I feel nice and safe. They try and keep the place cosy," "Safe and I like it. Get to know everybody. There is never any trouble," and "Totally safe here, wonderfully looked after." The comments from relatives included 'I know people who work here. Mum came in for respite before. Safe, no worries" and "Staff put so much love and effort in to residents keeping them safe". "Totally safe because the staff are superb, totally caring, empathetic. She feels wonderfully pampered. Mum's every whim is met."

Members of staff were aware of the types of abuse and the actions they must take to report abuse. The staff we spoke with knew how to identify abuse and the expectations placed on them to report abuse. These staff said they would make referral to the local authority if their concerns were not taken seriously by senior staff.

One person told us " I never have to wait long, someone comes straight away usually". Staff told us the staffing levels on their unit were good. A member of staff told us that agency staff were used to maintain

staffing levels. They said the service used the same agency provider and the same agency staff to ensure consistency to people. Another member of staff said on their residential unit there were three staff on duty in the morning and two staff in the afternoons. The third member of staff we spoke with said there had been sickness. At all times a registered nurse were on duty at the home. Three senior carers were on duty on the residential and dementia unit until 2pm when the levels reduced to two on duty and seven carers working across three units. At night there was a registered nurse, a senior carer and five carers

Requires Improvement

Is the service effective?

Our findings

At the previous inspection of June 2015 we found members of staff were not using the provision of the MCA to make best interest decisions. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to Regulation 11. However we found a repeated breach of the same regulation at this inspection.

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.

Consent forms were signed for decisions which included the use of bedrails, to take photographs and to share information where appropriate. We found for people with cognitive impairments their capacity to make these decisions was not assessed and relatives without power of attorney had signed the consent forms. For one person we saw a relative without power of attorney had given their consent for the use of bedrails and bumpers, share information and to take photographs. However, the person's ability to take these decisions for themselves had not been assessed.

The staff lacked an understanding of the Mental Capacity Act 2005 (MCA) as assessments were not undertaken to reach a best interest decision in line with legislation. The personal care plan for one person stated they were reluctant to accept assistance from staff and that "staff were to do this in XX best interest." The review of the care plan dated 20 May 2017 stated "declining assistance" after meals and when continence assistance was needed. The action plan was for "staff to act in XX best interest as there was a potential for skin breakdown". Some staff were able to tell us the principles of the MCA, the records showed aspects of the learning had not been embedded. A member of staff said "always assume people have capacity, time was to be given for people to make decisions and ensure people have the information delivered in a way they are able to understand." Another member of staff said "best interest decisions were taken by staff to prevent things from occurring." They also said families "could be involved in best interest decisions".

Relatives without LPA signed consent forms for the use of moving and handling equipment, to take photographs and to share information where appropriate. We saw consent was also gained from relatives for the use of sensor mats and for the use of bed rails. For one person the personal information stated an LPA was in place and consent had been gained from relatives for photographs and for flu vaccines. This person was also at risk of falls as their balance was restricted. The risk assessment had identified bed rails as a preventative measure when the person was in bed. However, the LPA in place was for finance which did not cover care and treatment. For another person consent was signed by the relative to use a hoist, stand aids, to take photographs and to share information where appropriate but the staff were unaware that an LPA was in place. The MCA care plan for another person stated the relative had signed care plans and other consent forms. We found no evidence that an LPA was in place for this relative.

The daily report for one person showed staff were using continence aids without the person's knowledge and consent. The person's capacity to understand the consequences of their decision not to use continence aids was not assessed. Staff had approached a relative without lasting power of attorney (LPA) to make these decisions.

This was a breach of Regulation 11 and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. Most people were subject to continuous supervision. While DoLS care plans were in place, MCA assessments had not been completed for the people with DoLS restrictions. We found for a number of people the action plans stated "if [name of person] were to leave the unit XX would be vulnerable and at risk of neglect and harm. No awareness of danger of traffic." A member of staff said one person had access to the codes for the entry and exit doors. Another member of staff on the dementia unit told us there were door entry systems on entry and exit door which included access to the garden. We noted for one person the DoLS had expired in April 2017. The manager told us a review of MCA and DoLS was to take place.

