Runwood Homes Limited

Brewster House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We carried out an unannounced inspection of Brewster house on the 13 March 2018. Brewster house is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service accommodates up to 71 people across two floors, each of which have separate adapted facilities for people who may or may not be living with dementia. At the time of our visit, 63 people were residing at the home.

A long-standing registered manager was in place. 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.

Brewster house has been inspected at yearly intervals over a three-year period due to it requiring improvement in a number of areas. During this inspection we found that the management and staff team had worked hard to continue making improvements at the service and that these had been maintained. We did find some areas that continued to require some improvement, and have made recommendations throughout the report to support the service in these areas. Where we did find areas that required improvement, the management team were able to demonstrate that they had also identified these areas and were working on how to improve. Consequently, we found that Brewster house has achieved a good overall rating.

Medicines had not previously been managed robustly. The deputy manager had made this a focus for improvement and we saw excellent processes were in place following best practice for managing medicines in care homes.

Staff had a good understanding of safeguarding vulnerable adults, felt confident, and supported to raise concerns to team leaders and managers at the service. However, on review of some complaints we identified certain incidents, which could have been investigated as a safeguard but had not been reported to the commission or local authority. We have made a recommendation for the service to improve in this area.

People's personal information was not always stored safely in line with the Data Protection Act, 1998.

Whilst the service had appropriate infection control processes in place, protective equipment for staff and safe disposable of waste, we did observe that bathroom areas of the home were not always clean. We have made a recommendation in regards to this.

Safe recruitment practices were in place and staff were provided with a robust induction and probationary period to prepare them for the role.

The management team accessed a variety of different training opportunities for staff that met with people's changing needs. The service had good access to other health and social care professionals to support staff to care for people.

People told us that they enjoyed the food provided at the service and had plenty of choice. When people had additional requirement's these were met. For those with a risk of poor nutrition and dehydration, specialist advice had been sought and care plans interventions were in place to manage these risks.

Staff demonstrated caring responses to people and people told us staff and managers where kind. Relatives told us they observed staff being kind and we observed some positive interactions between people and staff during every day routines and activities.

People were not always involved in running the service and but where possible were engaged in developing their care plans. The management team were able to demonstrate plans being developed to improve people's involvement in how the service ran, including recruitment of new staff.

The management team were passionate about continuing to make improvements at the service and had worked hard to improve on areas where there had been previous concern. Staff and people living at the service all commented on how approachable the management team were.

Governance and oversight at the service was good, and the registered manager investigated incidents, accidents, and complaints in a robust way. The only exception to this was a concern that people's clothes would sometimes be misplaced or worn by others. In spite of this the service demonstrated that it was constantly learning and developing.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff had a good understanding of safeguarding. Internal investigations and actions taken to mitigate risk were robust, however, potential safeguarding referrals had not always been made.

Staff had not ensured that bathrooms were always clean in line with infection control practices.

People were protected from the risk of unsuitable staff as the provider followed safe recruitment procedures.

People felt safe and staffing was deployed in a manner that considered people's needs and staff experience.

Medicines management was excellent.

Is the service effective?

Good

The service was effective.

Staff had access to a good induction and received regular mandatory training updates.

Additional training was sourced to support staff in various aspects of care provision and ongoing learning.

People had access to a variety of choices of food and drinks that met their preferences and individual needs.

Staff had a good understanding of the Mental Capacity Act and the service had recognised where capacity assessments needed improvement.

Is the service caring?

Good

The service was caring.

Staff were very caring and knew people well.

People told us that staff were approachable, warm mannered and kind.

People's privacy was respected and dignity protected.

Is the service responsive?

Good

The service was responsive.

Care plans were person centred and addressed people's needs in line with their preferences and wishes.

The service and welcomed feedback from staff, people and relatives about the home and took action to remedy concerns.

Those who had received end of life care had been cared for in a sensitive manner that met their need and the needs of the wider family.

Is the service well-led?

Good

The management team were proactive, transparent, and caring.

The registered manager and deputy manager worked well together to support improvements at the home.

Good governance systems were in place and the service was constantly learning.

Archived personal information about people was not kept secure in line with the Data Protection Act, 1998.

The service engaged with internal and external agencies to support ongoing improvements and share best practice.

Brewster 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 checked 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 13 March and was unannounced.

