Care Quality Commission

Mr T & Mrs C Murphy

Bronte

Inspection report

Lower Lane
Ebford
Exeter
EX3 0QT
Tel: 01392 875670
Website:www.bronte-devon.com

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

Bronte is registered to provide accommodation with personal care for up to 20 older people who require accommodation and personal care. On the day of our inspection there were 18 people living there. The inspection took place on 19 June 2015. The visit was unannounced and was carried out by two inspectors

At our last inspection of the service on 24 June 2014 we found they were not compliant with record keeping. We asked them to provide us with an action plan showing how they planned to address the issues we found. After our inspection the provider sent us information telling us they planned to update all care plans to incorporate risk assessments including moving and transferring, falls, skin care and nutrition and associated recording forms. They told us they were in the process of completing this, although they did not give a timescales to say when it would be completed by.

The providers are a husband and wife team. One of the providers is the registered manager of the service and the other provider regularly manages the service and is referred to in this report as the duty manager. A registered manager is a person who has registered with the Care

Summary of findings

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.

People who lived at Bronte were not safe. Prior to the inspection the local authority safeguarding team shared concerns with us about the quality of care people were receiving. During this inspection we identified areas of concern that showed people were not receiving a safe level of care.

There were insufficient staff employed to meet people's needs. The providers had experienced difficulty recruiting new staff and this had resulted in some staff working long hours to cover vacant shifts. Staff recruitment records showed safe recruitment procedures were followed before new staff commenced work in the home. The provider told us all new staff received induction training at the beginning of their employment. However, they were unable to provide evidence of this during our inspection. Some of the care practices we observed showed staff were not following current accepted good practice. Training on some topics had been provided to staff but there was no method of identifying individual training needs, or planning the future training needs for the whole staff team. This meant some staff may not have the skills or knowledge to help them support people effectively.

Care plans did not provide accurate or up-to-date information about each person's needs. Some care plans provided only brief details about the support each person needed, and two people who had been admitted in recent months did not have a care plan in place that identified their care needs. Risks to people's health and welfare, for example pressure wound prevention and care, malnutrition, dehydration, falls and moving and handling, had not been fully assessed. Where risks had been identified these had not been regularly reviewed, and staff had not been given sufficient information about the care they should provide to reduce or address each risk. People had not been involved or consulted in drawing up or reviewing their care needs.

There was a risk medical appointments may be missed because the systems for recording and planning medical appointments were not fully effective. Where people required staff to accompany them to medical appointments this had not always been planned effectively.

There was a lack of awareness by the managers and staff of recent changes in legislation and good practice guidance. Some staff had recently attended training on the Mental Capacity Act 2005 (MCA) but this had not been attended by the registered manager. Some people living at Bronte may have their liberty restricted. One Deprivation of Liberty Safeguards (DOLS) application had been submitted by the registered manager after advice from the local safeguarding team. However, the registered manager had not considered the need to apply for other people whose liberty may have been restricted. The duty manager was also unaware of the need to notify the Commission of serious accidents or incidents, or of any deaths that may have occurred.

Medicines were not managed safely. Staff had not received adequate training on safe administration of medicines. We saw medications were left with people in pill pots at lunch and not observed while they took the medications. There were no systems in place to check stock levels or audit medicine administration processes on a regular basis.

People were not offered an adequate choice or variety of food at mealtimes. Staff told us they knew what foods people liked or disliked, but we observed staff giving people food at lunchtime without explaining what foods were being offered, or giving any choice of alternatives.

Two people required assistance from staff to help them eat their meals. We saw one member of staff assisting two people at the same time, and this meant they were unable to give each person sufficient attention, or check they were able to eat their food safely or comfortably.

Staff provided care to people in a calm and efficient manner, but often failed to ask people if they wanted assistance, or explain how this would be provided. This meant that staff did not always demonstrate a caring approach.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Summary of findings

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not fully protected from abuse or avoidable harm. There was a risk staff may not recognise potential abuse.

There was a risk people may not receive appropriate medical attention promptly when needed.

Medicines were not always administered safely.

There were insufficient numbers of suitably trained staff to meet people's needs safely.