People were able to make day to day decisions. For example, meal choices and clothing. A member of staff said they showed people the options available to enable people to make decisions. This member of staff also provided an example on the approach used to gain consent from one person who prefers a slow approach. They said more experienced staff had given them guidance on how to gain agreement from the person to deliver personal care. It was stated "we ask do you mind if I come and do your personal care. The person will then agree." Another member of staff working on the dementia unit said people made everyday decisions such as "what they do or don't do, what to eat and to have a wash. We rely on family and next of kin for information and we observe behaviours regarding refusal."

Staff told us the quality of the training needed to improve. Mandatory training set by the provider included fire awareness, moving and handling, dementia, safeguarding of vulnerable adults from abuse and Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). A member of staff said training was a combination of online and face to face training. Another member of staff said the training was "ok" and that eLearning did not allow for group discussions which helped them apply the learning into practice. Another member of staff said DoLS training was poor quality and that some courses were short and workbooks were used to complete the training. They said this form of training did not increase insight as staff were not able to discuss scenarios and how to change practices. The third member of staff said the quality of the dementia training for staff supporting people living with dementia needed to be more specialist as currently it was at a basic level.

One person told us "I do most things for myself but staff are there when I need them, seem very skilled" and a relative said "Everybody is very good, know they do lots of training".

A new member of staff told us they had previous experience of working in a caring environment and had transferable skills which meant their induction covered shadowing staff, the home's routines and procedures. Another member of staff said the induction needed to be more detailed.

Staff were supported to undertake their roles and responsibilities through personal development. Staff told us one to one meetings were with their line manager. A member of staff said one to one meetings were three monthly and they discussed issues of concern and training needs. They said there were opportunities for their professional development where they were able to validate their registration.

Where appropriate GP had signed Do not attempt resuscitation (DNAR) orders for people to have a natural death. We saw one person had an advanced decision order where they had refused medical treatment unless this was to maintain their dignity and to manage their pain.

Staff were able to manage difficult situations in a positive manner which could potentially cause harm. Staff said some people at times refused care and treatment and the practice was to give people time and eventually people agreed to the delivery of personal care. A member of staff on the dementia unit told us some people had "days and moments" where they exhibited aggressive behaviours and staff explained the tasks to be undertaken, gave people time and agreement was often gained when they returned. Another member of staff on the dementia unit told us some people expressed their frustration with aggression and staff used distraction techniques. For example, one person responds to music and cosmetics when they become agitated. The third member of staff said for people who resist personal care the staff ensured there were verbal prompts and signs such as shaving before more personal care tasks were undertaken.

The comments made by people about food included "Food very good. Enjoy all of it," "Good food. I like the fresh food, meat and fish," "The Food is alright. You can have something else made for you if you ask," "Food fine but not enough Indian food, I would like more. There is plenty to eat and drink," "The food is good, I enjoy what I eat. I eat plenty but don't need as much now," and "Won't get any better food than you get here" and "If you don't like anything [staff] will make you an alternative, omelette, toasties, jackets".

The comments from relatives about the food included "If it is something she doesn't like then the staff suggest things that she might like. The Sponge cakes are second to none," "He eats everything he is given. If it is not nailed down he eats it , loves his food" and "Make good homemade cakes. The cook will make birthday cake for everyone when it is a person's birthday". A relative told us "I was asked if I would like lunch on Valentine's Day [with husband]. They laid a special table for us and another couple"

We observed morning coffee and afternoon tea was served from trolleys and snacks, fruit, biscuits, homemade cakes were available. People were able to make choices around the things they liked to eat, for example, when one person asked for a bowl of ice-cream for breakfast. A member of staff served them ice cream and stated "he loves his ice-cream for breakfast." We saw staff encourage people to drink. Jugs of juice were available in each area and cold water dispensers were also available. One person said "I have always got a drink, carers see to that" and another person said "Plenty of drinks when you need them."

