Brun Lea Care Ltd

Brun Lea Care

Inspection report

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Date of inspection visit:
16 November 2017
17 November 2017

Date of publication:
20 February 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 16 and 17 September 2017 and was unannounced.

Brun Lea is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Brun Lea accommodates 20 older people and people living with dementia. The home is in a single storey building. There were 18 people living at the home on the day we inspected. Fourteen people had been diagnosed as living with dementia.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

The registered manager was also managing another of the provider's homes. People told us that this meant they did not see much of the registered manager and would raise concerns with the head of care for the home.

This was the second consecutive time the home has been rated Requires Improvement. We saw that improvements had been made in the safe and responsive key domains but more work was needed in the effective, caring and well led domains.

We found that the care provided was safe and people's needs were met. However, people's experience of living in a care home could be enhanced if the provider and registered manager implemented areas of best practice within the home.

We have made a recommendation about keeping up to date with guidance.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the home support this practice.

The registered manager monitored staffing levels and ensured that there were enough staff to meet people's needs. Staff received appropriate training and support to allow them to meet people's needs safely. However, staff were focused on the tasks they were completing and failed to personalise the care to people's individual needs.

Staff had received training in keeping people safe from harm and concerns were raised appropriately and investigated. Risks to people were identified and care was planned to keep them safe. The registered

manager and staff worked with other care providers to ensure that information was shared when needed and that people received the care and support they required.

The environment was clean and staff knew how to keep people safe from the risk of infection. The home was also nicely decorated; however, it did not fully support the independence of people living with dementia.

People were happy with the quality of the food provided and were monitored to ensure they were eating enough to stay well. However, at times the care provided for people at mealtimes was not personalised to individual needs.

People had been involved in developing their care plans and were supported to make choices about their care. People's care at the end of their lives was planned to respect their wishes and to keep them comfortable. People were happy with the activities provided.

The provider had effective systems in place to monitor the safety of the care provided. They also gathered the views of people living at the home and their relatives to make positive changes in the care they receive.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe living at the home and any concerns over safety were reported to the appropriate authorities and investigated.

Risks to people had been identified and care was planned to keep people safe.

There were enough staff to keep people safe and recruitment processes ensured staff were safe to work with people living at the home.

Medicines were obtained, administered and disposed of safely.

Staff knew how to keep people safe from the risk of infection.

Learning from incidents was used to improve the care provided.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The environment did not fully support the independence of people living with dementia.

People received an assessment of their needs to ensure that the home was able to meet their care needs. Staff were provided with training and support to ensure they could meet people's needs.

People were happy with the food provided, but more care could be taken over the presentation of pureed food.

Systems were in place to ensure care was coordinated when people moved between services. People received support from appropriate healthcare professionals.

People's ability to make was assessed when needed and family and healthcare professionals consulted over decisions when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff at times focused of the tasked to be completed instead of ensuring that the care supported individual needs.

People were supported to make choices about their care and their independence was supported.

People's privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

Care plans contained accurate information on people's needs and the care provided supported people's health.

Some activities were provided to keep people entertained.

People's wishes for the end of their lives were recorded and respected. The registered manager worked with external organisations to support people through this difficult period.

People knew how to complain and complaints were responded to in line with the provider's policies.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a registered manager in place however, they managed two homes for the provider and this impacted on their visibility in the home.

Best practice guidelines were not always fully implemented in the home.

Audits effectively monitored the safety of the care provided.

People's views on the care provided were gathered and used to develop the home.

Brun Lea Care

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 home, and to provide a rating for the home under the Care Act 2014.

This inspection took place on 16 and 17 November 2017 and was unannounced. On the first day our team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care home. On the second day our inspector returned alone to complete the inspection.

In preparation for our visit we reviewed information that we held about the home. As well as notifications (events which happened in the home that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority contracting and safeguarding teams. We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the home, what the home does well and improvements they plan to make.

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 spoke with the registered manager, head of care, the activities coordinator, the cleaner and a member of the care staff. We also spoke with seven people living at the home and four relatives of people who lived at the home.

