Braunton Residential Home Ltd

Braunton

Inspection report

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Date of inspection visit: 25 and 26 March 2015
Date of publication: 01/07/2015

Ratings

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

Overall summary

The inspection took place on 25 and 26 March 2015 and was unannounced. The service provides personal care and accommodation for up to eleven older people. The service does not provide nursing care. The home has rooms on the ground floor and on the second floor which are reached by a passenger lift. The home has one large communal area on the ground floor divided into a dining area and a lounge area which leads onto a garden, which has ramp access. Short stays are provided as well as long term care. At the time of the inspection there were eight people using the service including two people on short stays.

The service had a registered manager. 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.

People gave us mixed feedback about their experience. Some people commented on aspects of the home they liked while other people told us they were not always involved in making choices or decisions about their care. Relatives gave mixed feedback with some commenting that staff were kind and others saying the environment

Summary of findings

needed improvement and staff turnover was high. The relationships between people and staff were not well developed. Most people told us they did not know the names of staff or the name of the registered manager.

We saw that care was mainly based around completing tasks and did not take account of people's preferences. Some people told us they felt isolated or bored as there were not enough meaningful activities for people either as a group or to meet their individual needs. Staff did not always speak with people respectfully or ensure their privacy. People were sometimes interrupted or ignored by staff who carried out tasks and did not seem to have time to spend with people. One person told us, "I get very lonely here sometimes." Two relatives told us their relative had benefitted from being at the home in the short time they had been there and since they came out of hospital. Friendships had developed between people which they evidently enjoyed and found supportive.

Care was delivered by staff, some of whom, told us they felt they did not have enough time to spend with people as they were too busy carrying out tasks. This affected team motivation and the atmosphere in the service. Some staff told us they did not have the time to spend with people to meet their needs for supervision or social interaction. Although staff had training, they did not always understand people's individual needs and preferences. Care was not personalised because people had to fit in with a routine they had not chosen. Healthcare professionals who worked regularly with the service told us there was a lack of compassion in the culture of care at the home.

Staffing was not arranged to ensure people's needs were met consistently, in relation to their day to day care and support, including their mobility While the service demonstrated some awareness of risk for individuals, guidance to staff in how to manage this risk was inconsistent and information about risks to people's welfare was not detailed enough to ensure people's safety.

There were needs assessments; however they were incomplete. Care plans did not record people's views about their care. One person told us, "I haven't got a care plan, I have never heard of one." Another person told us, "You should be able to do want you want and go to bed when you like." Care plans did not contain enough personalised information about people's preferences, interests or background to deliver an effective service. One person, who was able to mobilise independently and confidently manage most of their own care, told us they were happy living in the home and that they had choice over their daily routine. The management team acknowledged they needed to make the care plans more person centred and involve people in decisions about their care.

People were supported to receive a balanced diet; however there was minimal choice of meals and people's preferences did not influence the menu. There was an appropriate menu being provided for two people who had special dietary requirements.

People's mental capacity had not been assessed and recorded. Staff were not always following the Mental Capacity Act 2005 for people who lacked capacity to make particular decisions. For example, the provider had not made an application under the Mental Capacity Act Deprivation of Liberty Safeguards for two people, even though their liberty was being significantly restricted.

Although there was a policy for the prevention and control of infection, measures set out in the policy were not were not always carried out. The home was not visibly clean. A relative told us, "Although my relative is settled here I am not satisfied with the levels of cleanliness." The management team made efforts to rectify this during the inspection.

The home was not well led. Although checks and audits of the service were carried out these were insufficient as they did not identify gaps and omissions in the service. Risks to people were not adequately monitored and reviewed. The overall leadership of the service was shared between the owners, the registered manager and deputy manager with a shared responsibility for different aspects of the running of the service. Where concerns were brought to the registered manager or owner's attention, they were not always used as an opportunity to improve the service. Not all staff felt supported. Some staff told us they did not feel supported or heard when they raised issues however some staff told us they did feel listened to and felt supported to carry out their duties.