Risks to people's health or safety had not been identified or managed in ways that ensure people were safe or their needs were met.

The security of the home was not fully effective.

Is the service effective?

Requires Improvement

The service was not effective.

Staff had not received adequate training, supervision or support to ensure they had the knowledge and skills to provide effective and safe care to the people living at Bronte.

The service did not act in line with current legislation and guidance where people lacked the mental capacity to consent to aspects of their care or treatment. People were at risk of their liberty being restricted without appropriate legal authorisation being granted.

Is the service caring?

Requires Improvement

The service was not caring.

People were not always treated with kindness, dignity or respect. Staff were not always able to communicate fully with people.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's care was not person-centred. People had not been fully consulted or involved in planning and reviewing their care. Care plans did not provide sufficient information to staff about each person's care needs, their preferences, or any risks to their health and welfare.

People were consulted and involved in making decisions about daily life in the home through regular resident's meetings. However, opportunities for people to participate in social activities to suit their individual interests were limited.

Summary of findings

Information was not always stored in a way that ensured confidentiality.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager had failed to evaluate or improve their practice to ensure the quality of all aspects of the service were continuously improved.

Systems to assess, monitor and improve the quality of the service were not fully effective.

Records were poorly managed and not fit for purpose.

People who lived in the home and their relatives and other representatives were asked to give their views on the home through residents meetings and annual surveys

Bronte

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.'

The inspection took place on 19 June 2015. The inspection visits was unannounced and was carried out by two inspectors.

Before the inspection we looked at the information we had received on the service since the last inspection. We had received three separate concerns about the home from the local safeguarding team. These had been raised by health and social care professionals who had visited the home. We also checked our records and found we had received no notifications of deaths, incidents or accidents.

During our inspection we spoke with eight people who lived at Bronte, one relative, a community nurse and a professional activities organiser who were visiting the home that day. We also spoke with the duty manager.

We looked around home, checked medicines storage and administration, we looked at records relating to the recruitment, supervision and training of staff.

Inadequate

Is the service safe?

Our findings

There were insufficient staff to meet people's needs. Staff did not always provide care or support in a timely way, for example when helping people get up, assisting people with meals, or providing social support or activities.

On the day of our visit there were 18 people living at Bronte. When we arrived at 9.30am there were three staff on duty plus the duty manager. The staff rota showed two care staff were on duty from 7.30am to 9.30am and then a third care staff began working at 9.30am. No cleaning staff were employed and therefore care staff carried cleaning and laundry duties in addition to care tasks. A cook was employed five days per week. On the days the cook was not working care staff were also responsible for preparing and serving meals.

On the day of our visit two care staff prepared and served breakfast and early morning drinks to people in their rooms and then began assisting people with getting up, personal care and dressing. Most people were still in their rooms until late morning. After the inspection the registered manager told us many people remained in their rooms by choice in the morning. They also told us many people did not require assistance to help them dress. When care staff had finished helping people with their personal care needs they then went on to carry out cleaning and cooking duties. This meant staff were focussed on carrying out personal care tasks but had insufficient time to meet people's social needs for example through giving people time to chat, or by offering suitable activities.

The staff rotas showed some staff worked very long shifts, for example, from 9am to 9pm, and then a sleeping-in shift overnight and then worked from 7.30am until 1.15pm. After the inspection the registered manager told us some staff had chosen to work long shifts. The low numbers of staff employed meant that there were insufficient staff to cover if staff were unexpectedly on leave for any reason, for example sickness. Agency staff were not used to cover vacant shifts. Staff told us that they could do with an additional one or two carers on each shift. The duty manager confirmed they were short staffed and said they had unfilled vacancies. They said recent recruitment efforts had been unsuccessful and had not resulted in any appointments for the vacant posts. After the inspection the registered manager told us they had re-advertised have re-advertised two positions.