We looked at a range of documents and written records including four people's care files and two staff recruitment records. We also looked at information relating to the administration of medicines and the auditing and monitoring of care.

Good

Is the service safe?

Our findings

People we spoke with said they felt safe living in the home. One person told us, "Nothing frightens me here. I feel safe." A relative said, "It's very secure and they know if he's got up and wandering about." Another relative commented, "It's very safe, friendly staff make it so, and it's a lovely house."

Staff had received training in how to keep people safe and knew it was their responsibility to report anything that they had concerns over. When concerns were raised the registered manager worked collaboratively with the local authority to investigate concerns and to make any changes in care needed to keep people safe.

Risks to people while receiving care had been identified and was care planned to keep people safe. People's ability to move safely around the home was risk assessed. Care plans contained information about any equipment each person needed along with how many staff were required to support people to move safely.

People told us that they felt safe when staff supported them to move. One person told us, "I've got my electric wheelchair and they use the rotunda to help me in and out of bed." A family member commented, "They use a stand aid hoist for the toilet. She's got a frame but it's not used much now as she struggles to walk." We saw one person being moved using equipment. We saw that this was done in a safe manner and staff communicated with the person they were supporting through the process to help them remain calm and comfortable.

People's ability to maintain a healthy skin was assessed and where needed appropriate equipment such as pressure relieving cushions and mattresses were provided. Where people were unable to reposition themselves independently staff supported them to move on a regular basis to relive pressure on individual areas of skin. No one living at the home had any pressure ulcers. Staff knew what to look for and ensured that if they had any concerns about the condition of anyone's skin they would contact the community nurses for guidance and support.

Where people had become distressed and had shown their distress through their behaviour, appropriate records had been kept detailing the behaviour and what had caused the distress. This allowed the registered manager to review the care provided and to identify if any changes could be made to the care to better support people's needs. Where people did not have capacity any distressed behaviour was discussed with their representatives to support the care provided to meet their needs. In addition, where some people were vulnerable, there was a mat across their doorway to alert staff if people living with dementia lost their way and went into the person's room instead of their own.

Where people were unable to keep themselves in bed when asleep, bed rails had been put into place. However, the best practice guidelines for the safe use of bed rails had not been followed. We saw that one person had agreed to have one side bed rail up as the other side of the bed was against the wall. We discussed this with the registered manager who agreed to take action to keep the person safe.

Most people we spoke with felt that staffing levels were appropriate but that staff often appeared rushed. We noticed that staff were usually visible in communal areas or passing through and could be seen. One person told us, "They seem to manage okay with everyone." Another person said, "I'd say there seems to be enough at a time."

People told us that call bells were usually responded to in a timely manner. We observed staff responded promptly to call bells. One person told us, "There's not a long wait for them to come." A relative said, "They leave her bell near her and they come quite quickly when it's used."

The registered manager had monitored the staffing levels in the home check if people's needs were being met in a timely manner. Where they had identified concerns they had increased staffing levels. For example, they had recently scheduled another member of staff to work form 4pm until 8pm as this was the time people wanted their tea and to be assisted into their nightwear. Rotas showed that the home had been staffed in accordance with the registered manager's description.

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the registered manager had completed structured interviews. Any gaps in people's employment history had been identified and investigated. The required checks had been completed to ensure that staff were safe to work with people who live at the home.

We found that suitable arrangements were in place to safely order, administer and dispose of people's medicines in line with national guidelines. Staff who administered medicines had appropriate training to ensure they followed the provider's policies on medicines administration and their competency was rechecked on an annual basis. We saw that medicines were administered safely. Records relating to the administration of medicines were accurately completed. One person told us, "I have eye drops 3 times a day. They wait with me for my tablets." A family member said, "They've got the right balance sorted now for her medication for hallucinations and anxiety, so she seems better."

