Ranc Care Homes Limited

Brentwood Care Centre

Inspection report

Larchwood Gardens
Pilgrims Hatch
Brentwood
Essex
CM15 9NG

Tel: 01277375316
Website: www.ranccare.co.uk

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

Summary of findings

Overall summary

We previously carried out an unannounced focussed inspection on 5th May 2016 in response to information of concern we received about whether people were receiving safe care and treatment at the service, specifically on the nursing unit. Areas of concern included how risk was managed, medicine management, information sharing, insufficient staffing levels and staff competencies.

During the previous inspection which focussed on the nursing unit and looked at the domains of safe and well-led we found three separate breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the safe management of medicines, risk management, staffing and the way in which the quality and safety of staff and the service was monitored.

Following the focussed inspection, the provider provided us with an action plan, which set out what they would do to meet the legal requirements in relation to the breaches and to improve the service. Because the breaches potentially affected all areas of the service we undertook a comprehensive inspection looking at all domains across all five units to check that the service had implemented their action plan and to confirm that they now met the legal requirements.

This inspection took place on 30th March 2017 with a follow up visit on 4th April 2017 and was unannounced. Brentwood Care Centre provides accommodation over two floors on five separate units for up to 112 people who require nursing or personal care. There were 83 people living at the service at the time of our inspection.

The service had 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.

At this inspection we found that the service had followed its action plan to address the breaches and those aspects of the service we had identified that required improvement which meant that the nursing unit now met the legal requirements and was no longer in breach of the regulations. However, this inspection looked not only at the nursing unit but also at the service as a whole and in so doing found a continued breach of Regulation 12 (1) (g) safe and proper management of medicines.

On two of the five units we found that people's medicines were not managed safely.

There were systems and processes in place to monitor the quality and safety of the service, however these were not always effective as we found medicine audits had failed to identify areas that required improvement to ensure people's safety. We recommend that the service re-evaluate its current system of auditing medication.

There were sufficient numbers of appropriately trained staff who had been recruited safely and were aware of their safeguarding responsibilities and knew how to protect people from risk of harm.

Staff knew people well and were aware of their preferences so were able to provide person centred care.

Training, supervision and support was made available to staff which provided a method of assessing staff competency and promoting learning and development.

Where appropriate mental capacity assessments had been completed. This ensured that any decisions taken on behalf of people were in accordance with the Mental Capacity Act (MCA), 2005.

People were involved in making decisions about the care and support they received. Where people experienced difficulties with decision-making, they were supported by staff who were aware of their responsibilities under the legislation.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and made appropriate applications when necessary.

People were supported to maintain their health and had access to wide range of healthcare professionals.

A choice of food and drink was available that reflected peoples nutritional needs and took into account their preferences and any health requirements.

There was a strong focus on providing good quality dementia care and new initiatives had been introduced to promote the health and wellbeing of people living with dementia.

Opportunities were made available for people to follow their interests and take part in activities and people were supported to follow their religious practices and beliefs.

People were supported to keep in contact with their family and friends and make new friendships.

There was a new manager in post who understood and met their registration requirements and demonstrated a commitment to improve quality and promote innovation within the service.

The service responded appropriately to complaints and used feedback constructively to drive improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

On two units we found that medicines were not managed safely.

There were sufficient numbers of staff to meet people's needs.

Staff understood their responsibilities to protect people from harm.

Risks to people were identified and managed safely.

Is the service effective?

Good

The service was effective.

Staff had the knowledge and skills to carry out their roles and responsibilities.

Staff had a good understanding of the Mental Capacity Act and how to support people to make their own decisions.

People were supported to have enough to eat and drink.

People were assisted to maintain health and wellbeing and have access to healthcare services in a timely fashion.

Is the service caring?

Good

The service was caring.

People's confidential information was not always kept secure, however steps had been taken by the management team to address this.

Staff knew the people they cared for and used this knowledge to build positive relationships.

The service listened to people and involved them and their representatives in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their needs.

People could choose to participate in a range of activities.