A health professional said on some days when they visited they there had not been enough staff. They had noticed that staff were particularly rushed in the mornings between 8 am and 9.30am when there were only two staff on duty.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

At our last inspection of the home on 24 June 2014 we found there was a lack of guidance in people's care plans relating to risks such as safe moving and handling procedures, skin care or malnutrition and weight loss. This meant people's care and support may not always be delivered consistently in a way that ensured their safety and welfare. During this inspection we found the records had not been improved and people continued to be at risk of harm from inconsistent or lack of care.

Before our inspection we received a concern from a health professional that some people were unable to reach a drink easily and appeared thirsty when given fluids. During our inspection we found these concerns had not been fully addressed and there was a risk that some people may suffer dehydration

We looked at the procedures for recording medical appointments and making sure people attended medical appointments. The duty manager said medical appointments should be recorded in the communication diary, but when we checked the diary some appointments had not always been recorded. Where appointments were recorded there was no information to show how people were expected to attend the appointment, for example transport arrangements or staffing arrangements if they needed a member of staff to accompany them. There was no information to show if staff were required to assist the person to get up and dressed earlier than their usual time. Where additional staff may be required to accompany people to appointments this was not planned in the diary. One person told us they thought the home would organise a member of staff to accompany people to hospital and other appointments if necessary.

The duty manager told us that following a recent incident when staff failed to seek medical attention promptly, all staff had been given instructions on when to seek medical

Is the service safe?

attention and she was confident that medical attention will be sought promptly in future. We spoke with a community nurse who told us they were confident the staff usually sought treatment and advice promptly.

Risks to people's health or safety had not been fully assessed or regularly reviewed. This meant there was a risk people may not receive safe care that prevented potential risks to their health and safety escalating. Most care files contained a 'tick box' risk assessment which listed some generic risks. Where ticks identified there may be a potential risk this had not been followed up by completing detailed risk assessments. For example, risk assessments had not been used to help staff identify the level of risk of people had of developing pressure sores, or to help them review the risks on a regular basis. Some people had pressure relieving mattresses and cushions in place but there was no information in their care plans to explain the use of the equipment, or any other measures necessary to reduce the risk of skin damage.

Daily reports completed by staff for one person showed an external professional from the older person's mental health team had been involved in carrying out an assessment. However there was no reference to this assessment in the person's care plan nor did we see what the outcome of the assessment was or what actions were being taken as a result of the assessment. The records did not explain why the assessment had been needed.

Daily reports by care staff included references to visits by doctors. It was difficult to see which were comments by a GP and which were written by care staff. This meant that any advice or instructions by the GP could easily be overlooked.

There were no risk assessments to identify those people who may be at risk of constipation. Incomplete records had been completed by staff showing when each person had a bowel movement. Where records showed people may not have had a bowel movement for several days there was no evidence to show staff had checked the records, identified a potential risk, or taken any action to address it. The care plans did not give any information to staff about those people who may be prone to constipation, or any actions necessary to prevent this for example seeking medical advice, or the use of prescribed medications.

One person's daily reports mentioned that the person needed assistance to eat. However, there was no mention of this on their care plan. The records did not provide evidence of assessments carried out by relevant professionals such as speech and language therapists (known as SALT). However the person's relative told us that they believed that the home had taken advice regarding their family member's diet.

Another file contained a risk assessment regarding a person's mobility. This document concluded that the person was at medium risk. It referred the reader to the care plan, but the only information in the care plan was that two staff were needed to hoist the person. There was no further information, for example the type of hoisting equipment to use, the slings to use, or how staff should position themselves and support the person during the hoisting procedure. There was no further information on how to assist the person to move during specific tasks such as from the bed to a chair.

There was a risk people may suffer weight loss without any actions taken to identify the cause or consider any care or treatment necessary to prevent further weight loss or associated illness. People had been weighed regularly and their weights had been recorded, but no actions had been taken to review the information on a regular basis. For example one person had lost 6 kilos in weight since February 2015. There was no evidence to show the information had been reviewed or that any actions had been taken as a result.

Medicines were not always managed safely. At lunch time we observed the duty manager administering the lunch time medicines. We saw that some tablet medicines were left in a medication beaker by people's plate for them to take when they had finished eating. Although the duty manager did not observe the medicines being swallowed the medicine administration record was initialled to indicate the person had taken the medicine. Some people were supported to eat and their supporter helped them to take their medicine but for other people they had to remember for themselves. This was not safe as someone else could have taken the tablets from them. It was also unsafe because the records could not be relied upon as an accurate record of medicines swallowed.