People had the choice of where they ate. Some remained in their rooms, whilst others ate at the dining table. Meals served to people in bedrooms were taken on trays and were covered. For one person cared for in bed we saw staff explaining each part of the meal, asking which he would like to eat. The staff spoke to the person throughout, offering small portions of the meal and waiting before offering more. We saw another person being encouraged to eat in a dignified way. The staff were supportive and spoke to the person in soft tones and listening to what was wanted. Staff offered drinks during the meal.

We spoke with the chef who explained the variety of meals served which ensured people's dietary requirements were catered for. They said meals were served for people on diet controlled diabetes, enriched and textured diets. Menus were prepared from feedback received from people on their likes and dislikes. This chef said "I like to go around and ask people if they enjoyed the meals." It was stated that choices were

available at each mealtime and menus included a soft option. For example, cheese and onion pie without the crust.

The chef also told us "hostess" staff were employed for each unit to support people at mealtimes to assist people with menu choices before each meal. On the dementia unit people selected their preferred meal from the two meal options shown to them by staff.

People told us they were registered with a GP and their visits were regular. One person told us " I see a doctor she comes in on a regular round each week anyway. The chiropodist comes in to do my feet every six weeks or so." And a relative said "Totally pleased with the medical care. They are very conscious of her skin condition. GP comes in regularly and recently changed her prescription for skin cream."

GP visits from the local health centre were weekly. Following their visits to the home some GP's emailed a summary of the visit and actions staff needed to take. The records showed referrals for specialists input were sought from occupational therapists (OT) and dieticians. Reports of GP visits showed staff were observant to changes in people's behaviour and monitored people's healthcare needs. For example, staff had observed one person having 'blackouts 'and requested a GP visit to identify potential causes. People living with dementia and with mental health care needs had input from the mental health team.

There was a good deal of natural day light throughout the building. Artificial lighting was adequate to support people living with visual impairments. However, the corridors in the dementia unit were dark. The lounge area in the dementia unit was redecorated with light colours and wallpaper by a group of staff and people who gave their time freely. This unit has its own secure outdoor area but people did not have the freedom to access the outdoor space without staff supervision. The manager told us access was going to be researched for people to have the freedom to walk into the garden during the day.

Good

Is the service caring?

Our findings

The comments from the people we spoke with about their day to day care included the staff "Keep me young. Don't know what I'd do without them", "Staff are very good, all interested in you", "Carers are friends, more like family," " I have nothing to worry about the care. Stop to have a natter now and then," "Care staff pretty good, helpful, they are good carers!" "Shave me – brilliant. Don't cut me very gentle," and "Everyone is very human".

Members of staff were aware of people's likes and dislikes and how to communicate. For example, we observed a member of staff twice ask one person if they wanted cakes with their afternoon refreshments and twice this person refused. We saw the staff's puzzled look by the refusal. The staff then showed the cakes to the person and they accepted the cake eagerly.

People were cared for in a kind and compassionate manner. A member of staff told us supporting people to make choices and decisions made people feel they mattered. For example, supporting people to follow their spiritual believes. Another member of staff said they made time to sit with people and were "treated as individuals". They said making time for people and talking to people about their family helped to develop relationships. The third member of staff said "the person is the most important. [I] take time to listen to people. Family need to be heard, it's important what they say."

A member of staff gave us an example to describe the caring approach towards people living with dementia. They said when one person refused to leave their bedroom, lost their appetite and were reluctant to interact in group activity; the staff began to have their breaks with the person. This was to reduce the potential of isolation and once staff had established the cause of their refusal a change of locations was suggested. We were told that staff now have a clear understanding of the person's history and the triggers of a deteriorating mental health. This person has become more sociable, their appetite has improved and rarely refused social activities. Another member of staff said to ensure people were cared for as individuals the staff were aware of people's preferences and used people's preferred method of communication when they were interacting with them.

"Me and My life" booklets were used to document people's history, education, significant events and family relationships. However, they were not in place for all the people at the service and for some people they were partially completed.

