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

Summary of findings

Overall summary

Brunel House is a 'care home' that provides a service for up to 65 people across three units which include nursing and dementia care. 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.

This inspection took place on 26 of September 2018 and was unannounced. We returned on 27 September to complete the inspection. At the time of the inspection there were 58 people living at the home.

At the last inspection dated July 2017 we found breaches of fundamental standards in relation to Regulations 5, 9,10 11 and 12. The provider developed an action plan detailing how they would take steps to meet the requirements of the legislation and action plans were monitored by the provider. While we found that some improvements had been made these were insufficient in all areas.

This is the second consecutive time the service has been rated Requires Improvement

A registered manager was in post. '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.

There was a programme of monthly audits included sample checks of care plans and medicine audits. We saw there were repeated issues in relation to medicines. Clinical audits were monthly and related to areas of risk such as pressure areas, weight and falls. Along with reports of commissioners visits we raised with the registered manager that reports of daily entries were not person centred. For example, staff documented reports of clinical support and direct care provided. The registered manager explained how this was to be addressed. However, records were not always up to date and accurate.

Risk management systems were used to assess people's individual level of risk. Action plans were devised where risks were identified. However, risk assessments were not always updated to show where the risk had increased and monitoring checks were not consistently completed.

Care plans were not always person centred. Some care plans were inconsistent with the aim of the plan, the individual's abilities and current needs. Some end of life care plans although included the priorities of care lacked person centred care. Daily notes were task focused and included direct care delivered. Where people used repetitive behaviours care plans were not always in place on how staff were to manage these behaviours.

There was an electronic system for medicine administration and audits of medicine systems showed there were persistent issues. The audit reports showed that staff were not signing when cream and lotions were

applied. In the dementia unit we noted a number of people were prescribed with medicines for anxiety. The protocols were not person centred and did not give clear guidance on how people expressed anxiety.

The home was clean well decorated and free from unpleasant smells. We saw housekeeping staff on duty within the home.

The staff we spoke with knew the types of abuse and to report their concerns. They said they had attended safeguarding adults training to help them recognise the signs of abuse and about reporting concerns. People said they mostly felt safe living at the home. The registered manager told us the actions they will take to ensure people felt safe from those that made them feel at risk of harm.

We saw adequate number of staff available to support people with daily needs. People told us the staff responded to their request for support and assistance. They said if staff had time they took the time to have a chat. Relatives said occasionally staffing levels dropped especially at weekends. Some staff told us they felt rushed and expressed that better deployment of staff with equal skills was needed to be on duty.

Where possible people made decisions about their day to day care and relatives said they were consulted. Staff were knowledgeable about the principles of the Mental Capacity Act 2005. Capacity assessments were in place for accommodation, continuous supervision and complex decisions. Deprivation of Liberty Safeguards were applied for where appropriate.

Staff gave positive feedback about the training offered and attended mandatory training which the provider had set. One to one meetings with a line manager had taken place.

People had access to healthcare services as required and dietary requirements were catered for.

People we spoke with and relatives praised the staff for their caring manner. Without exception the people, relatives and professionals we spoke with said they would recommend the home.

We saw some good interactions between people and staff. Staff knew people's preferences and how they wanted their care delivered.

The complaints procedure was on display. There was one complaint from a relative and a satisfactory outcome was reached.

There was continuous learning from accidents. Preventative action was taken to ensure people's safety. For example, in the dementia unit lighting was improved to remove shadows which caused distress that resulted in falls to some people. Since then number of falls have reduced.

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

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 consistently safe

Care plans were not always up to date on how to support people to stay safe.

Staff knew the procedures for safeguarding people from abuse. People mostly felt safe at the home.

Medicines systems had improved but procedures were not always in place for medicines prescribed to be taken as required.

There were sufficient staff on duty to provide people's needs.

Is the service effective?

Good

The service was effective.