Summary of findings

People's experience of the service was affected by the provision of frequent short stays, either for respite care or as a 'step down' bed from hospital. This meant there were new people coming to live in the home on a regular basis, who were not known to people or to staff.

The service was in regular contact with community healthcare services. Advice was sought from the hospital on behalf of people to arrange medical examinations, urgent treatment or nursing care. Equipment was arranged for people who needed it and there was evidence that the home sought advice appropriately when needed. However staff at the home and local community healthcare professionals both told us they did not always work well together because communication was a problem, which meant people did not always receive care which was responsive to their needs.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 related to how staffing was arranged, the lack of effective risk assessments, respecting and involving service users and how consent to care was sought; infection control and how quality and risks were assessed and monitored.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Staffing was not arranged to ensure people received consistent care and support.

Risks were not adequately assessed and described based on individual need.

Risks relating to infection control were not adequately managed because staff did not all follow the policy. Arrangements for keeping the home clean were ineffective.

Medicines were administered safely.

Staff were recruited safely.

Is the service effective?

Requires improvement

Staff were not following the Mental Capacity Act 2005 for people who lacked capacity to make particular decisions and the service did not have a proper process to safeguard people's rights.

Staff received training and supervision took place.

People were supported to have a balanced diet. People told us the food was good but there was limited choice.

Is the service caring?

Inadequate

People were not always treated with dignity and respect and their privacy was not ensured. The culture of the service was task orientated and relationships between people and staff were not well developed.

People were not involved in decisions about their care and their views were not sought or recorded on their care plans.

Is the service responsive?

Requires improvement

People's needs assessments and care plans contained limited information about people's likes and dislikes, background and interests.

People told us they would like more activities and things to do.

People were unsure how to make a complaint and their views about the service had not been sought.

Is the service well-led?

Inadequate

The leadership of the service did not ensure people's right to choice and self-determination.

Systems in the home were insufficient to manage the risks arising from the provision of a short stay service.

Summary of findings

Systems to assess and monitor the quality of the service were insufficient and had not identified concerns raised at the inspection.

We received varying views and several concerns regarding the leadership within the home from staff and external professionals linked to the home.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 25 and 26 March 2015 and was unannounced. A single inspector carried out the inspection. We did not request a Provider Information Return (PIR) from the service before the inspection. A PIR 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. However before the inspection we looked at information we held about the service including notifications from the provider and recent information from the local authority. At the inspection we asked the provider to tell us about anything they thought they did well and any improvements they planned to make.

We spoke with six people using the service, four relatives and looked around the home. We looked at four people's care plans. We spoke with five members of staff, the registered manager and the owner. We also spoke with two senior managers from the local authority with recent experience of reviewing the service and with five community healthcare professionals who had been involved in supporting people using the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at records about the management of the service including staff training, duty rotas, medicines administration charts and management checks which were carried out.

Inadequate

Is the service safe?

Our findings

Staffing was not arranged to ensure people's care needs were consistently met. Four out of five staff told us they did not have enough time to care for people, including bathing and help with walking. We observed two members of care staff on duty with management cover shared between the registered manager and owner. This was the daily arrangement as confirmed by the registered manager. Although the rota showed that three members of staff were on duty in total, two care staff were responsible for supporting people with their personal care, preparing and serving meals, cleaning, laundry and providing activities.

We observed that staff did not spend much time with people individually unless carrying out tasks such as serving food or helping them to the toilet. One member of staff told us that people did not always receive the help they needed with their continence due to the pressures of other tasks. We asked the registered manager about the assistance needed for one person who had recently become very poorly and could no longer move independently. They told us, "We can still get away with one member of staff." However we later observed one member of staff asking the person if they wanted to get up from their chair and lie down on their bed. The member of staff told us they could not assist the person to move safely on their own. When they said they did want to lie on their bed, the staff member told them at 1pm, "When the other staff comes back from their break we will help you to lie down." However we saw that this had still not happened at 2pm, as when the other staff returned from their break, they were occupied with other tasks. We asked a member of staff how they ensured the person who was unable to walk independently or use a call bell was given attention when needed. They told us they were regularly near their room as it was near to the kitchen and lounge and we observed this. There was a call bell system in the home for other people, which we observed worked discreetly to alert staff when someone in their room needed assistance.