A record of each medicine administered had been completed accurately and there were no unexplained gaps in the medicines administration records (MAR). However, amounts of medicines received into the home, for example when new people moved into the home, had not been

counted or recorded. There were no checks carried out on stock levels at the end of each four-weekly administration period for those medicines not supplied in four weekly blister packs. Balances were not checked against records of medicines administered. This meant there were no systems to check that all medicines had been administered safely.

Medicines were stored securely. Most medicines were stored in a trolley that was locked and secured when not in use. Controlled drugs were stored in a secure cabinet.

There was a risk people may not have creams applied as prescribed. Daily records completed by care staff referred to creams and lotions applied. However, this was not clearly explained in people's care plans. There was no description of what cream needed applying, where it should be applied, or how often. Some care plans contained body charts that explained where wounds or skin conditions were sited. There was no evidence that skin conditions were monitored or reviewed to check that treatments were effective, or consider if further medical attention was necessary.

People were able to administer their own medicines if they wished. However, risk assessments had not been carried out to show how they had reached agreement on safe procedures for the storage and administration of each medicine. At lunchtime one person held their own medicines that had been placed into a weekly 'dosset' box. We asked the duty manager about this. They explained that the person wanted to administer some of their own medications and how they had supported the person to do this. There were no records to show the procedures that had been agreed.

The security of the home was not fully effective. During our visit the front door was kept locked. Visitors rang the bell to gain admission. However doors opening from the sun lounge were opened due to the heat in the room. There was a risk people may leave or enter through these or other doors unnoticed. For some people with dementia type illnesses this may place them at risk of leaving the home and staff not aware they were missing. It also meant the people were at risk of uninvited intruders.

There was a risk people may not receive adequate support in an emergency. Personal emergency evacuation plans (knows as PEEPS) had not been drawn up to show the support each person needed in an emergency such as a fire.

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

Systems had not been effectively established to protect people from the risk of abuse or improper treatment. Staff had not received adequate training or information to enable them to recognise potential abuse or know how to report suspected abuse. The manager told us some staff had recently received training on safeguarding adults but not all staff had been able to attend the training session. They planned to hold another training session on safeguarding later in the year. The names of staff who attended the training and those who had not yet received the training had not been recorded, therefore there was a risk some staff may not receive training or information on how to protect people from abuse. One member of staff told us they had not received information or training on safeguarding at the start of their employment. We asked them what they would do if they were concerned about possible abuse and they said they would tell the duty manager.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

We looked at the recruitment files of five staff including three staff who had been recruited since 2013. The files showed there were effective recruitment and selection processes which meant the risks of abuse to people were reduced. Checks and references had been obtained to make sure new staff were safe to work with vulnerable adults.

Some people who lived in the home and relatives we spoke with told us they thought people were safe. Comments included, "Mother is safe here, yes.

Requires Improvement

Is the service effective?

Our findings

There was a risk people's needs may not be fully met because training had not been effectively planned or provided to ensure all staff were competent in all aspects of people's needs. During our inspection we saw examples of poor practice indicating staff had not received adequate training. For example, we saw staff providing care without seeking consent first or explaining what they were about to do. We also saw a member of staff assisting two people with their lunch in an undignified and uncaring manner. Through our discussions with staff we were assured that they cared about people and wanted to provide good care, but a lack of training meant they were unable to recognise poor practice or the importance of treating people with dignity and respect.

Seven care staff were employed. The duty manager told us four staff held a relevant qualification in health and social care. Some overseas staff had achieved qualifications in other countries. Three care staff held no relevant qualifications. There was incomplete evidence of training provided to each member of staff. Some certificates of training were displayed in the entrance hall. However, there were no other records of staff training or ways of checking which staff had attended each training session. The duty manager told us she had recently realised staff had not received training or updates on essential topics and therefore she had booked some training sessions with a professional training organisation on a monthly basis for the forthcoming year. Some staff told us they had learnt how to do their jobs by observing other staff. This meant where staff had observed poor practice they had copied and continued the poor practice without questioning or challenging it.