Staff had suitable skills and received training to ensure they could meet the needs of the people they cared for.

People's health needs were assessed and they were supported by the staff to stay healthy.

Staff were knowledgeable about people's abilities to consent to their care and treatment and they were supported to make decisions.

Is the service caring?

Good

The service was caring

People gave positive feedback about staff. People told us the staff knew how to care for them in their preferred manner. We saw examples of good interaction between people and staff.

People said staff respected their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

Care plans were not always person centred and did not reflect people's current needs. Documentation was not kept up to date.

There was a programme of group and one to one activities

Complaints were recorded and investigated.

Is the service well-led?

Requires Improvement

The service was not consistently Well Led

Without exception the people, visitors and professionals we spoke with said they would recommend the home.

Audits were in place for all areas of service delivery. Actions plans arising from audits were part of the quality assurance system. There was monitoring from the provider to ensure improvements were taking place

People knew the registered manager. The registered manager and deputy were committed to improving the service. The staff said they worked well together as a team.

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 was unannounced on the 26 September 2018. We returned on the 27 September and 1 October 2018 to complete the inspection.

Before the inspection we reviewed other information, we held about the service including notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us. We also looked at information in the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

The inspection was carried out by two inspectors 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 13 people and six relatives about their views on the quality of the care. We spoke with the registered manager, deputy manager, quality assurance manager, regional Head of Quality and three registered nurses. We also spoke with three care assistants, activity staff, housekeeping staff and chef. Health and social care professionals we spoke with during the inspection included the GP, palliative registered nurse, two district nurses, chiropody and social worker. We looked around the premises and observed care practices for part of the day.

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 three care plans in detail and specific care plans for a further three people. Other documents reviewed during the inspection included training records, staff duty rosters, policies and procedures and quality monitoring documents.

Requires Improvement

Is the service safe?

Our findings

At the inspection in April 2017 we found a breach of Regulation 12. We found that medicines systems were not effective and where risks were identified action plans were not in place on how to minimise the risk. Some risks were not recognised by staff and action taken on how to minimise the risk. The provider submitted an improvement action plan with timescales on how the breach of Regulation 12 was to be met and in parts the action plan was complete.

At this inspection we found arrangements were in place to manage risks. Risks relating to people's care needs had been identified, assessed and reviewed. The deputy manager told us the measures taken to ensure people stayed safe. For example, for people at risk of malnutrition their food and fluid intake was monitored, enriched meals were served and there were referrals to dieticians. For people at risk of pressure damage care plans were devised, there was regular repositioning and equipment was used such as air flow mattresses to promote continuous healing.

The information in the care plans and risk assessments was not easy to refer to quickly due to the size and complexity of the care planning and risk assessment format used. The wording in some care plans and risk assessments was often generalised which did not give staff the detailed information they might need. Guidance was not consistently followed where risk assessment was for staff to assess the improvement or deterioration of health. Monitoring charts were not completed consistently. Fluid monitoring charts did not include people's intake target and there was little evidence of the action taken by staff for people with poor fluid intake. Some repositioning charts were not completed to show staff had followed the action plan to support the person to change position regularly.

Where people were at risk of falls there were a range of assessments to determine the level of risk. We visited one in their bedroom on both days of the inspection. We noted alarm mats on both sides of the bed consistent with the falls risk assessment. This person told us this was because they were at risk of falls if they attempted to "gets out of bed without staff help". We noted the call bell was at hand and was aware of it and knew how to use it. They said, "they always came quickly if I start to get out of bed".

There were people who at time expressed their anxiety, fear and frustration using behaviours which staff found difficult to understand or manage. The guidance to staff on how to manage difficult behaviour was variable. We observed during the inspection one person use repetitive behaviour and records showed the staff were experiencing some difficulties with supporting this person to settle. We noted staff used measures that did not follow the principles of the Mental Capacity Act (2005). We acknowledge the staff had requested input from the GP and palliative care registered nurses. However, a care plan was not in place on how staff were to manage repetitive behaviours.

