Brendoncare Foundation(The)

Brendoncare Park Road

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 19 and 20 December 2016 and was unannounced.

Brendoncare Park Road to be referred to as the home throughout this report, is a home which provides residential and nursing care for up to 49 older people who have a range of care and nursing needs. The home is situated close to the town of Winchester. The home comprises of three units one of which is over two floors in the original Brendon House. All other rooms are at ground floor level and facilities include two dining rooms and two lounges with a secure rear garden. At the time of the inspection 41 people were using the service.

The home has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and their relatives told us they felt the service was safe most of the time. We received some feedback about occasions when people had not felt safe.

Risks to people's safety had been assessed and guidance was provided for staff to manage these risks appropriately. However, the information staff were required to record so that risk management plans could be evaluated was not always completed to show people had received the care and treatment they required. This included: records to confirm people's food and fluid intake when they were at risk of poor hydration and nutrition and records to confirm people had received their topical medicines (prescribed creams and lotions applied to the skin) to prevent a deterioration in their skin integrity. Some equipment such as air flow mattresses used to prevent pressure sores developing were not set at the correct setting according to the person's weight. People's repositioning needs had not always been recorded as carried out as required. This meant there was a risk people could experience deterioration in their health when actions to reduce risks were not recorded or monitored as carried out so people's treatment could be effectively evaluated.

Information available to staff at handover about people's needs and risks was not fully completed or effectively communicated to all staff. This meant there was a risk that staff who did not know people well would not be fully briefed about people's needs and risks.

People's medicines were safely managed and administered appropriately with the exception of those medicines that are prescribed to be given at a specific time to help people manage their symptoms. We found these were not always given at the prescribed time which could result in less effective treatment for the person.

The registered manager took prompt action to address these concerns however more time was required for these improvements to be fully embedded into practice.

Most people we spoke with said there were not always enough staff readily available, staff were hurried at times and could take a long time to respond to call bells. Some staff told us staffing levels were 'stretched' and they did not always have time to spend with people to meet their emotional or social interaction needs. Some actions had been taken to improve staffing levels and more actions were planned, however; more time was required to implement and embed these improvements across the service.

Staff understood and followed the provider's guidance to enable them to recognise and address any safeguarding concerns about people. Recruitment procedures were completed to ensure people were protected from the employment of unsuitable staff.

People were supported by staff who had relevant up to date training available which was regularly reviewed to ensure staff had the skills to proactively meet people's individual needs.

People, where possible, were supported by staff to make their own decisions about their care and treatment. Staff were able to demonstrate that they complied with the requirements of the Mental Capacity Act 2005 when supporting people during their daily interactions. This involved making decisions on behalf of people who lacked the capacity to make a specific decision for themselves.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager was carrying out a review to ensure that people had been appropriately assessed as to whether they could consent to living at the home prior to applications being submitted. Some authorisations had been granted by the relevant supervisory body to ensure people were not being unlawfully restricted.

People spoke positively about the food available in the home. People confirmed they were offered a choice of meals and their dietary needs and preferences were catered for. People who required assistance to eat or who received their nutrition via a tube into their stomach were appropriately supported by staff.

When required people's health needs were assessed by a range of visiting specialist healthcare professionals. This enabled nursing staff on site to deliver people's planned healthcare treatment in line with specialist guidance.

People and their relatives told us staff were kind and caring and treated people with dignity and respect. Staff did not feel they always had enough meaningful time to spend with people outside of task focused care. However, staff we spoke with were able to tell us about the people they supported and people told us their care was delivered in line with their preferences once they had got to know them.

People's decisions were respected by staff and this included people's wishes and decisions for their end of life care. We saw that people's relatives and loved ones had sent written compliments to the home to thank the staff for the 'care and kindness' people had received at the end of their life.

People or their relatives were not always involved in developing their care, support and treatment plans. Care plans were not always personalised with the detail of people's individual preferences for their care and their personal history. The registered manager told us care plans were in the process of being further developed to reflect people's personalised needs and information.

Activities were provided in the home by an activities coordinator and a team of volunteers. People spoke positively about the group activities available to them. People who chose not to or were unable to attend group activities received some individual support. However, there were not always enough staff resources to

enable people to receive the level of social interaction they would prefer. This meant some people's social and companionship needs were not met.