People and their relatives were confident to raise concerns if they arose, and that they would be dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality assurance audits had not always been effective at identifying areas that required improvement.

The management team was approachable and supportive of staff.

The new registered manager was pro-active in developing the service.

Feedback from people was invited and used constructively to make improvements.

Brentwood Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 30 March 2017 and was unannounced with a follow-up visit on 4 April 2017. The inspection team consisted of two inspectors, a specialist nurse advisor 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 service.

We reviewed all the information we held about the service including notifications sent to us by the provider. Statutory notifications provide us with information about important events which the provider is required to send us by law. We also looked at the action plan the provider had formulated in response to breaches found during the previous inspection. We spoke with the local authority and quality improvement team who had worked with the provider and were familiar with the service.

During the inspection we spoke with eleven people who lived at the service and one person's relative. Some people who used the service were living with dementia and were unable to tell us about their experience so 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.

Throughout the day we also used informal observations to look at staff interactions with people and with each other including observing the daily stand-up meeting of senior personnel. We spoke with the registered manager and fourteen members of staff who were a mixture of care staff and nurses.

We looked at twelve peoples care records, eight staff files and looked at information relating to the management of the service such as training records, supervision notes and quality monitoring audits.

Requires Improvement

Is the service safe?

Our findings

At our last focussed inspection of the nursing unit we found a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people were not adequately assessed and monitored, medicines were not always managed safely. There were insufficient staff deployed and training and competency checks for nursing staff was patchy which meant we could not be assured that staff had the necessary skills and knowledge to support people safely.

At this inspection we found that medicine management on the nursing unit was undertaken safely and in line with current professional guidelines. Medicines were only administered by nursing staff who had received training and had their competency assessed to ensure they had the necessary skills to administer people's medicines safely. People had individual medicines administration records (MAR) which had their photograph on so that staff could identify people correctly before giving medicines to them. This minimised the risk of people receiving the wrong medicines. Records relating to medicines were completed accurately and stored securely and we found no gaps on people's MAR indicating that they had received their medicines as prescribed.

We observed the morning medication round and found that the nurse followed the current professional guidance and policies regarding medicines management. All prescriptions were correctly adhered to and all medications had been dispensed using local agreed prescribing protocols. All medicines were labelled and stored correctly and the medicine trolley was clean and tidy.

People's medicines were administered to them in the correct way and the nurse assessed people individually for PRN (as needed) medicines. We observed the staff member using a range of techniques to assess people for PRN including using bowel and nutritional assessment charts and speaking to people to find out whether they had slept well or had been kept awake with pain and asking them how comfortable they were. With one person they considered their current state of breathlessness to see whether they required their inhaler therapy, this was done in conjunction with asking the person what they wanted to do. The nurse was very patient and allowed people time to swallow their medicines without rushing them, saying things like, "Take your time," and, "These tablets can be hard to swallow," and, "Show me that they have all gone." This practice demonstrated a kind and compassionate approach.

When questioned the nurse was able to give a full and comprehensive explanation of the systems and processes in place for safe medicine management including the protocol for missed medicines and the disposal and return of medicines.

We looked at medicines management on three other units and found that medicines were stored safely for the protection of people who used the service. There were arrangements in place to record when medicines were received into the service and given to people. We observed a senior giving people their medicines and they did this by following a safe procedure. They checked they were giving the medicines to the right person. They also signed the medicine charts after they had given each person their medicines. However we found that the provider's arrangements for the safe management of medicines on two of the units required

improvement.

Each person had a completed MAR which recorded the medicines that people were prescribed. The MAR contained a running total of medicines that were boxed rather than in a pre-packed system from the pharmacy. We checked the stock balances of medicines in the trolleys and found they were not always correct which meant staff were unable to account for them. We counted ten boxes of tablets, out of these, four contained the incorrect balance, and we were told that the senior regularly audited medication but they had not identified the mistakes we found.