The psychological care plan for another person in the dementia unit stated they were not able to make decisions and an application was made to the Deprivation of liberty Safeguards (DoLS) for continuous supervision. The care plan stated, "distressed due to the dementia diagnosis" and the staff were given guidance to become aware of this person "preferences". As this person may become distressed the staff

were to divert the person to a quiet environment with familiar items. Behaviour charts were to be completed for episodes of [difficult behaviours] as a means of "reflection to identify changes and to update the care plan". The staff had recorded in the monthly monitoring reports that they had observed this person to be "distressed, angry and with paranoid behaviours". The staff had documented in September 2018 that referrals were made to the mental health team for support but these behaviours had been occurring since July 2018. The evaluation notes had not been used to update the care plan devised in June 2018 and guidance was not made clear on the person's preferences, the familiar items to be made available and how to divert the person.

For one person in the residential unit the care plan contained details on how the person presented and the effects their behaviour had on others. It provided staff with guidance about distractions techniques to use when the person presented with behaviours that were difficult to manage. During the inspection we saw that staff were very responsive when this person presented with difficult behaviours. However, for two other people the care plans lacked guidance.

Medicines systems had improved but procedures were not in place for all medicines prescribed to be administered when required (PRN). We noted that for one person the staff had administered multiple options of pain relief as well as medicines for insomnia and anxiety at the same time. However, protocols were not in place for PRN anxiety or insomnia medicines and for pain relief protocols stated, "for general pain". The protocols for multiple options of prescribed pain relief were not clear on the order these medicines were to be administered. We spoke to the GP and palliative nurse who advised the staff on the medicines to be administered to assist this person to develop sleeping patterns. There was some confusion on the order anti-anxiety and medicine for insomnia were to be administered. The registered manager following our feedback requested a review of this person's medicines.

In the dementia unit there were six people prescribed with the same medicines to reduce anxiety. For example, lorazepam. The protocols for the six people stated for "aggressive or agitated behaviour if cannot be calmed by other means" or "if agitation cannot be calmed by talking and reassurance". The PRN protocols were not person centred or gave clear guidance on how each person presented with "aggressive or agitated" behaviours.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records detailed known allergies to medicines and for some people medicine care plans were reviewed regularly and changes added, for example when the consultant or GP had changed a medicine or a dose.

An electronic medicine system was recently introduced to reduce the potential of medicine errors. A registered nurse explained the system. "Each person has a photograph and when in colour it alerts staff that medicines were due. For example, PRN medicines were in brown and turned grey once administered." They told us the benefits of the system included "tells us what is due and how much to give. It's time controlled and monitors stock. The reason for administering PRN medicines must be documented."

Although people told us they felt safe living at the home they raised concern about other people in the home that entered their bedrooms. They told us two people at the home did not always made them feel safe. One person told us "I suppose so. Twice yesterday I had people wandering in- usually when the door is left open." The registered manager told us two people that entered other people's bedrooms were assigned one to one staff. The registered manager told us a review of placement was to take place for two people to ensure the safety of others at the service.

The staff we spoke with showed understanding of safeguarding procedures and their responsibilities. They all confirmed their safeguarding e-learning was up to date. One explained that the electronic system alerts them and the manager when updates are due.

The staffing levels were adequate to meet the day to day living needs of people. The registered manager said the home was operating above the home's dependency ratio assessment. e staff we spoke with explained that there was little time to support people above meeting their basic needs. Comments from staff included "we need another [member of staff] on this floor – there isn't enough time for quality time." "The morning meds take about 90 mins and medicines starts at 8am so [this staff] is not helping with other things. Two staff [were left] to get people ready for the day." "There is a lot of paper work and forms. It's so busy. We are doing the bare minimum with the time available." The registered manager told us there was additional staff rostered for administrative tasks.