We were invited to have hot chocolate and homemade cake with people living in the dementia unit and although some people chose to remain inside most people enjoyed eating outdoors. This was a social occasion with housekeeping staff joining with carers to provide an interactive experience. People enjoyed the experience. A relative said their relative had lunch in the garden on nice days.

One person said staff "Very careful to knock and wait before coming in my room. They do respect my privacy." Staff respected the rights of people. They gave us examples on how people's rights to privacy and dignity were respected. For example, doors were kept closed when personal care was being delivered and

people were covered to ensure they did not feel exposed. A member of staff said the accommodation was arranged into single bedrooms and consultations were in private.

A member of staff said they had attended training to support people on End of Life pathways. They said the principles included "care and comfort. Having familiar objects around them, access to friends and family and having medicines for managing pain available to prevent undue delays were important." End of life care plans included the person's wishes and the care to be provided once they had reached their end of life pathway for example, to be made comfortable and free from pain. End of life plans also detailed the type of resuscitation orders in place and where people were to be resuscitated in the event of a cardio pulmonary attack this was made clear in the plans.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection of June 2015 we found care plans did not give clear guidance to staff on how people's care was to be delivered. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to Regulation 9. Although staff told us there had been improvements, care plans were not fully person centred and lacked guidance to staff on how to meet people's needs. This is a repeated breach.

Care plan formats included people's ability to manage parts of their care, the desired outcome of the plan and the support needed from the staff. Some care plans were person centred but lacked detailed guidance. While care plans were reviewed the action plans were not updated where there had been changes in people's needs. For example, the personal care for one person stated they were able to carry out aspect of their personal care. The review notes included additional guidance for staff to give time for the person to accept assistance and in April the care plan was reviewed again and staff had recorded "needs full support to maintain personal care." We found little detail in the action plan on the additional support needed.

For another person the care plan for safe environment was dated 17 November 2015 and stated where the person liked to sit during the day, that they were able to summons assistance and were able to reposition themselves. The review dated 23 March 2017 stated there was deterioration in their condition. The care plans was not updated and an action plan on how to support the person was not developed. This meant the review process was not used to develop guidance on how staff were to meet people's changing needs.

People were not involved in the preparation of their care plans. A member of staff said this was "because of their capacity." They said on the dementia unit two people "could be involved but their attention [span] was limited." Another member of staff said where it was people's preference they were involved in the planning of their care.

A member of staff said there was "room for improvement" of care plans. They said the staff updated and reviewed care plans. Another member of staff said seniors developed care plan in the residential and dementia units and sometimes they made entries in daily reports. We were told that during induction staff were encouraged to read care plans and although they didn't read care plans from then on they were kept informed about people's current needs during handovers.

Mental health care plans lacked detail on the signs and symptoms of mental health needs. The records for one person stated they were diagnosed with severe depression but a care plan was not developed. Guidance was not in place on how staff were to identify the signs of a deteriorating mental health and how they were to support the person during these periods.

A screening tool to identify the signs and symptoms of depression was used to assess one person's level of depression. A member of staff gave us detailed examples on the approach used for one person living with mental health needs. The mental health care plan stated that this person was able to express their wishes, enjoyed music and signing and staff were instructed to complete antecedents, behaviour and consequence

(ABC) charts when the person was experiencing "low mood." However, the signs of low mood were not included in the care plan. The review of the care plans gave staff guidance to encourage the person to join activities and to have meals in the dining room.

Care plans were not developed on how staff were to manage difficult behaviours caused by frustration and anxiety. The review notes for one person indicated that at times they resisted assistance with personal care. Staff had recorded "has become agitated during personal care and can become physically aggressive. Staff continue to try daily." Staff had used antecedents, behaviour and consequence (ABC) charts to record incidents of aggression. ABC charts were not analysed to identify triggers and how staff were to respond to triggers. Care plans were not updated from the review and the lack of analysis meant staff were not given guidance on how to manage difficult behaviours.