One person's medicine had changed time of administration from 7 pm to 9 pm and was prescribed to be given once daily however we found on one occasion that the medicine had been given at 7 pm and again at 9 pm. The registered manager was alerted and followed the medication error procedure that included checking with the GP that the person was not at risk from receiving this medicine twice. Another person was prescribed a medicine with instruction from the prescriber to take a medicine on alternate days, although the blister pack only contained the medicine for alternate days staff had signed to indicate that this had been administered every day. On another person's record, we found that staff were signing for the same medicine twice on two separate MAR's. This was a transcribing error as we found the correct amount was still available to demonstrate that this medicine had not been administered for each signing.

Controlled drugs were not always safely managed. Controlled drugs are drugs classified under the Misuse of Drugs Act 1971 and have specific requirements in relation to storage, administration and recording. The index was not being used consistently and handover entries completed at each shift were confusing and sometimes recorded in error that a person's pain patch had been administered, although the balance did not change. We found evidence within the controlled drugs register that the prescriber's instructions were not always being followed. For example, a transdermal patch should have been applied once weekly but we found on four occasions that the patch had not been administered on the correct day.

We saw that senior staff were responsible for completing medicine audits to check that medicines were managed safely but these had failed to pick up on the mistakes we found. We talked to the registered manager about our concerns who took immediate action to provide additional supervision and mentoring to the staff members concerned. They also showed us copies of audits completed at regional level which looked at medicines and we saw that these audits had identified the mistakes we found and action plans had been put in place.

The provider had failed to ensure that people's medicines were managed safely. This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found significant improvements in the way that risk was managed across the whole of the service including the nursing unit. People had individual risk assessments that were tailored to meet their individual needs that had been regularly reviewed. The service had introduced a 'resident of the day' scheme which meant that every person had their care records reviewed on a set date every month. This ensured that the information held about people including risks and how to manage them were checked and updated if necessary to ensure the information was still current and relevant.

The registered manager had introduced a daily 'stand up' meeting every morning where any changes to people's care and support needs was discussed with the seniors from each unit. They then feedback to their staff so that everybody had the most up to date information about people to keep them safe.

Staff we spoke with demonstrated a good awareness of the risks to people and how to manage them. For

example, one staff member told us, "[person] needs their walking stick and always needs someone with them to help them stand." Another worker said, "We need to be aware that [person] needs to stay relaxed; they can get a bit rigid when we hoist them; we keep them relaxed by explaining everything to them." We saw that the information staff shared with us about risks to people matched what was written in their care records.

At our previous inspection on the nursing unit we found that people identified at risk of weight loss had not always been weighed as prescribed. Whilst food and fluid charts were kept for people, they were not always filled in completely and the information collected was not used constructively. Since that time a new registered manager had been appointed who had introduced a weekly clinical review meeting. This meeting was used to review all information collected across the service on risk such as incidents of falls, pressure ulcers, infection and weight loss and identify those people at risk so that plans could be put in place to keep people safe. For example, we saw that where a person had been recorded as losing weight, the service had responded by increasing the frequency of weighing that person from monthly to weekly and a referral had been made to the GP. We looked at this person's records and saw that they had since put on weight.

Risks to people's skin integrity were well managed. People at risk of pressure ulcers had pressure relieving equipment in place. People's pressure care records, for example, waterlow scores which measure the risk to people of developing pressure ulcers were up to date. Where a person had a leg ulcer, their care plan was up to date and the wound had been documented using photographs in line with best practice guidance. The latest photograph showed the wound as healing indicating that the person had received good quality pressure care.

People were supported to move around their home environment safely and without restriction. One person told us, "We have freedom here, we can go where we like, when we like, they [staff] wouldn't tell me to sit down or even do something I didn't want to do."

We found that the service had developed a strong focus on falls prevention which had historically been an area of concern. The registered manager had started to use a falls analysis software package to look for trends as to why people were falling to help prevent future falls. People had falls risk assessments in place and if a person fell, a falls risk analysis was added to their care records. This was then reviewed monthly by care staff and also by the management team. Falls were also discussed in the weekly clinical review meeting to ensure that appropriate plans were put in place to minimise risks to people. For example, where it was observed that a person had fallen three times in the morning, staff had faxed a referral to the GP to review the person's health and medication since which time there had been no further incidents of falls.