The inspection team was made up of three inspectors 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 before the inspection a provider information return (PIR), which is a statement of information registered providers are required to send the commission at regular intervals to help us understand the service provided and any current risks to the service. We also reviewed all the notifications we had received from the service to ensure these were of good quality and in line with the Regulations Registrations Act 2009.

We observed the daily lives of people living at the service, and looked at how staff engaged with people. We spoke to 10 people living at the, four relatives, and eight members of staff, including the registered manager and deputy manager.

We carried out a review of six people's care. This included looking at daily care entries, risk assessments and care plans and care reviews, as well as referrals made and specialist advice gained and followed by staff working at the home.

To gain an understanding of the running and managerial oversight of the home, we reviewed all clinical governance processes in place, including policies and procedures, action plans and audits. This information tells us how a service is identifying risks and constantly adapting and improving to support people in their care.

We spoke with the local authority who shared with us their own reviews of the service, recommendations made, action plans for improvements and whether these had been met.

In addition we reviewed six staff files to inform us about whether safe recruitment processes had taken place and that staff received ongoing training and supervision to ensure they had the skills to meet people's needs.

Requires Improvement

Is the service safe?

Our findings

When we last visited the service, 23 November 2016, we rated the safe domain as requiring improvement due to unsafe medicine practices. During this inspection we found significant improvements in this area, however some improvements need to be found in relation to infection control and safeguarding notification's. Consequently the service continues to be rated as requires improvement in the safe domain.

Staff had a good understanding of safeguarding vulnerable adults, felt confident, and supported to raise concerns to team leaders and managers at the service. They were able to describe signs of abuse and the procedures to report any concerns they might have about people's wellbeing. One member of staff said, "I would inform the manager, it is my job to speak up, and I know we also have a number to call."

However, on review of some complaints we identified potential for some issues to have been safeguarding concerns, which had not been reported to the commission or local authority. Whilst this needed addressing, we did find that in all cases a thorough investigation into complaints had taken place and actions taken to mitigate risk to people. In all cases, we found that the person had not been exposed to harm. The area manager told us this had been identified in a recent inspection at another service run by the provider and they were working on sharing information with registered managers to ensure that this improved.

We recommend that the provider review policies and procedures relating to what constitutes a safeguarding referral to ensure that appropriate notifications are made to safeguard people.

We found on two occasions identified risks did not have corresponding interventions in place to inform staff how to monitor a person specific need and act appropriately. For example, one person at high risk of falls had received all the appropriate input from other health professionals and sensor mats had been put in place to mitigate risk of falls at night. However, there was no corresponding care plan and the staff we spoke to did not know about the sensor mats. We found these under the person's bed.

Another person had had a growth removed and the advice on a multidisciplinary report had been to continue to monitor this and alert the GP if it returned. However, there was no care plan intervention to inform staff what to do, although staff told us they were aware the person had had a growth removed. Whilst we found these two examples, we observed that risk was managed well and people were kept safe.

We recommend that the service reviews processes in place to ensure that all advice sought from professionals to manage potential risk is recorded within care plans, and disseminated to all relevant staff in a timely way.

The service was clean throughout and there were sufficient arrangements in place to help ensure the cleanliness of the service. The risk from infection had been assessed and the risk of infection was reduced by staff that were knowledgeable and used their training to keep people safe. Staff had access to and were observed using personal protective equipment (PPE) such as, gloves, aprons, and hand wash. However, we observed two of the bathrooms were not clean. We observed that in two bathrooms there was worn and

stained slip mats in the bath, both baths had faeces stains present, which were dry, indicating that they had not just occurred. We showed the regional manager what we had found and they took immediate action to ensure that these were cleaned and to investigate why staff had not identified this on their walk rounds.

Taps and toilet cisterns were heavily lime scaled. Heavy timescale deposits can be a breeding ground for legionella bacteria to form. We checked that the service had carried out legionella testing and acted on recommendations. Domestic staff told us it was difficult to get rid of the lime scale as the bathrooms and toilets were always in use.

We recommend that service review processes for cleaning heavily lime scaled areas and bathroom areas to ensure that they provide people with safe and dignified surroundings for personal care.

People were protected from the risk of unsuitable staff as the provider followed safe recruitment procedures. Staff files included evidence of employment history, proof of identity and Disclosure and Barring Service (DBS) checks. The DBS carry out criminal record and barring checks on individuals who intend to work with people who use care and support services and helps employers to make safer recruitment decisions.