The provider had a complaints procedure in place and records confirmed complaints had been managed and responded to in line with these procedures.

There was a positive culture in the home and people and staff agreed it was 'homely' and 'friendly' place to live and work. Relatives told us the registered manager was a confident and effective leader. Staff were supported by management to carry out their responsibilities through the process of supervision and appraisal.

Some staff had identified shortfalls in effective communication between managers and staff and staff meetings were poorly attended. The registered manager had taken action to address this but not all staff felt this had improved sufficiently at the time of our inspection.

The quality assurance system in place was not always effective in assessing, monitoring and improving the quality and safety of the service people received, for example; the actions identified in a pharmacist audit and a provider quality assurance visit to improve the recording of topical cream administration had not addressed sufficiently to ensure this was rectified. Whilst people's views had been sought on the quality of the service, it was not evident the information had been used to drive continuous improvement to the service.

The registered manager fulfilled their legal requirements by informing the Care Quality Commission (CQC) of notifiable incidents which occurred at the service. Notifiable incidents are those where significant events happened. This allowed the CQC to monitor that appropriate action was taken to keep people safe.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

The actions required to manage risks to people's health and wellbeing were not always recorded or monitored to ensure their care and treatment could be evaluated effectively. This meant people could experience deterioration in their health and wellbeing when actions to reduce risks were not evidenced as carried out.

People's medicines were managed safely with the exception of time specific medicines. These were not always administered at the correct time and this could make them less effective in helping people to manage their symptoms.

Staffing levels were calculated on people's assessed dependency needs. People and staff did not feel there were always sufficient staff available. The provider was reviewing staffing levels against a more detailed assessment of people's needs.

People were safeguarded from the risk of abuse. Staff had completed relevant training and understood their roles and responsibilities in relation to protecting people from the risk of harm.

Is the service effective?

Good

The service was effective

Staff received an induction into their role, on-going relevant training and supervision of their work. People received their care from staff that were appropriately supported in their role.

People were supported by staff in line with the Mental Capacity Act 2005 to make decisions and their choices were respected. The registered manager was reviewing people's needs to ensure applications for DoLS were submitted as required so that people were not unlawfully deprived of their liberty whilst living at the home.

People enjoyed a choice of meals which reflected their preferences and dietary needs.

People were supported by nursing staff on site and visiting healthcare professionals to meet their healthcare needs.

Is the service caring?

Good

The service was caring.

People experienced caring relationships with staff.

People were supported to express their views and make decisions.

People's privacy and dignity was promoted in the provision of their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had a range of care plans in place. People and their relatives were not consistently involved in developing their care plan. Care plans were not always sufficiently personalised to reflect people's preferences about how they would wish to receive their care and treatment.

A range of activities were available provided by an activity coordinator and volunteers. There were not always enough staff resources to meet the social interaction needs of people who chose not to, or were unable to attend group based activities.

A system was in place for people to raise their complaints and concerns and these were acted on.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were processes in place to enable the provider and registered manager to monitor and audit the service and make improvements. However, these were not always effective in identifying, addressing or preventing a reoccurrence of risks to the quality of care people received.

It was not evident how information the provider sought from people was used to drive continuous improvement to the service.

There was a positive culture in the home. Relatives and staff spoke positively about the leadership provided by the registered

manager.

Brendoncare Park Road

Detailed findings

Background to this inspection

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

This inspection took place on 19 and 20 December 2016 and was unannounced. The inspection was carried out by two inspectors and an Expert by Experience (ExE). An ExE is a person who has personal experience of using or caring for someone who has used this type of care service; on this occasion they had experience of caring for an older person who lived with physical and mental health conditions. The ExE spoke with people using the service and their relatives, observed a mealtime and interactions between staff and people living at the home.

Before our inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. The provider also completed a Provider Information Return (PIR) before the inspection. A PIR is a form which asks the provider to give some key information about the service, what the service does well, and what improvements they plan to make. We checked this information as part of our inspection. Prior to the inspection we spoke a safeguarding adults nurse from the NHS West Hampshire Clinical Commissioning Group and a senior social work practitioner from the local authority.