The day before this inspection some staff received a training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS). However, not all staff had attended the session. The names of staff who had attended had not been recorded and there was no system in place to make sure the staff who had missed the training would receive this at a later date. The duty manager did not attend the training as she provided care to enable other staff to attend the training. Future training sessions planned for 2015 included dementia awareness, safeguarding adults, emergency first aid, equality and diversity and moving and handling. There were no records of training on other topics relevant to people's needs such as medicine administration, infection control or food safety.

We asked the duty manager for evidence of induction training records but she was unable to provide these during the inspection. After the inspection the registered manager told us all new staff had received induction training that met nationally recognised standards. However, we did not see evidence to support this. Some staff we spoke with told us they had received no training since they started working in the home and instead they had learnt by watching and copying more experienced staff. Others told us that they did get training. Staff said that the manager arranged for a trainer to attend the home and all staff were required to attend the training.

Staff received supervision, but there were no systems in place to make sure this was provided on a regular basis. This meant staff may not have the opportunity to discuss development needs or issues of concern. Some staff said that they had not received supervision, but would like to. Other staff told us that they had supervision once or twice a year. They explained that the duty manager had a note book from which she would ask how they are enjoying their work, what their future plans are and if they had any problems.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

There was no evidence to show that consideration had been given to each person's ability to make informed decisions about things that were important to them. Those people with memory loss or illnesses such as dementia the service had not considered their best interests. People were not always asked for their consent to care before care was provided and their capacity to consent had not been fully assessed. The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. One member of staff told us that last year they had received training on the Mental Capacity Act 2005 (MCA). They said "It is for people who can't make their own decisions, and how you are going to assist in that

situation." They went on to say "Yes there are some people here in that situation, they don't talk much and you can't get much information from them." Despite recent training on MCA we observed staff during our visit and noted they did not always seek consent before providing care.

We saw from the daily recording sheet that the manager had considered if one person needed covert medication. However, there was no evidence to show that an MCA assessment had been considered to establish their ability to make important decisions about their care and support needs. There was no record to show that an assessment had been completed. There was no evidence to show the person had been consulted about their need for support with medication, or that their consent had been gained to hold and administer their medications. The record showed the manager had decided covert medication was not needed but there was no further information to show how that decision had been reached. There were no records to show who the concerns had been discussed with, for example, the person, their next of kin, or their GP.

We also saw from the daily records completed by staff that one person's behaviour was causing staff concern. The person was placed on medication to modify their behaviour. There was no records to show the person consented to the medication or not and their capacity to consent to taking it had not been assessed.

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

Some people may be at risk of their liberty being restricted or deprived without the correct legal authorisation being obtained. DOLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The duty manager told us they would seek advice and make an application if necessary.

Before this inspection we were contacted by the local authority safeguarding team. They were concerned that an application had not been submitted promptly for a person who wanted to return to their own home but had been prevented by staff from doing so. A social worker had visited the person and found they had made frequently made attempts to leave the premises but staff would not let them do so. The person was under constant supervision and control. They had advised the duty manager to make an urgent DOLS but despite the matter being followed up several times by the local safeguarding team an application had not been made promptly. During this inspection the manager told us a DOLS application had been submitted to the Local Authority for this person. However, their care plan contained no information about the DOLS application or information about the person's wish to return home or the reasons why this was not possible. There was no information to staff to explain how they should monitor the person, or what they should do if the person attempted to leave. We saw from daily reports completed by staff the person had packed their bags to leave on a frequent basis.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

People were not offered an adequate choice or variety of food at mealtimes. During our observation of the midday meal we saw choices and preferences were not always offered. Menus were not clearly displayed but people we spoke with knew what foods to expect each day, for example "It is Friday, so we will have fish." Staff were also able to tell us what the menu for each day of the week was, for example, on Tuesday it was chicken casserole, on Wednesday it was quiche and salad, on Thursday it was beef or chicken curry and on Friday it was fish and chips. Every Sunday they served a traditional roast dinner.