Staff did not always store peoples personal information safely. We observed that there was a significant number of open and taped boxes of archived personal information about people living at the service, and who had lived at the service that was found stored in the communal entrance hall behind a sofa and under the stairs. The Data Protection Act 1998 makes clear that all personal information about people be stored safely and securely. We immediately addressed this issue with the registered manager and administration officer who informed us that the information was waiting to be collected from head office. Staff told us that it had been there for several days. The registered manager took immediate action to store the information correctly and chase transport for the archived information.

Risks associated with people's care and support had been assessed when they first moved to the service. This included those associated with moving and handling, nutrition and hydration and the risks of falls. This meant that whenever possible, the risks associated with people's care and support had been identified, minimised and appropriately managed by the staff team. Reviews were carried out monthly and when required to identify changes in risk and need.

The commission had received a high number of notifications about the amount of falls at the home. However, on review of all the information the service was able to demonstrate they appropriately monitored peoples fall risk and put in place measures to mitigate identified risks. They also actively referred to other health and social care professionals. For example, the falls team which specialise in managing risks of people who are at high risk of falling, and occupational therapists to access specialist equipment.

People told us that there was enough staff on duty to care for their needs. We observed people had access to nurse call buzzers and these were answered within a reasonable time frame. Observations in the communal areas demonstrated staff were sitting and talking to people throughout the day, and people in the bedrooms told us staff often popped in for a chat to make sure if they needed anything. One person who liked to remain in their room told us, "Staff are really good, I prefer staying in my room, but they always come. They are always in here, I tell them I prefer my own company but they are always looking after me, bringing me biscuits. They come in and talk too, we are well looked after." The registered manager reviewed staffing and people needs regularly to ensure enough staff were present.

Every person living at the home had up to date PEEPs in place. PEEP is a personal emergency evacuation

plan, for example to support staff to move people in event of a fire. Equipment to mobilise people was readily available and the plans accessible to staff in the event of a fire. We observed during inspection the fire alarm being activated by a distressed person in the home. We found that staff acted calmly, quickly and efficiently to identify whether there was a fire and to keep people safe.

Staff told us that they felt staffing was adequate; "Everyone manages quite well, we have one in each lounge and a float. We all work well as a team." In addition, "Yes there is enough but like anywhere more would be nice, I am new to this lounge so getting to know everyone, this being in the lounge is what we usually do."

The service provided good continuity of care to people with a stable staff group. They had not needed to use agency staff to fill vacancies or sickness as regular staff were happy to support in these situations. The registered manager told us that they always tried to look at the staff group on duty to identify individual skills and levels of experience so that people would be cared for safely. They also ensured that new members of staff worked across the two floors with the most experienced team members to facilitate their learning and development. In addition to this, whether ever possible they aimed to staff each floor with the same care staff to ensure continuity. The registered manager told us, "We have a blind person for example, who gets very distressed at different voices so we try and ensure that staff on duty are familiar to them and it's reduced their level of anxiety."

Medicine management had significantly improved since our last inspection and robust systems were in place to monitor medicines given to people living at the home. The deputy manager had taken responsibility for making the improvements and during this inspection; we found processes in place to be excellent. Previously we had concerns about the safe storage of medicines, but on this inspection the service were able to demonstrate improvements made. The service had undergone a recent inspection from the pharmacy they used and received an excellent report. Medicines were stored, managed and dispensed safely in line NICE (National Institute for Health and Care Excellence) guidance for managing medicines in care homes. When people needed PRN (as required medication) to manage pain or to help them with anxiety and distress, clear PRN protocols were in place for each person. These protocols informed staff when medicine would be appropriate to offer, how they should be given in line with people's preferences, and what actions they should take to monitor the effectiveness of medication.

Staff had been trained to administer medicines safely and they were observed to ensure that they were competent in this role. Medicines administration records (MAR) showed when medicines had been given or if not taken the reason why. Body maps were in place for transdermal patches which show staff where to apply them each time to prevent skin irritation. For one person this had been assessed as not being possible as they would remove them. Particular attention was therefore being given to monitoring the condition of their skin. Instructions for creams were specific and the deputy manager had worked with GPs to ask for specific instruction on prescriptions to be recorded on people's MAR (medicine administration record), for example; "Apply 3 times a day to left wrist."

Peoples allergy status were updated on all appropriate charts from admission and for people requiring medicines that need careful monitoring, such as warfarin team leaders had clear instructions on when they needed to ensure that people received blood tests. For people in receipt of anti-psychotic medicines and medicines for depressive illness, medicines were reviewed at least three monthly within the multidisciplinary team, including GP, specialists, and the person.