One person told us "Staff are well trained, caring and kind to me. They appear to be interested in me as a person but don't always have time to chat if they are busy". The comments from the relatives we spoke about staffing levels included "I feel staffing levels are adequate." "There are not enough staff. Saturday and Sunday are the worst. They are run off their feet." "The staffing is as good as it can be."

The registered manager told us a dependency tool was used to assess staffing levels and the home was operating above the minimum. They said the allocation across units was for 12 staff in the morning including one registered nurse and two seniors. In the afternoon the allocation was for one registered nurse, two seniors and seven caring staff. At night there was one nurse, one senior and six caring staff awake in the premises

Good

Is the service effective?

Our findings

At the inspection in April 2017 we found a breach of Regulation 11. We found that 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. The provider submitted an improvement action plan with timescales on how the breach of Regulation 11 was to be met and the action plan was complete.

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.

We observed staff asking people to agree and consent before care or assistance was given. For example, staff used phrases such as: - "would you like me to…?" "is it alright if….?" "where would you like to sit?". Staff took time to talk to people and explain what they were going to do, why they were doing it and what the outcome was likely to be.

Mental capacity assessments were in place for personal care, flu vaccines, for staff to administer medicines and to share information. The registered manager maintained a record of "trusted people" that held lasting power of attorney (LPA) on behalf of the person living at the home. Detailed within this document were the types of orders in place and if there was evidence of LPA. For example, finance or care and welfare. A relative told us their family member had made advance decisions giving them access to all records including medical information. This relative told us they had enduring power of attorney which was superseded by lasting power of attorney (LPA).

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). The registered manager maintained a record of DoLS applications for continuous supervision and for restrictions to leave the property. Within the records were details of approved orders, where there were DoLS conditions and outstanding application in progress.

The staff received training to develop their skills and were supported to deliver effective care to people they support. The staff we spoke with confirmed they received training and told us they were up to date with mandatory training. The topics they listed included fire, moving and handling, safeguarding, Mental Capacity (2005) and Deprivation of Liberty Safeguards. Staff said they mainly did e-learning and would prefer more face to face training at the home. The relatives we spoke with said the staff "were well trained, capable and confident to look after them or their loved ones".

There was one to one supervision with the line manager. The deputy manager told us group supervision had

occurred with registered nurses and seniors to discuss medicine and handovers. This deputy told us one to one supervision had occurred with staff during their induction and with night staff. Some staff told us their one to one supervision was based on day to day tasks, support needed with their role and training needs. Some staff said the deputy manager was recently appointed and supervisions had lapsed while the post was vacant.

People were supported to maintain a healthy diet. People living at Brunel House were asked to choose what they wanted to eat at mealtimes by means of a verbal description or shown two plates with the meal choices. A written daily menu was displayed outside the main dining rooms and menus were on the tables.

When people were referred to the home for admission their care was coordinated between services. The registered manager or deputy manager carried out assessments of need before an admission to the home took place. We saw copies of one person's discharge summaries from the hospital and pre-admission assessments. The pre-admission assessment for one person detailed the medical history, priorities of care and the staff needed to assist with personal care.

The comments from people we spoke with included "The food is good on the whole- there is always an alternative." "There is a good variety and choice and always enough to drink". "I'm a good cook myself- the vegetable soup the other day was superb. Drinks are plentiful"

The chef told us the menus were on a four-week rolling cycle. The chef said menus were devised from information gathered from people about food preferences during their admission to the home. The chef told us feedback from people about meals was sought during their visits to the units and at a recent relative's meeting menus were discussed. There were people that preferred vegetarian meals and all meals served were enriched. The chef said enriched diets were served because people at the home were mainly underweight. Where people were served with pureed meals the catering staff were provided with guidance on the texture of meals from Speech and Language Therapists (SaLT). The chef said this ensured they catered for all dietary requirements.