We observed two people who needed support with their mobility, who did not receive this. For example, one person with a history of falls was observed getting up from a chair in the lounge and walking around unsteadily for five minutes until a member of staff noticed and gave them their walking frame. However the member of staff then left to complete another task and left the person unsupervised. The person was unable to use their frame independently and another person living in the home guided them about where to put their hands. Another person told us, "I've fallen several times since I came here," was observed getting up from the dining table and struggling to balance with their walking frame. They were given assistance from a visitor who was there to do people's nails, until a member of staff came. Another person told us they observed people not always getting the assistance they needed, "Sometimes you call and they come straight away, it all depends what they are doing – there are not enough to go round." A member of staff told us they found the medicines had become more complicated and that checking and administering the medicines safely took more time. They told us this impacted upon the time they could spend with people.

This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Risks in relation to falls were not being assessed and managed effectively. This was because risk assessments did not adequately describe risks for each individual and moving and handling assessments were not kept up to date. Three out of five staff told us they did not have enough detailed guidance about risks to people. There was minimal information in two of the care plans we looked at. For example, one person had been prescribed medicines for their mental health which affected their alertness and had been previously assessed as at risk of falls. Their moving and handling plan and falls risk assessment had not been updated to reflect this change. We noted that they had fallen twice since it had been noted on the accident log that they had fallen due to their medicine. Although at that time specialist advice had been sought about their mental health and filed in their care plan, their moving and handling assessment had not been updated.

A member of staff told us that handovers between shifts were poor and information about people's needs was not always written down or passed on. Another member of staff told us the care plan information was difficult to follow. We noted that information about people's needs was not filed in a systematic manner. People were admitted for short

stays, either for respite or recovering from hospital treatment. The registered manager told us that there had been 35 people admitted in the last year, four of whom still lived permanently in the home at the time of inspection.

Staff did attempt to guide people in accordance with their need. We observed one member of staff explaining to someone on a short stay, that they needed to use their walking frame at all times to keep them safe while walking or standing and relayed to the person the specific advice they said was given by the hospital. However this was not written in the person's care plan or risk assessment, which meant not all staff may be following agreed practice for that person in relation to their mobility. This person had fallen in their room the previous week, and sustained a minor wound to their hand.

People did not always receive care which ensured their welfare needs were met. Most people sat all day in the lounge area and were not prompted to mobilise, even though most people could walk with assistance. We observed three people who become restless on three occasions on each day of our inspection. They did not receive any occupation, stimulation or attention from staff. Although staff emphasised how people were encouraged to sit in the lounge area for social time, we did not see anyone being offered a choice about this or being encouraged to walk around the home. We had to call a member of staff for one person who was sitting in the lounge and slipping out of their chair onto the floor because staff had not noticed this. Staff were frequently engaged in other tasks which meant when some people tried to walk independently they were at increased risk of falls.

The above was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

The arrangements for keeping the home clean were not adequate. The home, and some of the equipment which was used by people, was not visibly clean. The hoist in the main bathroom which served all the people in the home was covered with debris and grease at the base. The walking frame used by one person was not clean and its legs were covered in debris. In one of the bedrooms, there was a stale odour and the surfaces of the furniture, such as the side table, were not clean. The toilets in the some of the bedrooms were not clean and the light pulls were black with dirt. In a number of areas the skirting boards were dirty or splashed with dirt. Areas of the landing were dusty and dirty. At lunchtime in one of the bathrooms the bin remained full to overflowing. The areas of the home which were not clean were pointed out to the owner who agreed to rectify these immediately. The following day these areas had been addressed. Care staff told us that they were responsible for cleaning but felt this impacted on the quality of care they could give to each person. One member of staff told us that deep cleaning was supposed to be carried out at the weekend and that this meant, "there are no baths at weekends." Some areas of the home could not be effectively cleaned as they were not sealed. For example, in one bedroom the frame around the toilet door was bare wood. On the adjacent wall, four wall tiles were missing.