Good

Is the service effective?

Our findings

During our inspection on the 23 November 2016, we found that the service required improvement in the effective domain. This was related to staff training and the need for staff to have a better understanding of how to respond to people's specific needs. During this inspection the training for staff had improved, and consequently we found that care provided to people was effective.

People using the service had their care and support needs assessed. People's care and support needs were assessed prior to them moving into the service and this was used to develop a care plan. Some care plans evidenced discussion with people and their loved ones to manage peoples identified needs in a way that limited restrictive practices. For example, how often observations would be carried out with people to minimise intrusion, but to ensure that people were kept safe.

Staff contacted other health and social care professionals to seek advice about a variety of care needs. For example, if a person was identified as being at high risk of falls this was discussed and referrals were made to the falls team, who support people at risk of falling and give advice to care homes on how to mitigate risk. Additional equipment was sourced, such as sensor mats by people's beds to alert staff in the night to people at risk of falls getting up so that support could be offered.

Staff told us that they had received training, which helped them understand people's needs and provided them with the skills and knowledge to fulfil their roles. A member of staff told us about the dementia training they had taken part in and explained how it had helped them to provide a high standard of care, "It helps me to understand people, to connect with them."

The administrator kept updated records of what training all levels of staff had undertaken and when they were next due refresher courses. These were kept in the office and staff were expected to come and check whether they needed additional training. This had worked well and we saw that the majority of staff were receiving training on time. When there were gaps in people's training this could be explained by absence, such as a member of staff being on holiday, in which case they would be expected to complete training on return.

Most the learning was via a computerised e-learning system, but the service also provided face-to-face training such as Parkinson's awareness. Staff told us, "Training is mainly on line, but recently I did diabetes and Parkinson training in house, which I found very helpful" and "We have on line; I did feel we learnt more face to face, it does cover most things."

Staff told us that they felt supported and they could talk to the manager or deputy at any time. Records showed that staff members had supervision meetings with their line manager in which they could raise any issues they had and where their performance was discussed. One member of staff said, "Every month I have supervision. The senior does it." In addition, "We have supervisions and I do feel supported, if I have a problem I speak up and have my say, they usually listen" and "I do feel supported by managers; we have supervision and staff meetings."

People were assessed using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults were malnourished or at risk or malnutrition. If identified as at risk of losing weight and having high risk of pressure sores, appropriate referrals were made to dieticians who provided advice and support to the home. We saw care plans demonstrated that external advice was used and staff were able to tell us people's risks and how they supported them in line with advice given. For example, one carer spoke to us about a person who was at risk of malnutrition and said, "We encourage them to eat and drink. That's why we have the milkshake; we put yogurt, cream, and ice cream in it."

Lunchtime was a pleasant and sociable atmosphere and people were encouraged to be as independent as possible, although staff were on hand to support if needed. We saw staff showing people two plates of food to choose between at lunchtime to help those who found making a choice difficult to understand what was on offer. A member of staff told us, "We have two plates of food always, we tell them what it is, and sometimes you have to explain." One person had chosen casserole but then decided they did not want it, a member of staff brought another choice and when the person saw it they said, "Oh yes, I will have this." One person told us, "I had a fish cake; I have it every day because that is what I like."

Care staff adapted how they supported people to make choices about food. For example, care staff recognised that not everyone understood what a casserole was so changed the wording to stew when it appeared people did not understand what casserole was. People were asked if they wanted a clothes protector rather than just being given one, which supported people's dignity.

Catering staff told us, "I do all the ordering and we do the menus all together. We try and do different things and I ask the residents and family members what they would like." They went on to tell us, "Lots of residents here do like salads, but we constantly change the menus as people come and go." The told us, "I do cook some cake for the afternoon trolley, and we do some chopped up fruit that goes down well."

Lunch menus were displayed on dining tables, which included large pictures of the choice available that day. Condiments were on the table and people were offered salad cream for their salad. Care plans contained information for staff to support peoples nutritional needs based on detailed risk assessments.

When people had been identified as having diabetes, care plans documented how staff could support them to make healthy choices of food. Where people had been identified as being at risk of choking, appropriate referral's had been made to Speech and Language Therapists who would advise what type of textured diet people should be supported with to prevent choking.