We also heard that some people preferred traditional Chinese food, and their families often brought in foods to suit their preferences. Comments included "The Chinese families always bring food; one person's daughter brings in frozen food so they get a choice. We have a certain basic routine menu, but the cook swops things around so we don't get bored." We were told that while there was no choice at lunch time the tea time had a choice of sandwich filling or soup or pizza or pork pie.

A person explained that the lunch menu was a fixed menu. They told us that particular known food requirements are catered for, such as one person always wanted a bowl of rice with their food and another person could not manage chips.

People told us they were generally satisfied with the standard of meals. A relative said "They seem to like the food, despite everything having to be mashed up and she

Requires Improvement

Is the service effective?

has to be fed." A person who lived in the home said "You have to eat what is served up for you. The food is improving but could be better. I have cereal for breakfast, and I presume it will be fish for lunch as it is Friday."

People did not always receive assistance to help them eat their meals. At lunchtime one person was struggling to eat their food. They sat for 45 minutes waving a spoon over the food. Then a member of staff noticed and cut the fish up. After a further ten minutes the person started to eat. By this time the tables were being cleared away. Another member of staff went up to the person and said "Have you finished?" as they took the uneaten plate away. We saw the person experiencing the same difficulty with their pudding and hardly ate anything. We asked staff about this and were told that if people did not eat at lunch they would make up for it at tea time.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

The property is a bungalow with level or ramped access to most areas inside and outside the building. People were able to access most areas of the home and gardens safely. There was a small step from the bedroom areas into the dining room and we saw most people were able to access this area either independently or with guidance from staff. There were handrails along the corridors to assist people to walk around the home safely.

All areas were well maintained. The lounge had friendly feel with items such as games, books and ornaments to make the room feel homely. There was also a conservatory which provided additional sitting area. However, on the day of our inspection the room was very hot. Chairs had been stored in this area making the room appear cluttered and uninviting. The gardens were well kept and on the terrace there was garden furniture beside a raised fish tank. We saw one person sitting in the garden during our visit.

All bedrooms were bright, comfortably furnished, and people had been encouraged to bring items of furniture and belongings to make the rooms feel homely and personalised. One bedroom was reached by walking through the conservatory which meant the room was more isolated from the main part of the home. The manager told us they had concerns about the distance of the room from the main part of the house for people who needed more support. They said people will be offered a more suitable room if they find the bedroom does not fully meet their needs.

We spoke with a community nurse who told us they were confident staff were well trained and competent. They said they had provided training to staff on specific tasks in the past and they had found staff had always been keen to learn. If the nurses had any concerns about staff competence or knowledge they had offered training in the past and found it had always been well received and attended.

Requires Improvement

Is the service caring?

Our findings

People who used the service were not always treated with dignity and respect. During our visit staff smiled and their manner was friendly and gentle when interacting with people. Staff provided care to people in a calm and efficient manner, but often failed to ask people if they wanted assistance, or explain how this would be provided. We overheard staff speaking in what sounded like a commanding manner, for example "Put your leg up", or "Eat, eat" without asking people if they would like assistance, seeking consent, explaining the assistance they were offering, or checking that the person was happy or comfortable.

We observed two members of staff using a hoist to move a person from their wheelchair into a lounge chair. They did not explain to the person what they were doing as they did it. They left the person sitting in what looked like an uncomfortable position. They did not check how the person was. The person had good communication skills and therefore staff could have easily checked with the person to make sure they were comfortable.

We saw one member of staff assisted two people to eat. They sat between them; one person was positioned so that it was hard to aim the spoon correctly. As a consequence the person had food all around their mouth and some of it fell onto their chest. The staff member used the spoon to scrape it off their face and chest and re-fed it to them. Every so often the staff member used a serviette to wipe the person's face. All this was done in silence. The staff member carried on assisting each person until both stopped eating. There was no consultation or explanation of what was being given.

Some staff communicated well with people, for example at lunch time we saw one member of staff asked people if they wanted sauce on their fish. However, another member of staff just poured the sauce on people's meals without asking. We observed another member of staff assisting someone to drink. They kept tipping the beaker so that the person had to drink but they did not talk to the person while they did this.