Risks of cross contamination were not effectively managed. We observed a member of staff preparing and serving food who was not wearing gloves. We saw one member of staff carrying out personal care, including giving tablets from their hands into someone's mouth, and serving food and not washing their hands in between these tasks. We observed a member of staff wearing open toed shoes in the kitchen while preparing food. They had a visible dressing on their toe which was not covered. In the bathrooms, hand towels and soap were in evidence however the hot tap in two of the bedrooms did not work properly. This meant that people, staff and visitors could not effectively wash their hands. One relative told us they pointed this out to the registered manager and had also previously asked that other items in the bathroom were repaired, which was done, however the hot tap was still not working properly. Another relative and a visitor told us they did not find the home clean.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Staff told us if they had safeguarding concerns they would report to these to the manager. The owner told us they had recently responded to safeguarding concerns which were being looked into by the local authority. They said these were unsubstantiated. The training record detailed that

Inadequate

Is the service safe?

one member of staff had received training in safeguarding in the last year and five members of staff had training in March 2014, with three members of staff having training over two years ago in 2013.

Medicines were administered safely. There were adequate arrangements for the storage and handling of medicines. We observed staff following safe procedures when giving people their medicines. Eight of 11 members of staff had received refresher training in medicines awareness since 2012, however it was noted that staff competency in medicines was checked through observation and recorded within the last year by the registered manager.

Recruitment was carried out safely. We saw that the appropriate checks on staff were made before they were employed to work at the home. We looked at three staff files which recorded references, checks from the disclosure and barring service (DBS), identity documents and health checks. One person previously employed overseas was on a medium term agency contract and their file contained appropriate checks and references.

Requires improvement

Is the service effective?

Our findings

People's consent to their care and treatment had not been sought in line with legislation and guidance as set out in the Mental Capacity Act 2005 (MCA). The management team and staff demonstrated they did not fully understand this. The training record indicated that the registered manager had not had training in this area. The owner told us they would complete any paperwork as necessary. One member of staff told us they had heard of the MCA from a previous care role and demonstrated some understanding of seeking people's consent and involving them in decisions. Another thought it related to the Mental Health Act. People's mental capacity was not reviewed, even where someone was known to suffer from mental impairment and confusion. A question in the care plan 'are they allowed out unaccompanied?' was not linked to any question about lawful restriction or any application for DoLS. As the MCA framework was not understood or applied within the service, people's mental capacity had not been properly assessed and reviewed and it had not been considered whether there were less restrictive ways of keeping people safe . This meant people's liberty may be unlawfully restricted.

We asked a senior member of staff why the front door had four locks. They told us this was because previously, "someone had lived in the home who could get out with three locks so we put four on." This meant that this level of restriction had not been reviewed as to its appropriateness for individual people currently residing in the home. We observed one person asking to leave the home, and being told by the owner that this was their home and that they should go and sit down. Their care plan noted they had 'advanced memory problems'. We asked the registered manager if anyone's care arrangements were subject to Deprivation of Liberty Safeguards (DoLS). They told us that all people in the home had given their consent to live there and they did not think this was needed. However they acknowledged that some people may have lacked mental capacity to make this decision.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Staff were given training in how to meet people's needs and carry out care effectively. For example, the staff training record showed that staff had been given training in health and safety, first aid, medicines awareness, fire safety, moving and handling, food hygiene, food nutrition screening and infection control. The three staff files we looked at contained certificates showing that online or workbook training had been completed, as shown on the staff training record. However there was no specialist training in conditions such as Parkinson's Disease, a condition experienced by two people who used the service, although advice was sought by the registered manager from the specialist nurse. There was no training in dementia care. One member of staff told us, "A lot we look after have dementia and are not quite clear, but we always find a way to understand what they want." Two members of staff told us their knowledge came from previous experience in other jobs as well as training. Two members of staff told us they had received training in challenging behaviour. One senior member of staff told us they had no say in what training was given, however another member of staff told us they could always request training and they had just requested end of life training. Staff were supported to achieve professional qualifications, for example, four members of staff had been helped to gain national vocational qualifications since working in the service. During the course of the inspection the service had commenced collaborative work with the local authority and a local organisation with the aim of improving the quality of care plans and training.