People were supported with their ongoing healthcare. People had regular visits from their GP, and allied healthcare support such as such as opticians and dentist, district nurses, GP's The relationship between the external professionals and staff was relaxed and we observed good communication between them. There were detailed GP and other professionals visit notes for each intervention in this daily notes and detailed print outs from the practice of the notes made by the GP in the practice records.

We observed notices on the doors to stairs and in lifts asking visitors to make sure people they didn't know did not leave the home with them.

All areas were clean, hygienic and odour free. People and visitors told us "It is very clean here and there are no unpleasant smells." We observed housekeeping staff on duty throughout our two days visits. We saw cleaning regimes were taking place and where floors were wet warning signs were prominently displayed.

Communal spaces were all well maintained, spacious and uncluttered which gave an air of calm and comfort. There were several different spaces on each floor for people with a variety of comfortable seating. Corridors were decorated in a neutral fashion on all floors using beiges and dark coloured wallpaper. Handrails were wooden as were the bedroom doors and the floors were washable brown wood effect flooring. This gave a lack of contrast between different areas.

Signage was good on toilets and bathrooms but there was a lack of general dementia friendly signage

throughout the building. Lighting created shadows at the edges of the corridors and in corners. There were displays of photos, sporting memorabilia in cases and tactile displays. Bedroom doors were personalised with a number, door knocker, letter box plus the name and photo of the person.

Good

Is the service caring?

Our findings

We observed throughout both days of the inspection good interaction between staff and people. All the staff used a calm manner and were polite, friendly and attentive to people. Staff used people's preferred names when they engaged in conversation. We saw that staff often touched people when speaking with them for example staff at times placed their hand on the person's arm or shoulder. We saw staff crouch down to speak to people at eye level. We observed a member of staff apologise to one person when they did not respond immediately to a request for assistance. The member of staff said, "I am sorry, I was waiting for another member of staff to help me."

Comments from people included "Staff are very good, very caring. I'm very impressed by the staff here. They don't mind doing things. My friends found this Home for me and they are very impressed too." "Staff are very friendly, nice and helpful. If I need something they will come." "They chat with me while I'm having personal care. During the day not so much".

Comments received from relatives included "They are very polite and friendly," "[family member] admitted for palliative care and has done marvellously well" "No matter how pushed they always do it with a smile- they're brilliant here" and "They are always welcoming – they are like family- they always tell you if she's not well.

The staff we spoke with were able to tell us people's likes and dislikes, family background and personal history. A member of staff said they always made eye contact with people which "people will know I am approachable". This member of staff said once staff create a bond with people they become familiar and people living with dementia were more likely to approach staff.

A member of staff in the dementia unit explained how sundowning (people with dementia may become more confused and agitated in the late morning or early evening) was managed. This member of staff said "Sundowning is difficult and affects the same people each day". Staff offer one to one time to people affected by sundowning, staff suggest a quite space for people to sit and offer refreshments as they may be thirsty. This member of staff said that "sometimes we are short staff and is difficult during sundowning. There are two people that target each other and it's difficult to manage these situations. One to one activities with people is needed during sundowning." The staff use "vapourisers", ensure the unit is tidy and calmer music is played. One person likes outdoors and during sundowning we make sure he is sitting in a position where he can see the garden." Documentary DVDs where presenters have a calming voice were played on the television during these periods. During the inspection we noted that at 5pm a documentary about the "blue planet" was on the television and the presenter had a soft and calming tone to their voice.

The deputy manager told us they had been in post for six weeks and during this period the staff's approach to people was observed. For example, there was warmth from staff towards people they offer comfort and reassurance. This deputy manager said "The first thing they [staff] think of is people. Staffing levels are adapted to ensure people have the right support." There were compliments from relatives about the caring approach from staff.