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

Two members of staff told us one of the reasons they liked their work was due to the caring nature of their colleagues: "Staff do care, they don't just do the job, the staff here are very nice."

Two people told us the staff were kind. Their comments included, "I try to be as nice as I can be to the staff, and up to now they've been nice to me. Nice, polite and friendly," and also "The staff are nice, polite, and friendly."

There were no people living at Bronte, at the time of our inspection, who were close to the end of their lives. Treatment escalation plans (TEP) were in some people's files and decisions had been made about whether the person should be resuscitated in the event of a cardiac arrest (these decisions are known as Do Not Attempt Resuscitation (DNAR). However, some indicated that a decision had been made by the medical practitioner without any explanation or evidence to show who this had been discussed with. Where the forms indicated the person was unable to make a decision due to dementia some forms did not show how this decision had been reached, or any discussion with people's family or advocates to reach a decision in the person's best interest. No action had been taken to request further assessments or DNAR forms to be completed with full evidence that the person's capacity had been assessed. There had been no consultation with the person about the decision to resuscitate.

We recommend that the provider reviews each TEP form to ensure they have been completed in accordance with the Mental Capacity Act 2005, and other relevant guidance such as that provided by the Resuscitation Council UK. Where codes of practice have not been followed we recommend that the provider asks the relevant medical practitioner to complete new forms that follow good practice guidelines.

Requires Improvement

Is the service responsive?

Our findings

People's care was not person-centred. Care needs had not been fully assessed, monitored or reviewed and people had not been fully consulted or involved in drawing up or agreeing how their care needs should be met.

Most people had a file containing a care plan providing brief details about their care needs. The care plans usually covered two pages with headings which included the person's physical, mobility, social, preferences, communication and medication. Under each heading was a short paragraph giving brief details about the person's needs. There was no detail or explanation about how staff should assist the person to meet their needs. For example under the heading of mobility for one person their care plan said they needed to use a hoist with two staff. No further information was given about their mobility, such as movements they were able to carry out without assistance or those movements they needed assistance from staff to carry out. There was no detail about how the person wanted to be supported with each care task. This meant there was a risk the person may receive unsafe or inconsistent care.

Each care plan file contained a pre-admission check list that people, or their carers, were invited to fill out before admission. These provided some brief details about each person. Apart from this information there was no recorded evidence to show how people had been consulted or involved in drawing up or agreeing a plan of their care needs. We spoke with two people about their care plans. We asked them if they had been consulted about their care plans. They told us they had not been involved in drawing up the document and had never seen their care plan before.

Two people who had moved into the home in recent months had no care plan in place. One person had only recently moved in and another was for a person who had lived at the home since February. This meant staff had no written information about these two people explaining their medical, personal or social needs, or any risks to their health or well-being.

Care plans had not been reviewed regularly, and people had not been involved or consulted when reviews were carried out. For example one file contained a form entitled monthly care plan review. There were two entries dated July 2014 and February 2015 that related to a medical overview of the person's health. The file also contained two identical care plans, one dated April 2014 and the other August 2014. However, there was no other evidence to show the information in the care plan had been reviewed with the person to make sure it was up to date.

Despite the lack of information in the care plans staff told us that they knew how to care for people as they had a long experience of what they liked or disliked.

Most people we spoke with said they were happy with the care they received. Comments included, "Oh I think it is wonderful, everything is clean and spotless, the care is very very good" and "Now she is settled there is no need for them to contact me, and I come in regularly." Another person said "None of these places are like living in your own home, and never 100% how you would like it, so you have to accept that you need care 24/7 and go with the flow."

Before our inspection a professional who had visited the home told us that during their visit they had not observed any interactions between the staff and residents. People had been sat in the lounge where the television was on but the sound was turned down so people were unable to listen. There were no activities provided during their visit and people were observed sleeping in their chairs. People who lived in the home commented "I don't do nothing here, just a little bit of dusting," and "The entertainment doesn't suit me."

During our inspection we met a visiting entertainer who told us they were contracted to provide one hour's entertainment on three afternoons a week. On the day of our visit the activity provided was bingo. The session was well attended.