During the inspection we spoke with eleven people living at the home and eight relatives, the registered manager, deputy manager, the provider's head of care services, two nurses, and seven care staff, an activities coordinator, the training coordinator and the chef. We looked at how medicines were obtained, stored, dispensed and disposed of. We also looked at the staff training matrix and staff training records. We observed care in communal areas throughout the two days including lunchtimes.

We viewed six people's care plans and daily records. We examined the Medicines Administration Records (MAR) for people living at the home. We reviewed staff files containing recruitment information for five staff members and viewed staff supervision and appraisal records and staff rotas for the dates 1 November 2016 to 20 December 2016. We also reviewed other documentation relating to the running of the home, these

included quality assurance audits, the provider's policies and procedures, complaints and compliments records.

This service was last inspected in December 2013 when no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

We received mixed feedback from people and their relatives about the safety of the home. Whilst most people we spoke with told us they felt they (or their relatives) were cared for safely, we received some comments from people and their relatives who told us they felt the service was safe most of the time but had experienced incidents which had led to them feeling unsafe at times. For example when another person who had become disorientated had entered their room and when they had perceived a lack of staff available or were cared for by staff that did not know them well.

People's care plans contained risk assessments in relation to areas such as falls, moving and handling, risk of pressure sores and for the use of bed rails. When risks had been identified, people's care plans contained clear and detailed guidance for staff on how to reduce the identified risks for people. For example, people's moving and handling plans contained details of which hoist and which size sling should be used to move them safely.

All of the risk assessments we looked at had been reviewed monthly, however, people's daily records were not always fully completed. There was a risk that nurses would therefore not have all the information they needed to evaluate whether the risk management plans they had put in place were being implemented and were effective in protecting people from harm. For example, staff were required to record people's food and fluid intake when they were at risk of poor nutrition and poor hydration to monitor whether they were receiving enough to eat and drink. Although some fluid charts had been completed and showed that people had received enough to drink, this was not the case for all that we looked at. For example; one person's daily fluid records showed they had poor fluid intake on three consecutive occasions in relation to their expected daily target intake. It was not clear from their records whether this concern had been identified by staff and what action had been taken to protect them from the risk of de-hydration. People's food charts were filled in, but had not always been filled in correctly. Staff had written over the guidance on the food charts and it was not always easy to review exactly how much people at risk of poor nutrition had eaten. This meant there was a risk that people may not have had enough to eat and drink to protect them from the risks of dehydration and poor nutrition.

Some people were at risk of developing pressure sores and they were prescribed topical creams and lotions to support them to maintain good skin health. Staff were required to record when they applied people's topical creams so that nurses could monitor that people had received the care they needed to prevent the risk of their skin deteriorating. We found examples where people's topical medicines had not been recorded as having been applied as prescribed. This included records for people who were assessed as being at high risk of developing pressure ulcers. There was a risk that people had not received their topical creams as prescribed which could increase their skin vulnerability. Although people's care records included body maps where nurses could indicate to staff where on people's bodies they should apply their topical cream, these had not always been completed and the areas for application had not been marked. There was therefore not always written guidance available to staff in relation to the application of people's tropical creams and there was a risk that staff who did not know people well would not know how to apply their topical creams as prescribed. This meant there was a risk that people may not receive the treatment they required to

prevent deterioration in their skin integrity.

People who were at risk of pressure sores had mattresses to relieve pressure on vulnerable areas. We found several examples of air flow mattress that were not set to the correct setting according to the weight of the person. Mattress settings were not always recorded or were incorrect this is important to ensure the mattress effectively helps to prevent pressure sores. In addition people at risk of pressure sores require position changes to relieve pressure. Records to evidence people's position had been changed were not always completed to show this had been done within the prescribed timescales. For example; a person's care plan guided staff to change the person's position every four hours, but the position change charts showed that this was not always carried out. On one occasion the chart showed the person's position had not been changed for six hours and on another occasion their position was not recorded as changed for six and a half hours. Another person's chart showed they had not been repositioned for 13 hours. When we asked one of the nurses about this they said they did not know who was responsible for checking that mattresses were set at the correct pressure. All of the above meant there was a risk that care was not always delivered in response to people's needs, because care plan guidance was not always followed. In addition it was unclear what checks were carried out to ensure that care was being delivered in accordance with the plans. We discussed this with the registered manager who implemented a monitoring system to ensure these records were checked for completion to enable areas of risk to people to be promptly identified and acted on.