Where people had been prescribed a medicine to be taken as required, there was information recorded in their care plans to support staff to offer the medicines in a consistent manner. In addition, where the medicine was to help people manage their emotions, other options to help people remain calm were identified to be trialled first. This was because the medicines to help they stay calm may impact on their ability to enjoy the rest of their day and should only be used when other options had failed.

We saw that one cream which should have been stored in a refrigerator was stored in the drugs trolley despite clear instructions that it should be kept cold. This could affect the strength of the cream and so it may not fully support the person to be well. We raised this concern with the head of care who was administering medicines. They arranged to have the a new tube of cream ordered.

Where people needed to have their medicines crushed so that they were easier to swallow or hidden in food, the registered manager had taken advice from a pharmacist to ensure that this did not alter the effectiveness of the medicine. In addition, if people repeatedly declined to take their medicines, then staff raised the concern with the person's doctor.

We found that suitable measures were in place to prevent and control infection. For example, the local authority had done an inspection of the kitchen in March 2017 and had given the home the highest possible score, to show that all precautions were in place to reduce the risk of spreading infections. In addition, care staff were able to describe how they used protective equipment such as gloves and aprons to keep people

safe.

There was an appropriate cleaning schedule in place and the home was clean and tidy and there were no unpleasant odours in the home. The member of domestic staff we spoke with was able to describe how they worked to reduce the risk of infection and told us that they had shadowed a more experienced member of staff when they first started at the home. However, they had not had any formal infection control straining since working at the home. We raised this as a concern with the registered manager who was able to reassure us that formal training was scheduled.

We found that the registered manager had established suitable arrangements to enable lessons to be learned and improvements made if things went wrong. This included the registered manager carefully analysing accidents and near misses so that they could establish why they had occurred and what needed to be done to help prevent a recurrence. Any learning from incidents was shared with staff to help keep people safe.

Requires Improvement

Is the service effective?

Our findings

People told us the accommodation met their needs. One person told us, "I find it easy to get around the place in my wheelchair." Another person commented, "It is nicely decorated and is pleasant for us." A family member said, "It's ideal for her here and no-one can just walk in the place." The provider had taken some actions to promote people and staff's well-being. For example, each room now had a hospital bed which could be raised and lowered as needed.

However, we identified some areas for improvement. We noticed that when the front door was opened for example for a delivery, a cold draught could be felt in the bedroom corridor and main lounge. In the afternoon, several people in the lounge commented on how cold it had become. In addition, there was a lack of space with did not support people's dignity. For example, there was no dedicated space for people to have their hair cut and this was being carried out in the laundry room. In addition, the dining room was a passage from some bedrooms to the lounge and beyond. A cleaner's trolley came through the dining room while people were eating their midday meal.

The environment did not fully support people living with dementia. For example, some carpets in communal areas were highly patterned and people living with dementia may find this confusing. In addition, the décor did not encourage and support people's independence. For example, toilet doors were painted the same colour as all the bedroom doors and the signage used was small and people living with dementia may have found it difficult to read. The garden area was not secure for people to access independently.

Some of the furniture in the home was worn and wardrobes had not been fastened to the wall to prevent them falling over. We asked the registered manager about the lack of ornaments and were told that they had all been removed as one person living with dementia had been taking them away. We discussed with the registered manager what harm this was doing and they agreed that if the person was happy then there was no reason they could not move objects around the home. The registered manager agreed to replace the ornaments around the home.

When people moved into the home a senior member of staff had completed an assessment to see if their needs could be met by the environment and care provided at the home. As well as the physical needs the assessment also considered people's emotional needs. In addition, they spoke about people's preferences for care and how they would prefer their care to be delivered. People's care needs were also used to plan the training needed in the home.

People told us that staff were capable in their work and knew their needs well. One person told us, "They are very nicely trained I think." Another person said, "They seem to know what they're doing with me." A relative commented, "They are brilliant and so patient."

New members of staff were required to complete a structured induction process to ensure they had the skills and knowledge to care for people safely. The induction covered the provider's policies and procedures and included shadowing a more experienced member of staff. In addition, new staff were required to

complete the care certificate. The care certificate is a national set of standards which covers the basic skills needed to provide safe care.