People told us they felt safe at the service. One person said, "I feel quite safe here, I can leave my watch laying around in my room; it's never gone missing." Another person said, "I feel safe with them [staff], they're very very good." We observed that people were always given their call bell when sitting or sleeping in their bedrooms. One person told us, "It's always here, I try not to call them but if I do they come quickly and treat me well." Another person said, "I'm not left waiting for too long if I press my bell."

At our previous inspection we found that staffing levels were insufficient to meet people's needs safely. During this inspection visit we found there were sufficient staff deployed to keep people safe. We observed that any request by people for assistance and support was met in a timely manner. Staff told us there were enough staff although agency staff were required to cover sickness.

People told us there were normally enough staff on duty however; they felt the service suffered when agency workers were on duty. One person told us, "It puts pressure on our regular staff as the agency ones don't

know what they are doing; our staff have to work much harder then and sometimes they just to it themselves because it's easier." Another person said, "The agency staff are good but they don't know the routine and our staff get fed up with it; it makes their job harder." A relative told us, "Staff numbers can be too low; when staff go off sick and we get agency staff it's not the same; our staff know how to handle difficult people but the agency staff don't of course."

The service employed a mix of permanent and agency workers to ensure they were fully staffed on a day to day basis. We checked the rota and found that the staff working that day matched with what was specified on the rota. The registered manager told us that recruitment was ongoing and that they had just recruited three new night nursing staff which meant that they would no longer need to use agency staff at night on the nursing unit. Where agency workers were used the registered manager told us they tried to use regular agency staff who knew people well.

Systems and processes were in place for the safe recruitment of suitable staff. Checks on the recruitment files for eight members of staff showed that they had completed an application form, provided a full employment history and photographic proof of identity. The provider had also taken up references and undertaken a Disclosure and Barring Service (DBS) check on all staff before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use health and social care services.

Staff were able to demonstrate their understanding of abuse and discrimination. Staff described what they would do if they were told, saw or suspected that someone was being abused or harmed in any way. We saw that the registered manager recorded and investigated safeguarding concerns appropriately and sent notifications to us in a timely way. Staff told us they felt confident that if they needed to whistle-blow they would be listened to and their concerns actioned. We saw that staff meetings were used to provide staff with information on safeguarding and whistleblowing so all staff were aware of their responsibilities and the reporting process.

Accidents and incidents were recorded and analysed. We looked at the accidents and incidents log and saw that appropriate measures had been taken to minimise risk. For example, where a person had fallen the service had observed the person for signs of injury, called paramedics, dipped the person's urine to check for infection and updated the person's care plan to reflect any changes in their support needs.

There were arrangements in place to manage and maintain the premises and equipment safely. Where manual handling equipment had failed safety checks, the maintenance person advised us that this equipment was taken out of service until it could be repaired or was replaced. We saw that health and safety, maintenance and fire safety checks had been completed including weekly checks of fire extinguishers, fire exits and smoke alarms. We saw that the service had recently had an inspection visit by the fire service and where it had been identified that they were non-compliant with fire safety legislation remedial actions had been advised. The provider informed us that all outstanding actions had been completed, for example, where it was identified that fire training for staff was not fit for purpose, face to face training for six members of staff had been booked.

Good

Is the service effective?

Our findings

At our last inspection of the nursing unit we found training for nursing staff in basic life support was patchy and was only provided via E-learning which meant that not all nursing staff had the practical skills and knowledge to cope with emergency situations. At this inspection we saw that in addition to the E-learning all nursing staff now received practical face to face training in basic life support which was delivered by the registered manager who was also a qualified nurse.

At this inspection which looked at the whole of the service, we found that staff had the skills and knowledge to care for people effectively. People told us repeatedly that they had every confidence in the staff and felt they were well trained and able to deal with any eventuality. One person told us, "Nothing seems to worry them [staff] here, even though some people do not treat them nicely."