We observed a staff shift handover meeting and reviewed the information available to staff at handover about people's needs and risks. We noted the printed handover information given to staff was incomplete and did not include all the information required to ensure staff who did not know people well would know how to manage their risks. For example; the handover information did not inform staff who in the home required repositioning due to being identified as at risk of pressure sore development; and who were at risk of poor nutrition and dehydration and therefore required food and fluid intake monitoring. Some people were at risk of choking and required thickened fluids to manage this risk. This information was not always completed in the handover sheet. Although care staff attending the handover meeting made notes on these sheets so that information could be updated with people's changed needs, we found the information was not always updated as required. For example; although the need to encourage a person with fluids to prevent the risk from dehydration was discussed at the handover we observed this was not written down for other staff to note. Staff told us the information from the daily handover was available on each wing for staff who did not attend the handover to read. This meant there was a risk that important information would not be available to all staff to ensure people's safe and appropriate care and treatment when their needs changed. We discussed this with the registered manager who took action to update the handover information to ensure people's needs and risks would always be recorded and available to all staff.

Staff responsible for administering people's medicines had completed the appropriate training and their competency to administer medicines was checked annually. We observed parts of two medicine rounds. On both occasions, the staff administering people's medicines were knowledgeable about people's medicines, took their time to support people, asked if any extra medicines were required, such as pain relief, and checked the person had swallowed their medicines before confirming the medicine had been administered. Medicines were stored appropriately and safely. Medicines that were no longer required were disposed of safely and in line with the provider's procedures.

Some prescription medicines are controlled under the Misuse of Drugs Act 1971. These medicines are called controlled drugs (CDs). Providers are required to have procedures in place to ensure that CDs are safely managed and that staff follow these to keep people safe. We found the stock levels of controlled medicines were accurate and records showed that these were checked regularly.

Whilst we saw that people's medicines were generally managed so that people received them safely, we found that not all of the medicines were given on time as prescribed. For example, one person had been prescribed medicines to be administered at specific times which were important to help the person manage the symptoms they experienced from their health condition. However, we saw the medicines had been administered late on at least seven occasions over a recent three day period. We informed the registered manager of our findings during the inspection who then took action to address this to ensure the person would receive their medicines on time.

Whilst the registered manager took prompt action to address the concerns we identified. More time was required for these improvements to be fully embedded into practice.

We received mixed feedback about the staffing levels in the home: 75% of the people we spoke with told us there were not always enough staff available, and that either staff were hurried when providing support or people had to wait a long time when they used their call bell for staff support. One person said "All the caring bit is good but finding someone is not always immediate." People's relatives were mostly satisfied with the level of staff available although their comments included having to wait a long time on occasions for staff to respond to call bells and less staff availability at weekends.

We discussed staffing levels with the registered manager and head of care services. They told us and records confirmed, staffing levels were based on a dependency needs assessment taking into account people's individual support needs and risks. We reviewed the staffing rotas for the period 1 November 2016 to 18 December 2016 and saw staffing levels were mostly provided in line with the assessed numbers required. Rotas confirmed that the same number of care and nursing staff were used at weekends. Management staff told us they were assured there were sufficient staff but this was not a view wholly supported by all nursing and care staff.

Staff confirmed people's care needs were met but they felt staffing levels were 'stretched' and they did not always feel they had the additional time to spend with people to fully meet their emotional and social interaction needs. A night staff member said "Now they (people) are requiring more care I don't feel we are giving them time we are rushing 'I must get on' I have to say to them and I feel awful". A care staff member said "No not enough staff to have the best level of care, the things they (people) miss out on is staff spending time with them or going through drawers (to assist people to organise), painting nails and getting to know them". Nursing staff said they did not feel there were always enough staff on duty and their comments included "We try to be flexible and offer people choice, but it can be a bit hectic" and "There are always two nurses, although three would be better, but if care staff go off sick, it's hard".

During our inspection we observed that call bells were busy and these were usually answered within four minutes. On one occasion the call bell went to emergency status (after four minutes). We asked a staff member about this who told us they had been supporting another person who required two carers and were unable to leave them to go to the person calling. One staff member told us call bells were always busy in the afternoon and this was when there were less care staff available. Other times staff identified as 'stretched' were nights, supper time and early mornings.