The mental health team had given staff advice on how to manage one person's aggressive behaviours and ABC charts were used document incidents of aggression. A care plan based on the guidance given was not devised and ABC charts were not analysed. Where guidance from the mental health team was not effective staff had not made the team aware that further input was necessary. This meant staff had not followed guidance and were not able to identified potential triggers. Care plans were not developed on how to staff had to respond to triggers and manage behaviours they may find difficult.

Wound care plans were in place and for some people body maps were used to indicate the location of the wound or injury. We saw for one person the wound care plan lacked detail on the healing process of the wound.

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

The people we spoke with about activities made the following comments " I like all the things to join in with," staff "always involve me in activities, enjoy lots of things," " I Join in with the activities. It is nice in the summer we go out on trips to the countryside. I love walking," "I prefer not to join in – like my own space. They do ask me to join in but don't want to," "Do go to some things- music sessions," " I go to the entertainment, there is certainly enough to do" and "Go to the little church in here –like the service."

Comments made by relatives included "Relaxed when she got here-loves chickens. [Reference to the chickens outside] and " I Know they take [name of relative] to the activities. Staff have been out in the mini-bus with him."

Activities are overseen by a full time co-ordinator. In addition two care staff supports activities, particularly at weekends. A volunteer, previously a senior carer at Brunel house was due to start the following week. The range of activities offered included reminiscence sessions, quizzes, manicures and pampering, cookery club and film afternoons. Outside entertainers provide exercise to music sessions and a variety of musical entertainments.

The activities coordinator told us people were encouraged to follow their previous interests. A gardening club and cookery group was available for those with a particular interest. Trips were regularly organised, including theatre trips, visiting garden centres, coffee mornings, visits to a country park and sing and smile sessions.

Where people followed their spiritual believes there was regular communion service. There were visits from a local priest together with a Methodist minister and some people went to their local church.

During our visit two people accompanied by two members of staff, were on a theatre visit to The Theatre Royal, Bath and before leaving for the theatre these two people had a pampering sessions which included nails, hair and make-up. We also observed the cookery club where people were making apple crumble and were fully involved in the activity.

Community links were strengthened in the way of sponsorship of a sing and smile local community choir. People living in Brunel House, other local care homes and people from the village attend the sessions in Box village hall. Pupils from the local primary schools after hour's club were due to visit Brunel House weekly. They were to interact with people, chat and become involved with craft activities. This emphasised the importance of social interaction.

We saw copies of the of the complaints procedure were on display in the home. The people and relatives we spoke with told us they had never had to raise concerns or make complaints. Their comments included "No worries or complaints," "Don't complain about anything. Would talk to staff if there was a worry I couldn't sort myself," "Any problems I would tell the girls [staff],"and "No complaints at all." The comments from two relatives included "No major concerns at all" and "No complaints."

A member of staff said they listened to people's feedback and took steps to resolve their complaints. Where complaints were more serious or complex they were passed to the deputy and manager for investigation. Another member of staff said concerns were mainly raised by relatives and in the first instance staff made attempts to resolve their concerns.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection of June 2015 we rated well-Led as requires improvement. We said morale was low and staff's confidence with senior manager had decreased. At this inspection staff told us since our last inspection there had been a number of changes of manager's and there had been a period of instability. While audits had taken place and the findings were mostly consistent with our findings, the improvements made since the last inspection were slow and inconsistent.

The staff told us about issues that had created instability for people living at the service. A member of staff said there had been "ups and downs and difficult stages. There was tension and frayed nerves. Staff had worked together to pull it [practices] together." It was also stated that the deputy manager "did well to hold it together in between managers. We lost some staff but we are over the worst leading to a brighter future. The views of people and staff are important. It is important that we all talk. No one is better [than others]." Another member of staff stated that "it would be interesting to see how this manager makes changes." The third member of staff said it had been "horrendous". A member of housekeeping and catering staff said there was a period where they avoided contact with office staff. The quality assurance manager told us the organisation had taken the feedback from staff seriously and acted to provide a more stable environment for people.