When new staff joined the organisation they received an induction. The registered manager told us that the induction provided was based on the care certificate standards which helps to ensure care staff have a wide theoretical knowledge of good working practice within the care sector. Staff told us that during their induction they had the opportunity to read people's care records and shadow existing members of staff. This meant that staff were given the time to get to know the people they would be supporting and understand how best to meet their needs. New staff were paired with senior staff so they could receive instruction and guidance and have their practice observed to monitor their competence. We spoke to a new member of staff about their induction experience who told us, "I think it's pretty awesome."

The registered manager kept a training matrix to monitor gaps in staff knowledge and ensure staff training was up to date. Where staff training had lapsed they were sent email reminders to book themselves on to training sessions. Staff told us the training was good and provided them with the skills and knowledge to do their jobs. One staff member said, "The E-learning is good, dementia training is also really good and recently I learnt a lot about pressure ulcers which was really helpful."

Staff received E-learning and practical training in how to move and position people safely. We observed people being moved and positioned throughout the day and saw that this was done in a kind and competent manner. New staff told us that they were not allowed to move and position people until they had had practical training and had their competency assessed.

The registered manager told us that they completed observations of staff practice to ensure staff were competent in their role. We saw examples of written observations which looked at how staff moved and positioned people, supported people with personal care and administered medicines.

Only senior members of staff administered medicines. We looked at training records and saw that all staff who administered medicine had up to date training certificates and had received a medication competency check to ensure they knew how to administer medicines safely and effectively.

Staff told us they received regular supervision and annual appraisals and felt well supported. Staff were

provided with opportunities to continue to learn and develop professionally as the service supported staff to undertake further qualifications in health and social care to improve their skills and knowledge. One staff member said, "I find supervision is really helpful, we talk about training etcetera, I'm going to do NVQ level2, I'm being supported with that."

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that the provider had made appropriate DoLS applications to ensure that people were not being deprived of their liberty unlawfully.

We found that the service had considered people's capacity for decision making and completed appropriate MCA assessments, consulting people's families regarding best interest decisions. One relative told us, "I don't want [named] taken back to hospital unless absolutely necessary, - I'd sooner they stayed here with staff they know; they [the service] are happy with that, it's in [named] best interests.

Staff had received training in the MCA and were able to demonstrate how they applied the principles in their daily practice. One staff member told us; "We always give people choices, for example about what to wear; I would show the person two items, trouser and skirt and then ask which colour, grey or black; I don't give too many choices as people can get confused.' Another staff member said, "Even when people are confused they still have a choice, we can't force people to do anything they don't want to." Staff understood the importance of gaining consent and we observed throughout our visit that staff always asked people's permission before helping them.

People were supported to have enough to eat and drink to meet their health needs. 'grazing stations' were set up on each unit which meant people had access throughout the day to a table laid out with drinks and snacks including crisps, biscuits and fruit. Smoothies, hot chocolate and ice cream floats were also made available daily to fortify people's food and drink intake.

On the day of inspection we observed lunch being served in one of the dining rooms. Tables were nicely laid with tablecloths, serviettes and condiments and written menus on each table. A choice of drinks were offered to people and staff took their time waiting for people to make a decision. Where one person was unable to choose, the staff member checked with a colleague about this person's preference. There was a choice of three options for lunch including a vegetarian option. Meals were nicely presented although they came with gravy already served which meant that people were not able to make a choice. We saw that some people chose to eat in the lounge instead and these people were served promptly and provided with any additional assistance they needed.

Feedback from people about food was mixed. One person said, "I'd like more fresh vegetables and the gravy is not very nice." Another said, "We could do with a bit more variety, I get fed up with soup and sandwiches nearly every night." Two people told us they would prefer gravy to be added at the table so that they could choose whether they had it and how much. However, other people told us the food was good. One relative told us, "The food here is good, faultless, if it's something my [relative] doesn't like, like bolognaise, I'll ask them to cook [named] some sausages instead, they don't mind. Another relative said, "Chef will offer me lunch if I'm here at mealtimes, they don't charge me which I really appreciate."