The provider was aware that staffing levels had required some adjustment and had started to address this. The registered manager told us they had recently increased care staff hours in the mornings to enable staff to support people to get up at the time they preferred. In addition the provider was introducing a revised dependency assessment tool to provide a more detailed calculation of people's support needs and staffing levels would be subject to review following this being completed. There had been a high use of agency staff due to staff vacancies but we saw this was now decreasing as more permanent staff had been employed.

This helped to provide people with more consistent care and increased the stability of the staff team. More time was required to implement and embed all of the improvements across the service to ensure sufficient numbers of staff were deployed at all times to meet people's needs.

People were protected from avoidable harm and abuse because staff understood their responsibilities to identify potential abuse and knew how to report any concerns. Records showed staff had completed safeguarding training and the staff we spoke with confirmed this. Staff told us how they would act if they had any concerns and their comments included "I've had training and I would report any concerns to the deputy manager or the manager". The provider had safeguarding policies and procedures in place available to staff to inform them of the process to follow should any concerns arise to protect people at risk of abuse.

The provider had completed the required recruitment checks to ensure the suitability of staff for employment during the recruitment processes. For example; staff records we reviewed did include a Disclosure and Barring check (DBS). The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services. The provider checked nurses had current registration with the Nursing and Midwifery Council (NMC) which confirmed their fitness to practice safely.

Good

Is the service effective?

Our findings

All of the people and their relatives we spoke with told us they thought the provider's staff were sufficiently trained to meet people's needs. Staff told us they had the training and skills they needed to meet people's needs. Staff comments included: "Training is up to date and face to face, the training is continual it's good".

People were assisted by staff who had completed an induction into their role when they started working at the home. The induction process followed the Care Certificate induction standards. These are nationally recognised standards of care which care staff are expected to adhere to in their daily working life to support them to deliver safe and effective care. New staff were supported by the provider's training coordinator and senior care and nursing staff during their induction to check staff had achieved the level of competency required to provide effective care.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. We viewed the training records for staff which confirmed staff received training on a range of subjects including; moving and handling, health and safety, infection control, and safeguarding for example. Other training completed by staff included: The Mental Capacity Act (2005), dementia, hydration and nutrition and dignity in care. Nurses completed training in subjects such as; tissue viability (pressure sore care), Diabetes, and wound care. The training coordinator told us "If there are particular needs staff can request training and I will do what I can to achieve this, for example they (nurses) have asked me to run a neurological conditions course as we have some needs". A nurse said "We get quite a lot of training. I've recently completed catheterisation training, and we're having some motor neurone disease training next month".

Nursing staff confirmed they had access to training and professional development and their comments included "I have had enough training to meet my NMC (Nursing Midwifery Council) revalidation requirements". Revalidation is a process designed to ensure all registered nurses are competent and safe practitioners. Care staff were also able to access continuing professional development training by completing a recognised qualification in health and social care at levels two and three.

People were supported by staff who had supervisions (one to one meetings) with a named supervisor. Staff told us supervisions were carried out and enabled them to discuss any training needs or concerns they had. One member of care staff told us "I have had two supervisions with a nurse it was very helpful". Staff told us they felt supported by the registered manager, and other staff. Comments included: "When I ask for help from the deputy manager or the registered manager I always get it". Effective supervision training was planned for everyone who supervised to support these staff to carry out this role effectively.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Best interest means decisions are made on behalf of people when they no longer have the capacity

to make a specific decision about their life or care.

We asked staff about issues of consent and about their understanding of the MCA. Staff had received training in this area and demonstrated a good knowledge of the Mental Capacity Act and how it related to their role. Staff told us about how they supported people with their day to day decisions. One staff member told us, "MCA I had training I look at the care plan I always ask residents 'what would you like to do'. They normally answer 'I'm doing this or that' and if not I always try to do the thing that is in their best interests or ask the nurses". Records showed that when people had been assessed as lacking capacity to make specific decisions about their care, the provider had complied with the requirements of the MCA. For example; When people had been assessed as being at risk of falling from bed, bed rails risk assessments had been completed and where able, people had signed to indicate they consented to their use. When people were unable to sign themselves, the plans contained details of how the decision to use bed rails had been reached in the person's best interests.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that some applications had been made which were being assessed by the local authority. At the time of our inspection the registered manager was reviewing people's needs to ensure applications for DoLS were submitted as required so that people were not unlawfully deprived of their liberty whilst living at the home.