The registered manager told us how they ensured the staff were caring. This registered manager said it's about systems and culture, "we share respect and care for each other's dignity and respect which are the values of the organisation. At interview we look at what people are bringing. It's about their approach, their response and what [they]want to see for yourself. It's about showing care as well as looking after the well-being of the staff. For example, during supervision we ask staff how they find things and we put in place the support needed. Developing practice towards personalisation." The registered manager said "we walk around auditing practice and we are responsive and act on what people say. If staff are not caring we need to know about that too."

People told us the staff "treat me with respect and dignity". During the inspection we saw staff knock on bedroom doors before entering. We saw housekeeping staff knock on bedroom doors and wait for an invitation to enter bedrooms. A male carer told us "Some people don't like me doing their care as a man. That's ok and we work around that and I help others instead". Another member of staff said "people's dignity is respected. [We] give people choices and the recording information is in a respectful manner." We observed staff manage an incident in a communal area where one person needed support to ensure they were appropriately dressed. The staff were discreet and preserved the person's dignity.

Requires Improvement

Is the service responsive?

Our findings

At the inspection in April 2017 we found a breach of Regulation 9. 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. The provider submitted an improvement action plan with timescales on how the breach of Regulation 9 was to be met and the action plan was partially complete.

At this inspection we found care plans had some aspects of person centred care and for some people a care plan was not developed on how their emotional care needs were to be met. They were difficult to navigate and the same area of need was duplicated in places. There was a wide range of information in care plans and some was confusing and difficult to follow. Some records were not completed daily by the staff as stated in the care plan. The deputy manager told us that since their appointment there had been a "massive improvement" in care plans. They were ensuring personalised information was detailed in the care plan and training has been organised. The deputy manager agreed that some care plans were detailed and there was a lot of information and stated "a lot of support and guidance is needed [in the care plans]. The quantity sometimes overrides the quality. There is a lot of information not needed."

A member of staff said "It's so busy with delivering end of life care, administering time sensitive medicines and some clinical procedures. We are doing the bare minimum with the time available. We are doing [care plans] as quick as we can. It doesn't feel we are doing a good job. You know it's not good enough." Another member of staff told us care plans were used for reference. This member of staff said "writing of the care plan is the seniors but they don't have the time. We need training as care assistants need to have input into the care plan. Some care assistants have strengths in some areas and this needs to be looked at when care plans need updating." The registered manager said the staff were given administrative time to update care plans. They accepted the comments made by care staff about having input into the care planning process.

Some care plans were inconsistent with the aim of the care plan, the individual's abilities and current needs. The skin integrity care plan for one person stated, "mobilises independently and can alter position" and there were continence needs. However. The care plan was not updated when there was skin damage was noted. On the 19.12.2017 staff wrote that skin integrity was intact and remains able to make independent adjustments. Due to reduced mobility, continence needs and health condition now at risk of skin breakdown. Profiling bed and air flow mattress in place. The evaluation on 1/08/2018 says skin remains intact and staff to report change but on the 12/09/2018 a moisture lesion on sacrum was noted. The GP prescribed topical cream and wound treatment plans were developed.

The pain management plan for the same person dated 20/12/17 states this person does not present with pain and was able to express any discomfort or pain. On the 12/09 2018 the staff documented in the evaluation notes that codeine and paracetamol was prescribed and the person was able to request pain relief. The care plan was not updated when pain relief was prescribed.

Me and My life were in place for some people and for others the information was incomplete. Daily notes in

the nursing unit lacked person centred approach and were based on clinical care delivered. The registered manager said care assistants also documented people's daily living and these were more person centred. However, these daily notes were task focused about the direct care provided. For example, for one person the staff wrote "assisted with washing and dressing, taken to dining room for breakfast. [Name of person] had a settled day in her room. She ate and drank well."