The service had also being working closely with "Prosper," a programme that had been developed in partnership with the local authority, health services, and a local university. Prosper aims to support care homes to improve safety and mitigate risk of harm to vulnerable older people. Staff told us that the service had benefited from this initiative and had helped them to look after people who were at risk of urinary tract infection, falls, and pressure sores. We saw evidence of how this work had improved previous high-risk areas, for example, those at risk of developing UTI had additional fluid monitoring in place and staff had a good understanding of signs and symptoms of infection.

Evidence seen in care plans demonstrated that people had access to health care services and received ongoing support where required. For example, records showed that people were seen by other healthcare professionals, including speech and language therapists, dieticians, opticians, dentists, audiology specialists, and chiropodists when needed. There was guidance from healthcare professionals recorded on care plans including information related to fortified diets or guidance related to diabetes and care plans were reviewed monthly. Care plans gave details of appointments and outcomes. In addition, gave details of

regular medication reviews with the GP.

Each person's bedroom door had their name displayed as well as a picture of something important to them and a note about a topic, which they enjoyed to talk about. This helped people to easily identify their bedroom as well as giving staff an insight into what was important to the person and providing a conversation starter. One person was very pleased to explain the information on their door to us, which brought back memories of their working life and was very person centred.

The environment was suitable for people in regards to safety and was in a good state of decor and repair. The service had recently been refurbished including a café specifically for people and their relatives. This was following discussions amongst people and staff that there was no were private for people to receive guests in the home. Relatives told us, "This is a lovely room, I wanted to pop in and have a look and see if it was finished. Much better than it used to be."

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Moreover, assessments of people's capacity should be decision specific recognising that people may retain mental capacity for one decision but not another.

The mental capacity assessments we reviewed were generalised, some linking a number of decisions within one assessment. Issues with appropriate mental capacity assessments had also been identified following a local authority assessment in June 2017. Whilst the home had worked on this and achieved compliance in November 2017, we found that capacity assessments continued to need improvement. The registered manager and area manager told us that they were aware of this issue and were in the process of reviewing all capacity assessments for people who needed them and were able to demonstrate this from an action plan in place.

In spite of this, peoples care plans included detailed documentation in relation to consent and capacity, which included an assessment to determine if someone had capacity. For people who lacked capacity to consent to important medicines needed to maintain their health and well-being, and who had refused to take medicines, appropriate best interest assessments had been carried out, before a person received their medications covertly. For example, when medicines were administered in food. In such circumstances registered people have to discuss with pharmacists about how the medicine should be administered to ensure that it remains effective and include identified people in that persons lives in making the decision. This includes a lasting power of attorney for health. This is a person nominated by the person who lacks capacity, and or is chosen by a court of law to act on behalf of the person who lacks mental capacity makes decisions about their health and well-being. We saw that in the two cases of people receiving covert medications progresses had been followed in line with guidance.

Regardless of whether people had been assessed as having capacity, we observed staff offer choices throughout the visit on all aspects of care. This is also in line with best practice. Staff told us, "We offer choices for people in most things, choices of food and clothes" and "We still offer choices to people and ask permission, even when they are not always able to answer. We can sometimes tell what they prefer."

Good

Is the service caring?

Our findings

During our inspection of the service on the 23 November 2016, we found that service was caring. This inspection demonstrated that the service continues to provide caring care to people.

Staff greeted people with a smile, made eye contact when talking to people and used positive touch to connect with, or reassure people throughout the day. It was obvious from our observations, that staff were familiar with people's needs, preferences and were responsive to how people were feeling as well as their physical care needs; ensuring reassurance was given when needed. This supported people's wellbeing.

One member of staff in a lounge area was chatting to a group of people about Mother's day, sharing what their child had brought them. This invoked a great deal of humour amongst the group. Staff sharing these personal stories with people living at the home encouraged people to reminisce about their own mothers' days past and present. It meant that people felt engaged and involved. People told us, "I am very comfortable here, could not have done any better, cheerful people we sit and chat and play cards, always something jolly here", "It is fairly good, staff are alright" and "My family visit whenever they want."

Staff encouraged people to be involved in lots of different things throughout our visit. The carer took turns to talk to people and asked them about their life and their interests. In particular one lady had just moved in and staff were very patient. They kept coming back to reassure her and got her involved in a game of scrabble with another person. Every staff member that came in said hello and instigated conversations with people.