People told us they liked the food and were able to make choices about what they had to eat. A person said "Food is good, always a choice and I can ask and I'll get" and another person told us they could talk to the chef if they did not like what was on the menu and he would cook an alternative that was liked. We saw the chef had information available on peoples' likes and dislikes as well as their dietary needs and these were catered for. This included allergies and specific dietary requirements such as a higher calorie diet, or a pureed consistency of food or any other specialised diet.

We observed lunchtime in the home and saw that people who required assistance to eat were appropriately supported by attentive staff. When people had complex nutritional needs, external support and advice was sought. Records showed that speech and language therapy (SALT) teams and dieticians were actively involved in people's care. Some people using the service had a percutaneous endoscopic gastrostomy (PEG) tube in place. This is a medical procedure in which a tube (PEG tube) is passed into the stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. Care plans in relation to people's feeding regime and care of the PEG's were well documented and provided clear guidance. Records showed that feeding regimes were followed.

People were supported to maintain good health through access to a range of health professionals. This included on-site nurses as well as other professionals who were involved in assessing, planning, implementing and evaluating people's care and treatment. This included specialist nurses for Motor Neurone Disease and Parkinson's, tissue viability nurses, palliative nurses; respiratory nurse, speech and language therapists and a dietician and nutrition nurse. People had access to three GP surgeries near to the home or their own GP if preferred. People we spoke with confirmed they saw healthcare professionals as and when needed.

Good

Is the service caring?

Our findings

People and their relatives had positive views on the caring nature of the staff. People we spoke with told us the staff were caring and treated them with dignity and respect. A person's relative said "Staff have developed relationships (with person) and are always friendly and welcoming." We observed caring interactions between staff and people. We saw people being assisted with kindness and patience by staff and responding to people with care and compassion.

Staff we spoke with were able to tell us about the people they supported and what was important to them. For example, staff told us about the drinks people preferred, their important relationships and their interests. A staff member told us how they supported a person to send text messages to keep in touch with people as they were unable to do this and a person said "Some super carers and they make me laugh they do the best they can". Staff told us they did not always have enough meaningful time to spend with people outside of task focused care. For example a staff member said "The care is good here, but it could be even better if we had more staff. We do a great job though considering". Other staff told us they took the opportunity to get to know people whilst delivering care. For example, a staff member said "I do that (getting to know a person) during personal care I ask people questions and they tell me their life story we have five minutes to have a chat at lunch time". People told us that once staff had got to know them, their care was delivered in line with their preferences.

During our inspection, we saw staff supported people's privacy and dignity. When people required support with personal care tasks this was done discreetly, behind closed doors to ensure people's dignity was maintained. Staff we spoke with told us they would explain the care to be given and seek the person's consent before supporting people. A staff member said "We close the door and curtains and we ask and give choices such as; clothes, food, and what they prefer to do". People confirmed staff treated them with dignity and respect.

People's decisions about their care were respected. For example, a person's relative told us their relative's choice of sleeping arrangement and how they spent their time was respected by staff. People told us staff asked for their consent prior to delivering care and treatment and that their choices were respected. A person's relative said "I've asked if (person) can have personal pictures and objects from home and they have agreed this".

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, equipment and medicines were provided as and when needed to enable people to be as pain free and comfortable as possible. People's wishes and decisions were recorded and available to guide staff. We saw that people's relatives and loved ones had sent written compliments to the home to thank the staff for the 'care and kindness' people had received at the end of their life. People's views regarding the end of life care they wished to receive were documented, known and respected by staff.

Requires Improvement

Is the service responsive?

Our findings

People's care and treatment was set out in a written care plan based on an assessment of their needs. We received mixed feedback about the involvement of people or their relatives in developing their care and treatment plans. Five out of nine people said they had been involved in a review of their care plan and one relative out of three said their relative had been involved in a care plan review. Although all of the care plans we looked at had been reviewed monthly, only one care plan out of five had documentation that showed that the person had been involved in the review. There was nothing in place to show that where people were unable to contribute to their care planning their relatives had been invited to attend care reviews. We spoke with the relatives of a person who was unable to contribute to their care plan. Although they visited their relative very regularly there was no record that their views had been sought and recorded to update the person's care plan. This meant there was a risk the views of the person or those acting on their behalf about their care and treatment may not be known or acted on to develop their care plan in a meaningful way.