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

We were told by one person living in the home, that the home had regular residents meetings every 12 weeks. They said these meetings were attended by the manager and covered such topics as, activities, outings, complaints and grumbles, and menus. The person explained that they were the chairperson of the resident's meetings. This person later mentioned that in the past people used to be given a glass of sherry on a Sunday, but this had stopped. They said they would follow up on that and find out why.

Inadequate

Is the service well-led?

Our findings

At our inspection in 2014 we found they had failed to keep accurate and up to date records. After our inspection the manager sent us information telling us they planned to update all care plans to incorporate risk assessments including moving and transferring, falls, skin care and nutrition and associated recording forms. They told us they were in the process of completing this, but no timescales for completion were given. During this inspection we found they had failed to take appropriate action to address the poor recording on people's files.

The staff rota showed that the duty manager was on duty in the home four days each week. On the other three days they were 'on call' and could be contacted by staff for advice. On these days a senior care worker was in charge. When the managers were away for longer periods a member of their family provided management cover. We did not see evidence of their employment record to show their previous experience, qualifications or suitability for this role.

Staff we spoke with told us they were happy with the management arrangements. Comments included "The management is all right, I should say it is run by (the duty manager)."Systems to assess, monitor and improve the quality of the service were not fully effective. Quality monitoring systems had failed to identify issues we found during this inspection. For example, there were no systems to regularly monitor medicine administration and stocks of medicines. Safe levels of staffing had not been determined to look after people safely and actions had not been carried out to address low staffing levels. There were no systems to monitor staff training needs and ensure all staff received training and updates in line with current legislation and good practice, for example medication administration, first aid or moving and handling.

Records of accident and incidents had been completed in an accident book. However the accidents had not been reviewed to consider the potential risk of further accidents such as fall, or any actions that may be necessary to prevent them happening again. Where people had sustained injuries care plans and daily records did not contain detailed explanation of the injury, or a body map to show the site of the injuries. There were no plans to show how the injuries should be monitored or treated.

Records relating the care and treatment of each person were not fit for purpose. People had not been consulted about their care needs, or involved in drawing up and regularly reviewing a plan of their care needs. Some people did not have a care plan that accurately described their health and personal care needs.

Personal information was not always stored securely to protect confidentiality. The office used by staff where care plans and daily records were stored was not locked when staff were not present. This is because the room provided access from one part of the home to another and was regularly used by people, staff and visitors throughout the day. Care plans were locked in the desk but other confidential information such as individual continence needs, and medical appointments was displayed on a notice board in the office. This information could easily be read by people when they walked through the office area.

The managers had failed to evaluate and improve their practice to ensure the qualities of all aspects of the service are continuously improved. The duty manager was unaware of recent changes of legislation relevant to the services provided by Bronte. For example, they were unaware of recent changes to the Health and Social Care Act 2008, related regulations and guidance to providers on meeting the regulations. They were also unclear about the Mental Capacity Act 2005 and how it related to people living at Bronte. This meant they were unable to lead the staff in current best practice.

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

People who lived in the home and their relatives and other representatives were asked to give their views on the home through residents meetings and annual surveys. The most recent survey received 25 responses which were mainly positive. Two people made suggestions of things that could be improved and these suggestions had been responded to through the resident's meetings. Positive comments made by people in response to the survey included "One of the best presented homes I have seen. Staff are always cheerful and friendly" and "My mother is very contented at Bronte. I am very pleased with her care and I am delighted with her state of health. Thank you." Several staff told us they liked working at the home as it had a "family-like" atmosphere. They thought this was because it is a small home and run by a husband and wife team. When the

Inadequate

Is the service well-led?

managers were on leave a relative provided management cover. Comments received from people included, “The management is all right,” and “If anything happens the first thing we do is tell (the duty manager), and if she’s away her niece is in charge.”

People who were independent or who had family who could support them were able to retain links with the local community. For example one person enjoyed going out for a walk every day. Another person said “Bronte came out on top of the homes I visited. I wanted to be near Topsham so to be close to family and friends.”