All staff seemed to know people very well and support people in a caring way. One of the housekeepers told us how they took time out of their daily tasks to spend time with the people they were supporting. "Sometimes if I am cleaning a person's room and they want to have I chat, I stop what I'm doing and chat to them. Everyone is different. Some like to chat, some don't. For example, [Person's relative] brought in some photos and they wanted to show me, so I am going to spend some time looking at them with [person] even if it puts me behind a bit. If you can put a smile on someone's face for just a minute at this time of life it's worth it."

Those people nursed in their bedrooms told us that staff were constantly popping in and out to check they were okay and to spend time with them. One person told us, "I'm very happy here. I think the care given is excellent, they really are lovely girls, and they always have time to come in for a chat. The food is very nice and I have lunch here in my room." They went on to tell us, "I prefer to stay in my room with the TV on – Cheltenham horse racing today. And I can do that – there's no pressure to join in, but I do go into the lounge sometimes when there's something good on."

Staff encouraged and supported family members in helping to develop care plans. People's care plans contained information about their preferences, likes, dislikes, and interests and were frequently reviewed involving people and their families. The service encouraged people and their loved ones to share information about their life history with staff to help staff get to know about peoples' backgrounds. For

example, care plans included the person's life history 'a story worth telling'. Some of these included photographs of people throughout their lives at different life events.

Wherever possible staff told us, they tried to encourage people to remain independent. One member of staff stated, "We always give people a choice. For example, [Person] can do some things for themselves so we encourage [person] to do it."

Staff were able to explain what privacy and dignity meant and were able to tell us how they ensured people's privacy and dignity was maintained while personal care was provided. Care staff all had particular lead roles within the team and one member of staff was assigned to a dignity champion role. This involved keeping up to date with issues related to dignity in care homes and supporting staff to consider potential dignity issues within their daily interactions with people.

In the main, we observed dignified interactions between people and care staff on sensitive personal care issues. For example, a member care staff whispering in the ear of a person who then assisted them to the toilet. We heard the person say in a loud voice "Thank you dear, you are a very nice person." However, we also observed a person being hoisted into a wheelchair using a specialist hoist in a busy lounge area. On this occasion the persons underwear was exposed and staff had not ensured their dignity was totally protected.

We recommend that the service revisit with staff dignity issues when using equipment that can potentially affect a person's dignity.

Staff protected people's privacy. One member of staff told us about a person who had previously been concerned with people walking around the service and going into their room. The person was then given a key to their bedroom. The person was pleased that they had their own key and staff told us, "Since we gave [person] their own key they have really settled down… we can always open the door with our keys."

Good

Is the service responsive?

Our findings

During our inspection of this service on the 23 November 2016, we found that the service was responsive. We found during this inspection that the service continued to provide responsive care.

People were assessed before they moved into the service to ensure that their needs could be met. Care plans reflected individual's preferences as to how they wished their care to be delivered. The care plans gave descriptions of people's needs and the support staff should give to meet these whilst promoting people's independence. An example of this was describing care support needed with oral hygiene. Care plans informed staff how much people could do for themselves, when they needed prompting and what type of support they needed.

As care plans were regularly, reviewed staff kept up to date with all changes, which were communicated through effective handovers. This included how to support people who required pain management. Care plan interventions clearly documented peoples own assessment of pain, what makes their pain better, what makes their pain worse. Staff told us, "We have handover every morning, at the start of our shift and at the end. We write down things to handover but still talk about anything of concern too. I pass on any concerns about a resident, talk to management, or a care team leader."

Care plans were completed based on the person's assessed needs such as dementia care, mobility, personal care, continence, eating and drinking, social activities, night care, and pressure care. Each plan of care was reviewed monthly with any updates. Staff told us that care plans gave them the guidance they needed to continue to provide person centred care and were able to give examples of how they provided person centred care. For example, supporting people to do things that they enjoyed, such as visiting local community, going to bed at a certain time, and sitting with people, they enjoyed spending time with amongst other things.

Care plans gave excellent detail on people's preferences, likes, dislikes, and hobbies. Wording included, "[person] loves day time gardening programmes, please like [person] know when these are on," and "[person] likes all cereal but prefers cornflakes." A person who was registered blind had interventions that considered this, including, "[person] will need you to describe clothing and colour to help them to choose."

Documentation included discussions with people about how they liked to be checked in the night, whilst considering risks. One intervention states, "[person] doesn't mind being checked in the night but has asked not to be woken" and another, "[person] prefers to sleep in their armchair but sometimes gets into bed late at night. [Person] prefers curtains closed, bedroom light on, door slightly open." These interventions demonstrated that the service had really considered how to ensure that all aspects of care for people were person centred.