We spoke with the chef who told us they kept a list of people's food likes and dislikes, allergens and any dietary requirements to ensure that people received food that met their preferences and any health needs. If people were on a soft diet, the chef separated the colours of foods and presented each food item in attractive quenelle shapes so that food looked appetising. The chef showed us a catalogue of pictures they had started to take of each dish they made so that they could create a pictorial menu to make it easier for people living with dementia to make food choice.

People had access to a range of healthcare services to maintain their health and wellbeing. Records showed that people received routine health checks by dentists, chiropodists and opticians. People's day-to-day health was monitored and discussed during the daily and weekly meetings. We saw that when needed referrals to other health care professionals were made appropriately and in a timely fashion. For example, we saw an entry in a person's daily notes where staff had noticed blisters on a person's legs and the GP was called immediately. Relatives told us that the service provided a good standard of care which had helped their family members recover from periods of ill health.

Good

Is the service caring?

Our findings

People and relatives told us the staff were kind and caring. One person told us, "I'm very happy here, the carers are gorgeous, always smiling, and they do care about us; I can't fault them in any way. " Staff told us they enjoyed working at the service and were fond of the people they supported. One staff member said, "I enjoy my job and try to treat people like I would my own relatives."

Whilst there were secure cupboards for the safe storage of people's care records, we found that people's confidential information was not always kept locked away. We discussed our concerns with the registered manager who advised us they were aware of this issue and had used staff meetings and supervision sessions to emphasise the importance to staff of ensuring people's care plans were always kept securely stored. They assured us they would talk to each staff member again individually to reinforce the importance of confidentiality.

When new people came to live at the service they told us that staff were very good at helping them to settle in. One person told us, "I've settled in well here, the carers have been lovely to me, I'm never made to feel like I'm a nuisance." A relative told us, "Staff were all so friendly when my husband first arrived here, the male carers especially are very good to him, very caring and understanding, they talk to him and explain everything they're doing even though he can't talk to them; I can't praise them highly enough for all they do for him."

People were encouraged and supported to make choices, express their views and be involved in their own care as much as they were able to. We found that staff knew the people they supported well and were able to anticipate their needs. A person told us, "The staff here are incredible people, they understand my needs and know how I like things done and nobody would be unkind here, it just wouldn't happen, it's not that sort of place." People told us they felt listened to. One person said, "You can tell staff something and they will listen to you, they're good, they treat us well, I view them as my friends now."

Relatives told us they felt welcome at the service and also felt listened to by staff. A relative told us, "They understand my needs and are always ready to listen to me if I'm upset or need some advice." Another relative said, "The staff here are so good, they've always got time for you."

Interactions between staff and people who used the service were positive and relaxed and staff demonstrated warmth and affection for people. We observed a person walking back to their room who was greeted constantly by staff who stopped to chat and give the person a hug. They told us, "Look, this is what it's like here, why would I not like it here, I love it here, they do look after me very well."

Relatives told us they felt welcome at the service any time which meant that people were supported to maintain relationships that were important to them. Where people had relatives who lived a long way away, the service supported them to stay in regular contact, for example, one person was supported to visit the reception area every evening so they could make a phone call to their relative.

The registered manager told us that they tried to facilitate new friendships for people and would pair people up and sit them together for lunch. We saw evidence of this in people's daily notes. For example, one person's daily notes stated, "[person] enjoyed their breakfast, took new resident to introduce to them, they had a nice chat together."

We saw that staff treated people with respect and promoted their independence. People looked relaxed and comfortable with the care provided and the support they received from staff. Staff addressed people by their preferred names, and chatted with them about everyday things and significant people in their lives. We observed staff knocking on people's doors before entering and asking people's permission before providing any care or support. A person told us, "Staff here treat me very well; I've never seen them shout or be unkind to anyone."