People's care plans did not always provide staff with information on people's preferences or life history to support staff to know and understand people's needs and preferences. For example, some care plans did not include a life history and lacked detail on how people preferred their care to be delivered to meet their preferences. This information is important to help staff develop relationships with people and provide personalised care treatment and support. For example, only one care plan we reviewed contained a history profile of the person providing information to staff on the person's life before moving to the home as well as a personal timeline of their life. This information was not in place in the other care plans we looked at.

Although care plans contained some person centred information relating to people's care needs, this was limited. For example, in one person's personal hygiene plan, it had been documented "Doesn't like to look dirty", but there was no detail in relation to how the person liked to dress for example, or what time they preferred to get up in the morning. Other plans did contain this detail for example, a person's plan detailed that they liked to wear "smart clothes, light make up and jewellery". The registered manager told us care plans were in the process of being developed to ensure they reflected people's individual choices, preferences and life histories.

We noted that wound care plans were detailed and where necessary advice had been sought from tissue viability nurses. There were clear photographs in place, with the date and wound dimensions recorded. This meant it was easy for staff to identify when wounds were improving or deteriorating.

An activities coordinator was in post who was supported by a team of volunteers to deliver a programme of activities for groups and individuals. We received mixed feedback about the activities available to people in the home. Most people told us the group activity programme was 'good' and that they got involved as much as they wish. However, people who required support to engage in individual activities told us their needs were not always met. For example, a person said "The morning activity is a no go for me because I haven't been done yet and if I am rushed I won't benefit. I would like to do a lot more in company I'm sure there are a lot of lonely people who might like a one to one chat. No one comes and spends time with me". This person's activity records stated '(person) enjoys a chat whenever she can'. Records showed they had a

keyworker meeting in November 2016, no activities in December 2016 were recorded and eight activity sessions in total were recorded between April and November 2016. Another person's activity record stated the aim was 'to maintain social skills and reduce isolation' This person also spent most of their time in their room. Records showed they had five individual activity contacts between September to December 2016. We spoke to the activities coordinator about this who acknowledged activity contacts were not always recorded. They said, "I do my very best to see every one every week I can't see everyone every day. If it's not in the file it doesn't mean I haven't been I can spend 10 minutes making their day or writing something down, my residents are more important". They added, "No I don't think we have enough staff to meet peoples activity needs because we are all so different some don't want to mix with other older persons. It's usually me that has a bit more time other staff don't have the time". This meant that some people may be at risk of social isolation and their needs for social contact and companionship may not be met.

People spoke positively about the group activities available. The activities coordinator consulted people about their suggestions for activities and these were acted on. For example, people had requested flower arranging sessions and these had been held and proved popular. A regular 'pub quiz' was held and one resident was involved in compiling the quiz from time to time, a person told us this was "very good". The activities coordinator said "I am passionate about what I do and I like them (people) to suggest things and we get ideas from there". Other activities included exercise sessions, board games, musical entertainment and discussions about local history to stimulate memories. Religious services were held twice a month at the home by visiting clergy from local church of England and catholic churches. Themed events were held monthly such as a firework display and an Australia day celebration. The Australia day event had included a tasting of kangaroo, crocodile and wagyu beef burgers. A resident had written to compliment the home on this activity and stated "Just another example of how Brendoncare is special by providing so many stimulating activities to keep minds and bodies active".

The provider had a complaints procedure in place and we reviewed the records of complaints received. Records showed complaints received had been responded to in line with the provider's procedure. People we spoke to said they knew how to raise a concern and make a complaint. Of the people we spoke with two people told us they had raised concerns and were satisfied with the way their concerns were dealt with. A system was in place for people to raise their complaints and concerns and they were acted on.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us there was a positive culture in the home. One person said "The home is a real community, carers and the people who live here". Most people and their relatives told us they felt staff were happy working in the home and their comments included "The staff are always cheerful" and "I have never found them moaning". Staff also spoke positively about the culture in the home. Staff comments included; "I feel well supported and appreciated by the company" and "It's a nice friendly place and we all get on well". One staff member said "Its people's home".