We saw that a new member of staff was shadowing a colleague to gain experience of providing care before working independently. The member of staff watched a person being supported to move using equipment. Following the process we saw that the head of care spent time with the new member of staff discussing the move and how certain steps supported people to be safe. A new member of staff told us, "Staff are very supportive and always willing to answer any questions I have."

Annual update training was arranged by the registered manager to ensure that staff were updated with any changes in guidance or best practice. However, we saw there were some gaps in the training where staff had not attended. The registered manager told us a letter has gone out with all the training dates for 2018. The letter advised staff that if they did not attend for mandatory training then they would not be eligible to work in the home. In addition, the registered manager had liaised with other homes in the locality to provide joint training and so increase the opportunities for staff to attend.

Staff received annual appraisals and routine supervisions throughout the year. Supervisions consisted of staff meetings and observations of care as well as one to meetings with staff to discuss their progress.

Feedback on the food was positive, with a choice being offered at meal times and special diets catered for. One person told us, "Lunch is the meal of the day for me! They use local veg and I love them. I get extra big portions too! I can ask for fruit if I want something as I don't have the cakes with my diabetes." Another person said, "I do enjoy my meals and can have what I want when I want. Every Monday, Wednesday and Friday I like to have tinned tomatoes and bread for my breakfast, so that's my treat. I like sitting with my friend in the dining room." A family member commented, "She has soft mash food and someone feeds her. She'll eat more for them than for me."

We saw that people had access to cold drinks and were regularly offered hot drinks during the day. One person told us, "I've my jug of water here in my room as I drink a lot. I like my coffee too." Another person said, "I drink a couple of beakers at lunch and have a cup in my room all the time." A family member commented, "She gets plenty to drink. There's always a cup of tea for me too." Staff we spoke with knew how to monitor people for signs of dehydration and were clear on the action they would take to support people to increase their fluid intake.

There was a four week rolling menu in place for people living at the home. The menu was reviewed every six months and altered to reflect the season of the year. People were offered a choice of food each day and if they did not like what was listed on the menu then they were able to request anything that they wanted.

The cook told us that the assistant manager would keep them up to date with the needs of people living at the home. The registered manager and would let them know if people were at risk of being unable to maintain a healthy weight so that their food could be enriched with extra calories.

Some people living at the home required their food to be pureed so that they could swallow it safely. The food was prepared to an appropriate consistency for them. However, all the meal was pureed into one unappetising brown puree. This meant that people were unable to distinguish between the different flavours and unable to choose not to eat anything they did not like. This did not enhance people's enjoyment of their food.

Where needed people had appropriate equipment available to support their independence. For example,

some people had plate guards to stop their food from falling off their plate.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. Systems were in place to ensure that if a person went to hospital or moved to another home the information about their medicines was available to the people who would be supporting them. Care plans contained emergency grab sheets so that all appropriate information was ready to hand over to other healthcare professionals in an emergency situation.

All the staff worked together to care for people. At each shift there was a handover during which the head of care allocated tasks to staff so they were clear of their responsibilities for the shift.

People were supported to live healthier lives by receiving on-going healthcare support. People told us they were supported by healthcare professionals who visited the home. One person told us, "The nurse comes in twice a week to check my bottom. I get the optician a few times a year." Another person said, "I get the chiropodist quite often and had the optician some months ago."

Records showed that people were supported to access healthcare advice and support on an ongoing basis. For example, we saw that people were able to have their eyes tested and that they were supported to attend for any healthcare screening they were invited to. In addition, people were able to access care for a GP or community nurse when needed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People had been asked for their consent to live in the care home and receive appropriate care. Where people had been unable to provide this consent appropriate applications for the person to be assessed under the DoLS had been submitted. Five people living at the home had a DoLS in place and a further three people were currently undergoing an assessment process. No one with a DoLS in place had any conditions applied.