We saw that the service had ensured that people who had no family or friends to support them had access to advocacy services. An advocate is a person who can provide independent impartial support so that people have a voice and can be supported to communicate their wishes.

People were supported to make their preferences for end of life care known and these were recorded where this had been agreed. We saw that where people had 'do not attempt cardiopulmonary resuscitation' (DNARCPR) orders in place these were filed in people's care folders and it had been recorded in their care records that the orders had been discussed with family members.

Good

Is the service responsive?

Our findings

Before people came to live at the service the registered manager, who was a qualified nurse, completed an assessment to ensure that Brentwood Care Centre could meet their needs. Staff told us when new people arrived they got a copy of the assessment and also spoke to people's family and friends to help them provide appropriate care and support as they got to know people and their personal preferences.

Each person had an individual care file which documented their personal needs. The care records included arrangements for people's nutrition and hydration, moving and handling, their medicines and any health needs. People had lifestyle profiles which identified their interests, likes and dislikes so the service was aware of people's routines and preferences. We saw that people and their relatives, if appropriate, were included in the care and support planning and were invited to yearly reviews.

Completing life stories for people as part of their care and support plan can be very helpful in getting to know the person and what is important to them and helps care providers deliver person-centred care. We saw that the provider had identified that people's life histories were not always completed or detailed enough to support staff to provide a person-centred approach. Therefore they had introduced a new section to people's care and support plans called 'map of life' which was a way of capturing important information about a person's life history including details of their family and work life, interests and holidays, hopes and dreams. We were told that this piece of work was ongoing and saw that some people's care records already included this added information. This helped staff to get to know people better which meant they could engage with them in a more meaningful way.

Despite the fact that not everyone had a completed life story we found that staff were aware of people's interests and hobbies and used this information in positive ways. For example, where it was discovered that a person loved birds, particularly owls, the service had arranged for a wildlife organisation to bring a selection of owls to the service for the person to enjoy.

We found that the service tailored care and support to meet people's individual needs. For example, where a person had a stoop due to their health condition which meant that their eye line was much lower than other people, the service had moved the person's name plate down low on the door to their room so that they could see it more easily.

The service employed activity staff who arranged a programme of activities and events so that people had things to do to occupy their time. We saw that activity meetings were held so that staff could obtain people's feedback and suggestions about the sort of activities and events they would like to do.

Relatives told us that they felt there were enough activities within the home and that staff would engage people in spontaneous activities if people were distressed or agitated to help make them feel better. However, we did observe throughout the day that whilst care staff often sat in communal areas with people, monitoring their safety or completing their written notes, there was often a lack of interaction and engagement with people. This demonstrated a lack of awareness by care staff that engaging with people

and promoting meaningful activity should be part of every workers role rather than just the job of activity staff.

We spoke about what we had found with the registered manager who told us they had previously identified this issue and addressed it at staff meetings. We saw minutes of a staff meeting which recorded that the registered manager had fed back to staff that they had observed one unit to be very quiet with a carer sitting and not doing anything. The manager reminded staff of the importance of engagement with people, taking around biscuits, cakes and drinks and talking to residents.

On the day of inspection we saw that one of the lounges was set up with various games. The activity staff brought people from other units who wanted to join in. Appropriate music was playing in the background and a choice of drinks was offered to people as they played. We saw that activity staff linked people together to participate in the games; some people played connect 4 whilst others enjoyed a game of scrabble. The staff chatted with people about day to day things and one person who was sitting with the group but not playing a game, sang along to various songs that they recognised.

We also observed a member of staff bringing life like baby dolls into the lounge. Research has shown that using doll therapy for people living with dementia can help bring back happy memories of early parenthood and helps make people feel needed and useful. A staff member told us, "Some people love these babies, they're so gentle and they take them down the corridor and put them into the cot in the small lounge."