Staff received supervision and that their competency was assessed from time to time by the registered manager. The registered manager told us that agency staff were not used regularly, however a senior member of staff complained about the frequency of the use of agency staff. They told us, "when agency staff are here, you might as well be on your own as they do not know what to do." We noted there had been a number of new staff who had not stayed with the service for more than a few months. This affected the ability of people to develop supportive relationships with staff and therefore affected their experience of the service.

People were supported to have sufficient to eat and drink. Staff showed awareness of individual diets where there was a particular requirement, for example, related to diabetes. A senior member of staff told us, "I generally know in my head what people's diets are." They also told us that only staff who had been trained and understood each person's

dietary requirements were given responsibility for meal preparation. We observed all meals and noted that most people ate independently. One person needed some help due to a visual impairment and had been given a plate guard to help them to eat independently. We saw they also received assistance to finish their food as the staff member put it in the middle of the plate.

There was limited choice of menu. One person told us, "You get what comes, if you don't want the main meal, they will make you an omelette." Another person told us they were asked before lunch what they wanted. We saw that everyone, apart from one person on a special diet had the same meal at lunchtime. Another person, when asked if they had a choice of food, told us, "sometimes." A choice of two puddings was offered. One member of staff told us it could be difficult to spend much time on the menu, for example to prepare many choices due to pressure of time.

When asked if they had enough to eat, one person told us, "If there is enough left, you can have seconds if you want." People told us that at breakfast they could have as much as they liked. We saw two people being asked kindly by one member of staff at breakfast if they'd had enough to eat. Another person told us, "The food here is good, if the vegetables are really hard, I might just leave that to one side." We saw that people were offered tea and biscuits at set times of the day. We asked people if they had snacks and drinks available during the day, to which people told us that they did. One person told us that if they missed their meal, perhaps because they had been out, they could have a sandwich.

People did not comment on their dining experience however we noted that the approach to dining in the home was affected by the time staff had to prepare and serve food. This emphasised efficiency of mealtimes more than people's enjoyment of their food. For example, at breakfast, food was served on individual trays and put on the table rather than dishes and plates being placed directly onto the table. At mealtimes, place settings did not include any placemats or serviettes and everyone's drink was served in plastic beakers from a plastic jug, rather than glasses, although people were independent with eating and drinking. Before people had finished their main course at lunch time they were asked what pudding they wanted, which emphasised that completion of the meal time was a task for staff. Most people ate in the dining room and held conversations with each other which helped to create a sociable atmosphere at lunchtime. We noted that while people were eating, there was no attempt to keep the dining area private. Staff and visitors walked through the dining area. A loud TV coming from someone's room was heard in the background. One person told us, "You just fit into the routines for meals." One person told us they had their choice of drinks.

People had access to healthcare services when a change in their condition was noted. The registered manager told us that care plans were being improved and that no one currently in the home had complex needs. They told us that should any issues arise with people's care, they worked closely with healthcare professionals for advice. However healthcare professionals reported that staff did not always heed advice or follow instructions correctly, although there had been some improvement in communications recently. There were arrangements with the local GPs and nurses. We saw in the care plans and daily notes that healthcare services were readily contacted for advice and assessment as some people who came out of hospital had complex needs. This indicated that the service took appropriate action when someone became unwell. The registered manager told us in the last year ten people had been admitted to hospital from the home. We noted one person who was supported to attend the eye clinic in November 2014. The service had contacted the Parkinson's nurse and mental health services for advice in relation to people's welfare, and assisted them to attend clinics when appropriate. A community nurse noted that staff needed more specific guidance on working with GPs in relation to end of life medication to ensure administration could be set up to meet the need for pain relief as soon as it arose. We saw equipment being arranged for one person to make them more comfortable and safe.