Communication care plans that ensure people were given information in a way they can understand were in place. However, the communication care plan for one person did not reflect the diagnosis of a medical condition that impairs language or reflect the guidance from the Speech and Language therapist (SaLT). For example, the care plan detailed the behaviours the person will present with if attention was not given promptly. We saw copies of the SaLT visit which included guidance such as using a communication book and developing a "cues" and "sound" record for when the person was unable to find the words to express themselves. The member of staff we spoke with said care assistants know her well and would work out what she wants. Regarding agency staff being able to communicate with this person the member of staff said they "will ask."

There were people receiving supported at the end of their life. A palliative nurse told us "the staff value having outside support and follow guidance. The staff access the hospice support early and they provide "support when dealing with challenging situations". The end of life plan for one person was descriptive on the arrangements for their death. For example, having a priest and family present. It highlighted that a treatment escalation plan (TEP) was in place. The priorities of care were detailed for another person on an end of life pathway. The plan lacked person-centred information on how the person wanted their care to be delivered.

Personal hygiene care plan dated 19.12.2017for one person included some aspects of person centred care. Staff had documented that this person was able to make decisions on preferences regarding bathing options. The number of staff needed for personal care, the preference of staff's gender and that there were no specific preferences on toiletries. make decisions about bath shower or bed bath.

A programme of activities was in place which included one to one sessions, community contact and to join entertainment from external entertainers. The full monthly activity programme was on display on all floors and in bedrooms. Morning and afternoon sessions were held on different floors of Brunel House and support to go between floors was provided by the activity staff.
Currently two activity coordinators were working at the home and one was recently appointed which meant that weekend activities would be covered by them rather than relying on caring staff. Activities staff were visible and we observed people being encouraged to join in. These staff also told us that with more staff they hope to make better use of the Mini bus and take people out on trips more.

Comments made by people about activities included "I used to go in the garden when the weather was nice for tea and cake". "I went downstairs to music yesterday." "I mainly enjoy the activities. They are not always my cup of tea." "I like the music and the Bingo. I don't get out on a regular basis. I keep asking but they keep putting me off. I would like a regular day out – to go shopping or to the bank." "I prefer to sit in my room or in the garden. I'm not a "joiner-inner. My daughter takes me out for a meal sometimes."

The complaints procedure was on display. There was one complaint from a relative and a satisfactory outcome was reached. A registered nurse on the dementia unit told us feedback from relatives was valued. This member of staff told us relatives were told "Please don't leave the building without addressing any problems or worries you may have. We can talk to relatives and explain why things are like this- we don't want them leaving us feeling worried or stressed or guilty."

Requires Improvement

Is the service well-led?

Our findings

The staff knew the values of the organisation and how their practice ensured these values were embedded. A member of staff said the vision was to be the "best care provider and to provide the highest quality of care." They said staff ensured "people were at the centre of what we do. We work in people's homes and we ensure we promote independence and respected. Everything is at the heart and nothing is too much for people."

Staff said they were valued by the registered manager. The new management team that included the registered manager, deputy and seniors were enthusiastic and committed to team working to improve the service. Comments from staff included "Management here is good – the door is always open. They ask how we are". "It is caring here – there is no back stabbing. We thank each other for a good shift". "[The registered manager and deputy] are approachable". "While we were without a manager it felt like we were set adrift but since [registered manager] came its better. It's settling down".

Although staff said the team worked well together and senior managers were approachable a member of staff told us "We all do get along. No issues I feel comfortable here (dementia unit) but I feel that everyday the staff on duty must be of the same strength". This member of staff said with all staff having the same level of skills continuity of care was delivered. Staff then became familiar to people and difficult behaviours were consistently managed.

The registered manager said their management style was "open visible and approachable. There is no silly question and staff feel able to raise concerns. I am fair, I will take action where is needed and have taken action." This registered manager also told us "I am caring and show they [staff and people] matter to me. I engage with new research and use the knowledge to develop the service."

The registered manager said the challenges related to consistent improvements and no to be "consistent improvement and no to be complacent". They said to maintain improvements there was to be more opportunities for progression "looking at strengths and how we can utilise the [staff's] skills to develop practice." There was to be a care practitioner role and champion leads were to be introduced.