People were supported to take positive risks where they had the ability to understand the risks and possible outcomes, For example, one person had chosen not to have protectors on their bed rails as it prevented them from independently being able to access a drink during the night. Another example was a person who chose not to have the bed rails in place. Staff had explained the risks of falling out of bed and had increased the number of checks on the person during the night to ensure they were safe.

Where there was some doubt over people's abilities to make decisions, a mental capacity assessment had been completed. Where people had been unable to make a decision, decisions had been made in people's best interest and the registered manager had ensured that appropriate staff, family and healthcare

professionals had been included in making decisions on their behalf. Care plans recorded where people had legally arranged for named individuals to be able to make decisions of their behalf when they were unable to make a decision anymore.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were friendly, kind and caring. We observed staff talking to people in a warm manner and sharing a joke or laugh. The atmosphere was relaxed. One person told us, "Such a kind team, I love them all." Another person said, "They're very helpful and caring to me." A family member told us, "They can be a bit rushed if they're short but are generally a happy crowd."

However, we saw that some of the care provided by staff was task focused and did not reflect best practice. For example, we saw that staff took a person to the toilet without asking them if they wanted to go. They told the person they were just getting them ready for lunch. Another example we saw was staff returning a person to the lounge after supporting them to the toilet. Staff were about to support them back to the chair when one member of staff noted, "It's nearly time for lunch, should we take them through." Staff proceeded to take the person to sit in the dining room. They did not ask the person what their preference would be. There were still 25 minutes until lunch time.

Medicines was another area where care became task focused with staff requesting that people remain in the dining area or lounge area while taking their medicine. We saw that one person who wanted to return to their bedroom after lunch was required to wait in the dining room until after they had taken their medicines.

At the mid-day meal care was not taken by staff to make it an enjoyable experience for people. The menu was not easy to read on the whiteboard and no staff explained the meal they were serving to individuals. There was no background music played and the room was often silent unless the call bell or telephone interrupted the silence. We saw one member of staff started to support a person to eat with no interaction with them to discuss the food. In addition, a member of staff stood beside a person giving support with dessert instead of taking time to sit with them.

At tea time, one lady waiting at the table for their tea was becoming distressed, staff walked past the person on several occasions without stopping to identify what was wrong or to offer comfort and reassurance. We saw that a number of other people on the same table were getting restless while waiting and this led to some sharp words between the people. In addition, one person who had eaten earlier wanted to leave the room and was asked to sit back down.

People we spoke with told us that they had freedom to decide where they wished to spend their time and could sit anywhere in the lounge. Families could take their relative out and about if appropriate. One person said, "I prefer to stay in my room but go through for my meals. I don't keep going in and out the lounge much as I worry I'll run over someone's toes in my chair." Another person told us, "I do everything myself if I can. I go by how I feel. I decide to go to the dining room for meals and join in games if I feel like it."

People told us that they were able to make decisions about their care routine, clothing, where to spend their time and meal choices. One person said, "I make all my own decisions, I don't like change at my time of life so do things my way." Another person told us, ""I ring the bell when I'm ready for bed or want to get up. Two come in the morning to wash and dress me so we pick clothes out together." People were also supported to

maintain routines which they had followed before moving into the home. For example, one person chose to have a glass of beer with their midday meal. People's wishes around socialising with other people in the home and been discussed with them and their preferences recorded. For example, one person chose to spend most of their time in their bedroom.

People were involved in making choices about their care. For example, we saw that one person was hoisted and we discussed this person with the head of care. They explained that they only hoisted the person if they were having a bad day. They had tried to assist the person to move with a standing belt but the person had not liked the experience and preferred to use he hoist.

People told us that their privacy and dignity was respected. We observed staff knocking on doors, even when open and allowing people privacy when in the toilet. One person told us, "It's very private in your room. I can have the door open or shut." A family member said, "He's so well treated and they respect that he likes his privacy in his room."