Views of people and staff on the home environment were mixed. Two people told us they liked the environment in the home. One person told us, "I like the way this room has been painted." Another person told us, "The extension in lounge downstairs is lovely since it has been made bigger." A relative told us they were happy with their family member's room and they were free to decorate it how their relative liked it. Two people commented on how bright some areas of the home were.

The bath hoist in the main bathroom was old and worn, although in working order. A member of staff told us they found it difficult to operate. The bathroom was in need of

Requires improvement

Is the service effective?

redecoration as it was dark and dingy. The bathroom facilities were acknowledged by the owner to be in need of an upgrade as these were old and they told us this was planned. We noted the main bathroom was used for storage of equipment and temporary disposal of clinical waste, which made it cluttered and restricted space for moving around in.

Adaptation to the bedrooms had been made by the provision of en suite toilets, however not all these were completed. In one room used for respite the woodwork had not been painted. A member of staff told us they had difficulties using hoists in the some of the smaller rooms. There was signage on some of the doors; however we noted that people's individual doors had room numbers which were written on pieces of paper. This gave an impression of non-permanency and was not personalised.

Inadequate

Is the service caring?

Our findings

The service was not caring. People were not always treated kindly or respectfully. We saw one person being told by a member of staff when being assisted to sit down, "Don't drop down; all of you all drop down when you get to the seat." Relationships between people and staff were observed as task oriented, although we saw one member of staff who treated people with kindness. This member of staff regularly engaged people in conversation while giving care and support, expressing warmth and affection towards people. One person told us, "They are about the best one of the lot." Another member of staff showed understanding and sensitivity to someone's needs when the person was struggling to take part in an activity, by making sure the activity was adapted. A relative told us, "Staff are kind, better than other places." However we saw a member of staff tried to offer choice to people they were not supported to do this because they were expected by other staff to focus on other tasks, including assisting someone to the toilet or dealing with laundry. One member of staff told us that when someone chose to stay in their room, this was because they were, "basically miserable."

People were sometimes ignored. We noted the management team and staff often walked past people without acknowledging them. A member of the management team responded to one person, by saying, "yes it is being dealt with," when they tried to ask them something. They then turned to the inspector and said "I have no idea what he is talking about." One person who told a senior member of staff they were not happy was told abruptly, "Can you just go and sit over there and be not happy." We observed one person, when they got up from their chair at the dining table, being assisted by a member of staff and told several times, "You are going the wrong way," and not being asked where they wanted to go. As the inspector was speaking with one person, a member of staff interrupted and ignored the person. Four out of five community health staff who had worked with people at the home told us that they found a lack of compassion in the culture of care at the service.

People were not supported to be actively involved in their care and making decisions. We saw a post-it note in one care file which referred to a person who 'will ask to go to bed at 6pm'. The note stated, as guidance to staff, that this person must not be allowed to go to bed at this time as they would not sleep through the night. There was no evidence that the person had been involved in their own care plan or in this decision. No one we spoke with knew what their care plan was. One person who had recently come to live at the home told us, "No I haven't got one, never heard of it." Another person who had been in the home a short time, when we asked them, told us they were treated with respect. However they then told us a member of staff the previous night refused to allow them to go upstairs to lie down on their bed as they wished. The person said, "Surely you can please yourself what time you go to bed? I get up very early and like to go to bed very early, my choice." Another person told us they had a choice about when they went to bed but not about when they could get up.

People were not treated with dignity and respect. Visitors were made welcome and we observed several visitors to the home. However we noted a lack of privacy for visitors when they were visiting people downstairs. Given there were new people in and out of the home this had a significant impact on the shared environment and therefore on people. For those people who lived in the home permanently there was no record that they had been asked if they chose to live in such close proximity to other people and their visitors. We noted that the communal areas downstairs did not afford privacy for visitors or phone calls in the way it was laid out. For example, we saw visitors and staff regularly walk through the lounge area and dining area in front of people while they watched TV. One person was observed taking a telephone call which was heard by everyone, as the chairs were laid out around the edge of the room.