Quality assurance systems were in place. There were monthly visits on behalf of the provider to monitor service delivery. We saw copies of visits from the quality manager in September 2018. The visit report included an assessment of specific areas previously identified for improvement. For example, risk management, the regulatory response to breaches from the last inspection and outcomes from commissioner's visits. An improvement plan was then developed from these visits with target dates for completion.

At the HR visit staffing records were reviewed which included areas for improvement. For example, training was not at 100% because two staff had not completed all training set as mandatory. Training booked in Oct and Nov for documentation and legal responsibility for all staff.

Each month the registered manager undertook specific audits for areas of service delivery. Some audits such as sample checks of care plans, equipment and medicines were monthly. For example, clinical audits were monthly and related to areas of risk such as pressure areas, weight and falls. The audits for August 2018 included, a sample audit of care plans, reviewing the business contingency plans, the presentation of the home (décor and maintenance), meals served and equipment such as mattress and seating cushions. In the September 2018 audit a "pass" was given for all equipment checks.

An improvement plan was in place for care plans. The target date to improve report writing was 30/10/2018. The registered manager told us there was to be training to staff in report writing. During the inspection we found care plans were not person centred and daily notes were tasked focussed. We noted that commissioners during their visits also identified that daily reports were task focussed and were not person centred. The registered manager said they were aware that not all care plans were updated due to priorities and some staff were given additional hours to update care plans.

A requires improvement rating was given for the medicine stock audit. An action plans was devised where shortfalls were identified. The action plan detailed the staff responsible for improvements and the target date for completion. For example, some topical creams did not have directions and topical medication records (TMR) were not signed. The medicines improvement plan showed some shortfalls were outstanding from the previous audit. For example, TMR not completed following an application. Staff not recording when people had thickened liquids which we also noted during this inspection. The target date for completion was 30/09/2018. However, medicine audits had not identified that protocols for when required medicines were missing for some medicines and for others lacked detail.

Staff received feedback from managers in a constructive way, which enabled them to know what action they need to take. A general staff meeting took place in February 2018 and changes in polices were shared, staffing issues and quality were discussed. Staff meeting on 20.6.2018 included medicines and reflection. A meeting with the night staff was on 16/08/2018 and completion of accident and incident report writing was discussed.

The registered manager said there was learning from accidents and incidents. For example, the nursing station in the dementia unit was removed and lighting improved when it was identified that falls were occurring in this area. When one person developed pressure sores from not accepting of repositioning there was reflection on how staff engage with people. The registered manager said "If we sing and dance and make the task enjoyable then the person will be more accepting of care. Staff need to introduce themselves and make people aware that personal care is more than a task".

The feedback we received from relative's health and social care professional was positive. The relatives and professionals told us they would recommend the home. A relative told us "there is a nice feel and the staff are pleasant. Staff always greet relatives and are helpful. I am happy he is here". Thank you cards for staff were on display throughout Brunel House – as wall displays on the three floors and in reception. A social care professional told us there was good working relationships with the registered manager and staff. They said, "people are treated with respect and people can be placed for life" as the service provided residential, nursing and dementia care.

There was partnership working with social and health care professionals. The registered manager said there were weekly visits form the community matron, twice weekly GP visits twice and input from the care home Liaison team. Consultant psychiatrist visits and there was good at communication about the care delivery. Oral health was to be improved with input from a local dental practice.

The registered manager was taking steps for people to be better known in the community. For example, summer fetes, toddler and scout group visits. Steps were being taken to maintain the links people had with the local community prior to their admission. The registered manager said, "It's important not to sit alone in the community it's also about giving back and building relationships." A "Sing and smile" group was funded by the organisation and held in the local church. There were visits from the Women's Institute (WI) to assess the clubs that people can join. For example, church group, luncheon groups.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not always up to date or accurate.