Staff had received training on understanding equality and diversity and understood that it was about ensuring that everyone was treated as an individual. An example of this was one person who due to their beliefs did not want to celebrate Christmas and chose to spend the day away from the party atmosphere in the communal areas. There was currently no one in the home who had identified themselves to the staff as being part of the lesbian, bisexual, gay and transgender community. However, staff were clear that they would support people's lifestyle choices.

Good

Is the service responsive?

Our findings

The registered manager had written to people living at the home and the relatives they wanted to involve in their care to ask them to attend a meeting to review the care plans. People we spoke with and their families felt involved in their relatives care, though not all had seen a care plan or had a review meeting regularly. One person told us, "My son is next of kin and when he's visiting, we chat with the girls about how I'm doing. If there's anything I want done differently, then they listen and make a note." A family member told us, "They're always updating me and I see his care plan and sign it at times. I get asked to a review sometimes to see if anything needs raising."

The care plans accurately recorded the care that people needed. Care plans had been reviewed monthly or when people's needs changed. People told us that staff monitored them on a regular basis to ensure they were safe and happy. One person told us, "They keep a close eye on us and often pass the door." A family member told us, "She's kept a close eye on. They write things on their records."

People told us that they had regular access to a shower or bath, or received a daily bed wash. People living at the home were clean and tidy and gentlemen shaven. One person told us, "I wash myself and have a shower now and then if I want." A family member said, "She has a bed bath every day and looks fresh enough. I find it a very clean place."

Where people living at the home had diabetes there were appropriate care plans in place to support them. The care plan recognised that people who had been living with the condition for a long knew their own needs around diabetes. For example, one care plan recorded that the person would know when their blood sugars were too low and would ask for biscuits to stabilise their blood sugars. Care plans recorded how regularly people blood sugars needed to be monitored.

Care plans also recorded how people were able to communicate their needs. For example, each care plan recorded how people were able to communicate if they were in pain to staff. Some people were able to tell staff if they were in pain. However, for other people staff needed to monitor their body language and assess them to identify signs of pain.

The activities coordinator told us that they asked people what they would like to do and gave people a choice of activities. We saw that some people were sat in the lounge enjoying a communal game of snakes and ladders. The activities coordinator told us how they were planning to help people make gifts for their families for Christmas presents.

Most people we spoke with were content with activities provided. They told us an activity was usually held in the morning and a list of the weeks planned activities were on a whiteboard in the dining room. One person told us, "The lady comes and plays dominoes and that sort of thing in my room. Sometimes I'll go and play ball in the lounge." Another person said, "Plenty goes on and I might do some things- and they will come and ask me to join in. I love the singers who come in. I go out for the church luncheon most months." A family member commented, "An activity tends to be in the morning. [Activity coordinator] is amazing, she

comes and plays dominoes with him and takes her time with him. In August they did a trip to Skegness and took him, and we were able to go too to help."

People's communication aids such as glasses and hearing aids were recorded in people's care plans. However, care plans did not assess or record people's needs around written communication. For example, if they were able to read or needed information in picture format.

We saw that were appropriate people's wishes regarding resuscitation had been discussed with them or their relatives if people were unable to make decisions. This information had been recorded on the official forms and forms were available in people's care plans to be shared with healthcare professionals when needed.

People had an advanced care plan in place which recorded their wishes for the end of their lives. For example, who they would like contacted and which funeral directors they wanted to use. Where people were at the end of their lives the registered manager and staff worked collaboratively with other healthcare providers such as Macmillan and the local hospital to keep people comfortable and pain free.

Following the death of a resident the registered manager kept in contact with the families to offer any support needed. In addition, the registered manager was aware that some staff may need emotional support when people living at the home died.

No-one we spoke with could recall having made a complaint. People told us they would be happy to approach the head of care or the registered manager if they needed to raise a concern. One person told us, "To be honest, I speak to [head of care] she and I understand what's what. I complain about the medical side here, as all the ill people take up more of the staff time." A family member told us, "No complaints so far, I'd see the head of care if I wanted to raise anything." One complaint had been received since our last inspection, records showed that the registered manager had thoroughly investigated the complaint and taken appropriate action to stop the issue reoccurring.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post, they also managed another home for the provider which was located approximately five miles from Brun Lea. They split their time between each home. The provider had appointed a head of care at each of the homes to support the registered manager and to ensure that staff had a senior person to support and advise them.