The above was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Requires improvement

Is the service responsive?

Our findings

The service was not responsive. Although people's needs were assessed before they came into the service, there was a lack of comprehensive care planning for some people in relation to their preferences, goals and needs. In one person's care plan under the section on interests, it was only recorded that the person liked watching TV, however their previous occupation indicated they could have been interested in other activities. We also observed they readily engaged in conversation with others in a group. In one section it was stated that the person had dementia however information was not formed into a picture of the person and how best to communicate and interact with them. We observed one person with a hearing impairment finding difficulty understanding a member of staff and telling us, "I can't hear what they are saying to me". The member of staff did not adapt their communication. There was no guidance in their care plan about how to communicate effectively with the person.

Some care plans were supplemented by detailed assessments from social workers which had been carried out prior to admission. However they were not reviewed and therefore did not provide a person centred approach in how the service should meet their needs in the care home setting. This meant that the service could not be sure if care was still meeting people's needs. There was not an up to date activity record which gave a picture of what people liked to be involved with or how to engage them in any specific occupation. One person's care plan contained a completed form 'All about me' which gave a more in depth picture of the person and their history and background. Their visual impairment was noted in their care plan but there was no description for staff about how best to support the person in their day to day routine. We noted they suffered from anxiety and that there was no specific care plan to guide staff about how to respond to this.

Where people had been admitted for a short stay, for recuperation after medical treatment, we could not find a record of how their needs were reviewed. For example, one person's mobility was variable and gradually improving so less assistance was needed by staff over time. The care plan stated that the person needed the assistance of one person for all transfers and supervision with walking with a walking frame. However when we spoke with staff about the person, they expressed differing views about the amount of assistance the person required, which meant the person may be at risk of falls.

Care was not personalised, people were encouraged to follow a set routine and we observed that people were offered minimal choice about where they sat or what they did throughout the day. The structure to people's day was based on the routine staff needed to follow to deliver the service rather than people's wishes. A member of staff told us "There are no baths at weekends". The same TV channel was left on all day. Two people told us they disliked what was being shown but there was nowhere else for them to go.

People told us they did not receive enough activities and stimulation. Occasional visitors, for entertainment or exercise were arranged. On the day of inspection, we were told a visitor was due to attend to offer exercise, however they did not come in and neither the staff nor manager knew why not. We saw supervision records showing the registered manager had checked with members of staff about how they provided activities, for example, quizzes and crosswords, which helped to ensure these took place. One person who was able to direct their own day to day care and mobilise independently, told us they were happy and settled in the home and had plenty to occupy their time, which we observed. We saw people who had developed warm friendships with each other and sat together. However four out of six people we spoke with told us they got bored or lonely or would like more activities. One person told us, "I get bored although thankfully I get a lot of visitors and I read a lot." A relative told us, "It is very homely here but I wish my relative would get taken out sometimes." Another person told us, "I get worried about things at home; I wish there were more activities."

People were not sure how to make a complaint. One person told us, "I suppose I would go to the nurse I like the best." Another person told us, "I wouldn't know where to go if I had a complaint, I don't know who the manager is, I can't remember." There was evidence that the registered manager had responded to feedback when given by relatives and tried to address problems. For example, one relative told us their relative had been cold, however that since they raised it with management, the room was always kept warm. They stated that the registered manager always tried to respond to any issues they raised, such as items

Requires improvement

Is the service responsive?

which may need repair. There was no recent formal survey of people or their relatives. One person told us they were not aware of any residents' meetings. We did not see any evidence of community involvement in the home.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (3) (a),(b), (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Inadequate

Is the service well-led?

Our findings

People and staff presented a mixed picture of the day to day culture of the service. One person able to communicate confidently and move about independently expressed satisfaction with the service. However overall the service was not focused on individual needs and was delivered in a hurried manner to a routine which was determined by the requirements of the service. People were not encouraged to express their views or helped to be involved in decisions about their care and support. People's care plans did not record in any detail how people liked their care or what their views were.