However, navigation through care plans was not easy, as care plan interventions were not kept next to their corresponding risk assessment. It is important for staff to be able to quickly access interventions for people to mitigate each risk and manage each need.

We recommend the service review care plan folders to ensure that they are accessible to staff and people who need them.

People were supported to follow their interests and take part in social activities. The provider employed a member of staff who was responsible for activities within the service. During our observations we noted that people were encouraged to be occupied, one person was looking at a crossword book, another person was looking at a book. Two people were playing scrabble with the member of staff supporting them.

Staff told us that some people chose to go to the day centre that was part of the service and we observed this was being used. People told us there was always something going on, "We sit, chat, and play cards here, usually something happening"; and "I do enjoy the activities here, there's always something going on." Staff told us, "We try to occupy people every day here, with scrabble and other board games; there is also an activity programme."

We observed the activity coordinator supporting people to exercise and people were actively involved in according to their physical abilities. We also observed a game of snakes and ladders taking place in the small lounge. A large games board was placed on the floor and everyone in the room was given the opportunity to throw the large dice and take part in the game. People were enjoying the competition and there was lots of laughter.

A display board in the lounge 'Life at Brewster House' included details of additional activities including a Gentleman Sparkle Club where people took part in bar games, quizzes, had alcoholic or non-alcoholic drink, and a Ladies Club were people took part in cooking, arts, spa. In addition to this they had Church service every Thursday and quiz nights for staff and people living at the home.

The registered manager had an open door policy and people, relatives and staff felt able to report concerns at any time. However, some verbally expressed complaints were not recorded, as they were dealt with immediately. One relative told us, "[The registered manager] is always happy to speak to us and listen to concerns, although I am not always sure what is done about it." In addition to the open door policy, the registered manager also had one identified day every week for people to come and express concerns. Although they told us, "Yes we have this day but no one really uses it as the door is always open." This day was clearly displayed in the reception area of the home.

The registered manager investigated most complaints to the service in a timely way and in line with the provider's policy and procedures. However, it was not always evident that information from complaints had been used to improve the quality of care provided. For example, one relative had complained about their loved ones clothes going missing. The investigation concluded that the person had been admitted to the home without labels being attached to their clothing and as the family had put away the clothes, staff had not noticed the lack of labels. However, other family members we spoke to told us that they had sometimes found other people wearing their loved ones clothes, or clothes that had gone missing and on occasion, a loved one wearing someone else's clothing. They told us that they had informed staff about the concerns and clothes would be located. However, staff had not formally reported these so this had not been investigated.

We recommend that the registered manager review processes for ensuring that these type of concerns are recorded and appropriate action is taken to ensure that people's belongings are respected.

End of life decisions were recorded in each care plan. We noted on one care plan a recent conversation had been held with the GP and family about a Do Not Attempt Resuscitation and CPR decision [DNARCPR]. The

person did not have mental capacity to make this decision themselves. These are decisions to consider whether addition lifesaving treatment should be given to people if they become seriously unwell. At the time of inspection, the service was not caring for anyone receiving end of life care, although had recently been supporting someone who had been on an end of life pathway and died at the home. The registered manager was able to tell us what support they received from external agencies to ensure that the person received a comfortable, dignified and pain free death. Although they did not have a formal process in place and staff had not received end of life care training.

We recommend that the provider ensures that end of life care meets current best practice guidance and that staff have the necessary skills to support people receiving end of life care.

Good

Is the service well-led?

Our findings

During our last visit to the service on 23 November 2016, we found that the service was well led and continued to strive to improve. During this inspection the service had continued to improve and remain well led.

The entrance to home was set out in a way that displayed all the relevant information for people and their families about what the service offered, whom they could to talk to and how to make a complaint. This also included information about how staff could raise their concerns via a whistle blowing process.

At the time of inspection, the service had not received any complaints from staff. A board displayed staff photographs, names, and job role for transparency and so that people knew whom they were talking too. It also displayed the services visions and values, menus and activities available to people.

Staff were encouraged to speak about concerns they had and were supported by the management team, and were clear on their roles and responsibilities. In addition to this, each member of staff had a designated champion role in monitoring and improving the quality of care provided, and these were displayed in the entrance hall. This included dignity champions, moving and handling champions, falls champion, and nutrition and hydration champion.