The current manager was not registered and but told us that they would be applying to register with CQC. Staff told us the manager had a mental health background and a good understanding of people living with dementia. They told us staff were able to approach the manager for advice and gain the guidance needed to deliver appropriate care to people. A member of staff said the manager was good and understanding. They said the team "helped each other".

The provider assesses the standards of quality using CQC's Key Lines of Enquiry (KLOE) which included Safe, Effective, Caring, Responsive and Well Led. Each KLOE was assessed and a score given to the assessed standard. For example, one for inadequate and four for outstanding. Where the rating was two or below and action plan was devised on the improvements to be made. We found that the provider had identified that improvements were needed in developing risk assessments and ensuring care plans included people's preferences. These audits were in line with our findings at the inspection.

The organisation's quality assurance team had undertaken a programme of audits which included medicine systems. Medicine systems were assessed as requires improvement and an action plan was developed on how the standards were to be met. The Quality Assurance manager said there were two visits per month and during these visits records were reviewed and feedback was gained from staff and people. A member of staff was designated to investigate the shortfalls from the quality assurance audits with timescales.

Monthly visits on behalf of the provider were undertaken by the operations director. The report of the visit included a summary of the findings, observations, areas assessed and improvements where identified. The action plan was ongoing and was updated following the visit to include new areas for improvement. For example, the action plan for April 2017 included tasks completed, new actions and actions taken forward.

Timescale for achieving each task with the role of the staff designated to complete the action.

The manager told us internal monthly audits were to be re-instated. They said the programme of internal audits was to monitor best practice and where there were shortfalls these were more easily identifiable. A development plan was drawn together from the internal and quality audits and the monthly provider visits action plans. The development plan included the name of the staff responsible for achieving the action with timescales. Each action was monitored each month up to the set deadline.

The manager told us accidents and incidents were reviewed by the quality assurance team and where there was learning this was shared in teams. For example, falls were assessed and where patterns were identified ways of minimising falls were considered. This included improving lighting in bedrooms for people to find their way around their bedrooms at night. They said that at regional meeting the learning from across the organisation and nationally is shared to further ensure learning and development.

The comments from people about the atmosphere of the home included "Plenty of laughs and jokes" and "A very pleasant place." The relatives we spoke with made the following comments. "Lovely atmosphere. What they have done is to bring in the flavour and atmosphere of Box village in to Brunel House- community spirit here" "Atmosphere good. It feels like a good hotel," "Think that there is a good atmosphere in here. Excellent on this floor [dementia unit]."

Staff said the values of the organisation were to be "the best provider." A member of staff said the values of the organisation included "being the best home and provide the best care." Another member of staff said "strive to be the best care provider".

People told us their views were not always gained. The manager told us feedback cards were in the foyer of the home. People and visitors were able to complete the questionnaires which were analysed by an independent company. Residents and relatives meetings were taking place and the times of the meeting in January 2017 was staggered to accommodate the preferences of relatives. At the most recent meeting people and relatives were updated about the manager's appointment, new staff and activities.

A member of staff said team meetings were regular and the minutes of the meeting were available for staff who were not able to attend. The minutes for the staff meeting held in January showed staff were told about policy changes, information was shared and concerns were discussed. For example, repairs.

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 Treatment of disease, disorder or injury	Regulation 5 Registration Regulations 2009 (Schedule 1) Registered manager condition A registered manager was not in post

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not involved in the planning of their care. Care plans were inconsistent and lacked detail on people's preference on how their care was to be delivered. Care plans were not updated on their changing needs following reviews.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff were not always respecting people's dignity when decisions were taken regarding refusal to use equipment and aids

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people had cognitive impairments their ability to make specific decisions was not assessed. Staff were gaining consent from relatives without Power of attorney to make specific decisions. Care plans were not developed on how best interest decisions were to be taken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always in stock for people who may experience pain. When required (PRN) protocols were not in place for all medicines prescribed to be administered when required. Where PRN protocols were in place they lacked detail on when these medicines were to be administered. Risk assessment on how to mitigate risk were not in place for all risks. Staff had not recognised risks and taken action on how to minimise the risk