The registered manager and owner expressed concerns about the ability of the service to respond to commissioning demands, as they perceived them, especially when faced with meeting the needs of people coming out of hospital at short notice, sometimes with high needs. The registered manager told us that over the last year there were 35 admissions of people, 15 of whom were staying for short term placements. There were a further 12 placements into the respite room, mostly for two or three days. Only four people still living in the home had been residing there one year ago, indicating a significant change over of people for the size of the home. There was insufficient consideration for the needs and experience of people for whom Braunton Lodge was their home. In addition the environment, systems of care planning, risk assessment and staff training were insufficient to meet the needs of such a relatively high turnover of people, some with high needs relating to long term conditions. This affected the safety and quality of the service as reflected in people's comments and our observations.

There were conflicting opinions between staff and between senior staff about how the service was run. Staff morale was, overall quite low and their feedback demonstrated a negative picture of management with discord between different members of staff. For example, two members of staff reported that they did not feel listened to by the registered manager, another stated that the owner did not 'step back' to allow the registered manager to run the service. We observed the lines of responsibility were not clear in the roles between the owner and the registered manager. It was not clear who had responsibility and accountability for each element of the service such as managing communications with community healthcare staff, meeting standards and the overall organisation and supervision of the service delivery. For example, one of the owners told us that if feedback from the inspection was negative, this better first be communicated to them and not the registered manager.

The service overall had not kept up to date with best practice, including the use of the MCA framework and Deprivation of Liberty Safeguards and the practice of choice and self-determination for people who used the service. This in turn affected the quality of people's experience and the behaviour and values of care staff.

The quality assurance systems for the service were not effective and the service was reactive rather than proactive in responding to issues in people's care. Practice was not routinely questioned and learning from incidents was not demonstrated. For example there had been ten separate admissions of people to hospital from the home, who did not subsequently return to live at the home. One admission included a person who died in hospital very shortly afterwards. We did not see details of advance care planning in people's care files, which would provide reassurance that these events had been considered from the perspective of people's experience of becoming unwell at the home. Although accidents and incidents were recorded management action to reduce the risk of repeat events was not effective. For example, one person fell and sustained a minor injury however there was no record that their care plan had been reviewed to check their care was still appropriate.

Checks on staff training and supervision took place and most of these were up to date. However checks on other elements of the service, such care plans and infection control had not been effective in identifying concerns which were picked up at the inspection. This meant that some people experienced care that did not keep them safe.

The registered manager and two members of staff did not agree with recent concerns followed up by the local authority, which were about people, all of whom had now left the service or died, receiving poor care. Although these had not been substantiated further the management displayed a lack of objectivity about feedback. Gaps or problems in the service were not acknowledged, except in a very defensive manner. When concerns were raised during inspection, the management team responded by trying to address the problems, however expressed surprise about all issues which were raised.

Inadequate

Is the service well-led?

The above was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: People were not involved in their assessments; reviews were not carried out when needed. People were not enabled and supported to be involved in making decisions about their care. Regulation 9 (3) (a), (b), (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: People were not always treated with dignity and respect. Regulation 10 (1), (2) (a), (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The Mental Capacity Act 2005 framework was not being followed and arrangements to assess people's mental capacity were inadequate. People's consent to their care had not been sought there was a risk that people's liberty was being restricted unlawfully. Regulation 11

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

Care and treatment was not being provided in a safe way because risks were not being adequately assessed or kept up to date. This meant that not all was being done to mitigate risk to the health and safety people who used the service. Regulation 12 (1), (2) (a) (b)

People were not being protected against the risks of infection because arrangements for keeping the home clean and managing potential cross contamination were not being implemented.Regulation 12 (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The service was not deploying sufficient numbers of suitably skilled and experienced staff to meet people's needs. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The systems and processes of assessing and monitoring the quality of the service were not adequate as they did not focus on the individual needs and experience of people using the service. Risks were not being adequately monitored which meant that people's care was not safe. Regulation 17 (1), (2), (a)