The governance system in place to monitor the quality of the service and identify the risks to the health and safety of people was not always effective. Although a system was in place to monitor the quality of care people received when risks to people had been identified they were not always acted on promptly to address these shortfalls. For example, regular medication audits were undertaken; we looked at the latest medicine management audit dated 21 November 2016 and the latest Pharmacist advice visit dated 29 June 2016. Both of these audits reviewed topical medicine administration. The pharmacist advice report recommended the use of body maps and topical administration records. The provider audit had not identified the issues that we saw in relation to poor record keeping of body maps and topical administration records. A monthly visit record of a quality assurance check carried out by the provider on 6 December 2016 did identify that topical medication administration records 'remained incomplete'. However we found these records were still incomplete at the time of our inspection.

Whilst people and their relatives told us the home was well-led, they did not always feel they had been asked their opinions and were therefore unable to say whether their views had been acted on. We asked nine people if they had been asked their opinions about how things are run, four said "yes". One said "not yet" (they had only been in the home a short time). Three said "no" and one person said that they "don't see management very often". We asked people if the management listened and acted on what they said. Of the nine people we spoke to three said "yes", one said "no". Three said they had not been asked for their opinion and were therefore unable to address the question. One person said "I guess so, I don't see any management". One person said "they listen but nothing is done or it is in hand".

We saw the results of a quality assurance survey completed by people living at the home with the help of volunteers in October 2016. People were asked their views on living in the home, staff and for their overall satisfaction with the standard of the home and likelihood to recommend the home. The results showed that people had identified some areas for improvement such as; staff not having enough time to talk to people and people not having a real say in how staff provide care and support to them. These concerns were also raised with us by people and relatives during the inspection. An action plan had not been produced from the findings to address people's feedback. Whilst people were asked to give their feedback and opinions about the service it was not evident that the information had been meaningfully used to drive continuous improvements to the service.

Staff spoke positively about the leadership and management in the home. Staff told us the registered manager was "approachable" and a staff member commented "The registered manager tries to get things

done; she would try and help you with any problems". We spoke with the head of care services who told us how the provider was supporting registered managers through regular meetings to share experiences and drive improvements and develop consistency in practice across the provider's homes. The registered manager told us they were well supported by the provider to meet the requirements of their role. Weekly management team meetings were held to ensure communication between the registered manager and other managers was effective and to monitor progress towards shared goals. People's relatives spoke positively about the registered manager and their comments included "(the registered manager) is always available and visible" and (the registered manager) is a wonderful leader and as a result the staff respond and it works in all sorts of ways."

Staff were asked for their feedback by completing an annual staff survey. We saw the results from the survey carried out in 2016 had identified communication as the main area staff had identified for improvement. This included communication with staff about how they do their job and staff not always being given the information they needed. Staff meetings were held a couple of times a year and although staff were given paid time to attend the attendance was poor. Minutes of a staff forum meeting held on 25th November showed that three staff had attended.

At the time of our inspection not all staff we spoke with thought communication between staff and managers was effective. For example, staff comments included "The biggest thing I find is the lack of communication things being passed on about residents or anything really" and "We don't often get the communication about events and things within Brendoncare. We do have a notice board". One staff member told us "Staff meetings are not well attended then you get three or four things said that are not generated" another staff member told us communication was "poor".

The registered manager had taken action to make improvements in communication between managers and staff. For example; they had made improvements in the regularity of staff supervision with a named supervisor and ensured that an annual performance appraisal was carried out. This was to ensure staff were provided with support and the opportunity to receive feedback about how they did their job. Action to improve communication with staff who did not attend meetings had been addressed by attaching minutes of these meetings to staff payslips. Nurses told us meeting were planned to be held from January 2017 specifically for nursing staff. Given the feedback we received from staff during our inspection more time was needed to evaluate the effectiveness of the actions taken.

A system was in place to record, monitor and review any incidents occurring in the home. Incidents were analysed for trends and monitored by the provider to ensure action was taken to make improvements and address any safety issues. The registered manager was aware of the requirements of their registration with the Care Quality Commission. They adhered to their registration requirements and submitted statutory notifications as required, for example, of incidents resulting in serious injury to people.