However, this had impacted on the manager's visibility within the home. One person told us, "I'm not sure who the manager is. If I had a worry, I could talk to any staff." Another person said, "I'm not quite sure which is the manager." A family member commented, "[Head of care] is the one we'd see. You don't get to see the manager."

The provider had been rated as requires improvement at their last inspection and at this inspection we saw that they had made improvements in safe and responsive However, their overall rating was still requires improvements and changes needed to be made to ensure people received a good standard of care.

While the care provided was meeting people's needs it had not always reflected the latest guidelines in best practice. For example, we saw that best practice guidelines around the use of bedrails and presentation of pureed food had not been followed and the decoration of the home did not follow the best practice guidelines for people living with dementia. The care provided should be centred more on the needs of the person receiving care rather than the staff's need to complete tasks. In addition, the manager had not fully implemented the accessible information standards.

People living at the home and their families told us that they were happy with the care they received and liked living at the home. However, while the care people received was safe, people's experiences could be enhanced by the implementation of areas of best practice in the home.

The registered manager told us they read appropriate industry magazines and websites and attended meetings to keep up to date with changes in best practice. For example, the registered manager attended the local authority infection control meetings to ensure that they stayed up to date with changes in best practice around infection control. Furthermore the registered manager had been working collaboratively with a group of other managers locally to identify best practice guidelines. However, these steps had not ensured that best practice was embedded in the care provided.

We recommend that the provider and registered manager ensure that they are up to date with the best practice guidelines for the care they provide and put plans in place to update the quality of care provided.

We found that a number of systems were in place to help care staff to be clear about their responsibilities. Care staff were invited to regular team meetings so that the provider and registered manager could keep them up to date with any changes in the organisation or changes to best practice. In addition, incidents and accidents were discussed along with the changes in care needed to keep people safe from similar accidents occurring. Care staff were also supported with individual and group supervisions where they were given the

opportunity to discuss any concerns they had.

In addition, records showed that the registered persons had correctly told us about significant events that had occurred in the home. We saw that they had fully investigated any concerns and had used the information to drive improvements in the quality of care provided. Furthermore, we saw that the registered manager had suitably displayed the quality ratings we gave to the home at our last inspection in line with the regulations.

We found that people who lived in the home and their relatives had been engaged and involved in making improvements. The last residents' and relatives' meeting took place in April 2017. One person told us, "They've had two meetings since I've been here. I go and give my two penny worth if I can. I've noticed some changes from things said, like they let the staff use their initiative to do some things quicker and safer, which I'd suggested." In addition, in October 2017 the activities coordinator spent time with people on a one to one basis to check if they were happy or if they had any feedback regarding the quality of care they received. A customer survey was also sent out twice a year to gather people's views on the care provided.

People told us that the registered manager had listened to their feedback and taken appropriate action. One person told us, "They're very good at listening, it's usually about food and stuff like that." A family member said, "They had a summer tea for families and a sing song but not many came. They asked us some questions for our views, so they do listen and care."

The provider has a suite of audits in place to monitor the quality and safety of care provided. We saw that these audits were mostly effective in identifying and rectifying concerns. We found that the registered manager had made a number of arrangements that were designed to enable the home to learn and innovate. This included members of care staff being provided with written policies and procedures that were designed to give them up to date guidance about their respective roles. The registered manager had also signed up to take part in the local authority's harm free care project. This supported the registered manager to monitor falls, malnutrition and pressure area care.

We found that the home worked in partnership with other agencies to enable people to receive 'joined-up' care. There were systems in place to ensure information was passed over when people moved between services and the registered manager worked collaboratively with specialist nurses to meet people's needs.