Each member of staff assigned to these roles were encouraged, and supported to keep up to date with changes in these areas of care and decimate information to colleagues within handovers. When a person had been identified as having a particular need, a champion in that area would support the development and oversight of the intervention used to manage that need. This promoted a positive culture of learning within the home as well as promoting a person centred response to peoples' identified needs.

Staff told us how proud they were to work at Brewster House, and that they felt they were valued by the organisation. Comments included; "I love it here – it's a nice team with a very supportive manager", "Overall I enjoy it here, I have never not wanted to go to work," and "The management team are approachable."

The registered manager and deputy manager had worked hard to ensure that staff felt supported to deliver the care as set out in the provider's visions and values. Staff who had exhibited exceptional caring attitude to people living at the service could be nominated for awards for the organisation and the service. In addition to this, the registered manager also knew staff's birthdays. The deputy manager told us, "[registered manager] is so kind and thoughtful; she always gives staff a birthday present when they are working on their birthdays and will often bring in treats for staff when they have worked hard." These forms of positive reinforcement supported staff to feel good about the impact they had on people's lives, and ensured that the quality of care provided remained good.

The deputy manager worked three care shifts during the week, during which time they demonstrated and role modelled best practice. As a registered nurse, the deputy manager was able to show us how they kept updated with all the changes and best practice guidance in supporting people living at the home, including

how they disseminated this information to care staff through supervisions and team meetings. They had also begun to collect a folder of information about individual achievements at the home that could demonstrate how responsive care had been and the impact on people's lives. Going forward this would be shared with care staff as a positive motivator and as a guide to how to support people with complex needs successfully.

The service had good governance processes in place to monitor and manage the quality of the care provided. This included regular inspections of the service by the area manager for the home. The registered manager provided us with a recent support, and we saw that the inspections were robust and picked on quality issues that needed improvement. Where found improvements needed, these in the main had been identified by the service, and actions were in place to make improvements, which would be continued to be monitored by the area manager and the homes management team. For example, these processes had identified that mental capacity assessments and training needed improving, and these were all under review at the time of inspection.

The area manager carried out regular inspections of the service and had identified where improvements were needed. We noted that in most cases within a recent inspection, they had identified areas that we also found, which gave us confidence that the provider oversight was good. The area manager worked with the registered manager and staff to develop action plans and timescales for improvement and continued to monitor this through regular audits and visits to the service. We saw evidence when loved ones had made a complaint and the registered manager had investigated and responded in a timely way. When errors had occurred, the registered manager issued an apology and took steps to use the event as learning for care staff. We saw evidence when this would be discussed in handovers, staff meetings, and individual staff supervisions.

Policies, procedures, and clinical audits carried out by the management team were regularly reviewed and easily accessible and outcomes were discussed through regular management meetings, staff meetings with various groups of staff and during staff handovers. This meant that all staff were aware of any challenges to the service and actions needed to make improvements. One such challenge was staff not always storing moving and handling equipment correctly, and keeping kitchenettes on various units clean. This resulted in team leaders and registered managers carrying out twice-daily walk rounds to check that equipment was stored safety and infection control was adhered to. Other issues around dignity were discussed, for example leaving incontinence wear exposed in people's bedrooms and not stored away. This was checked daily, so that people's rooms could remain homely and comfortable.

The activity coordinator undertook regular residents meetings and meetings with relatives to determine what changes people felt were needed to the home. People had previously voiced a concern of the lack of private space to receive visitors. Because of this, the home had adapted a room into a café for people to see loved ones.

The deputy manager told us that they hoped to include people living at the home in choosing potential new staff, by including them within the interview process. They told us, "We currently have six vacancies and we are recruiting for these posts. We have identified a couple of people living at the home that would be able to take part in asking potential candidates questions and helping to make decisions about employment, so we hope to introduce this soon if they would be happy to take part."

The registered manager took part in regular registered manager meetings for other managers of Runwood homes in the area. During these meetings, they each gave a handover about how their service was performing and any difficulties that they faced. Managers were then encouraged to share ideas about

improvements and learning, best practice guidance and ideas on how the services could be improved as a whole. The registered manager told us, "We also discuss recent reports for Runwood homes so that we can share good practice and help support each other to improve when a home needs it."

The service carried out annual staff and resident surveys to measure what people thought the quality of care was like. We reviewed the last survey results completed. The service had received a good response from staff and people using it, and where issues had been found action plans had been developed to make improvements. In addition to this the registered manager and care team had worked closely with other organisation's such as PROSPER, as discussed within the safe domain.