Aside from in-house activities, the service provided external entertainment for people to enjoy. People told us that an entertainer had visited the day before our inspection and they had enjoyed the experience. One person said, "Staff came to fetch me and took me up for it, it was such good fun, some people danced, we had a good time." Another person said, "Staff will always ask me if I want to go to an activity somewhere, I decide if I want to go though."

Activities and events were also organised outside of the home. One person told us, "We have good outings here, we go to Southend, to Hylands Park, various places when the weather's good, they've been very good."

Church services were organised to meet people's spiritual needs. One person told us, "I always go to the monthly church service here, which I find very helpful, I've always been a church goer and it's important for me; it's a very good service."

The service provided outdoor space for people to enjoy. One relative told us, "The gardens are well used in the nice weather, sometimes they have a barbecue, [family member] loves it." They also told us, "One of the things [family member] responds to is physical games, they like foam skittles or ball games, they come to life when they come out."

We found that the service was responsive to the individual needs of people living at the service. For example, for those people who experienced swallowing difficulties they had introduced 'Gloup', a medication lubricant to make the intake of oral tablets and medication a more pleasant and safer experience for people.

Of particular note, we found that the service was pro-active in responding to the specific needs of people living with dementia. We were advised that the provider had organised for five members of staff to be trained as cognitive stimulation therapists so that they could deliver a programme of Cognitive Stimulation Therapy (CST). CST is an evidence based treatment for mild to moderate dementia, recommended by the

National Institute for Clinical Excellence (NICE). CST can help improve people's mental abilities and memory, improve confidence and language skills and is fun.

CST therapy involves sessions of themed group activities which aim to stimulate and engage people living with dementia with evidence to suggest that it could be as beneficial as drug treatments for the symptoms of dementia. During our inspection visit we observed a CST session that had been set up. The session encouraged group discussion as well as providing opportunities for physical and mental stimulation by playing bowling.

The service had a complaints policy and procedure in place and we saw that the registered manager investigated complaints appropriately. At the time of inspection there were no open complaints. People told us they knew how to make a complaint and who to speak to. One person said they would not have the confidence to make a complaint but that their family would do so if necessary. Another person said, "I complained once because a person attacked me in my room; we had a meeting with my family, they were very apologetic." Another person said, "I'd talk to [senior] if I had a problem I feel sure they would listen to me and act."

We found that the service listened and responded positively to feedback from people. One person told us how grateful they were that the service listened to them and responded to their needs and requests. They said, "I told the manager I like to roll up my clothes in drawers so they took the wardrobe away to give me more space; that sums this place up."

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection there were concerns regarding a lack of managerial oversight, poor record keeping, sporadic audits with no clear action plans and a lack of monitoring and analysis of risks to people. We also found that the registered manager had not always provided us with notifications. A notification is information about important events which the service is required to send to the commission by law. At this inspection there was a new registered manager in post who understood their registration requirements including notifying us of any significant events to help us monitor how the service kept people safe.

The issues we raised at the previous inspection had been taken on board by the new registered manager and the provider who had developed an action plan in response to address our concerns. New systems and processes had been put in place to improve managerial oversight and assess and monitor the quality, safety and effectiveness of the service provision. We found that there had been significant improvements, particularly with regard to maintaining up to date information about people in their care records and monitoring and sharing information on risks to peoples safety around falls, pressure care, nutrition and hydration. However, further improvement was still required as medication audits to check the safety and quality of medicine management had not been effective at picking up on mistakes and areas that required improvement.

We recommend that the provider re-evaluate their current quality assurance process for the safe management of medicines and put in place appropriate support mechanisms to develop staff knowledge and competence to enable all staff to complete safe and effective medicine audits.

The registered manager had introduced weekly clinical review meetings to support information sharing around risk. There was also the introduction of a daily morning meeting of managers and senior staff. Notes were taken and actions were followed through. This provided a clear line of communication, discussion and accountability across the service and had improved the linking of current information and good practice across the whole of the service.

To improve managerial oversight of the service, the registered manager completed random night visits, sometimes doing two visits in a row to assure themselves that people were being well cared for. We saw a checklist the registered manager had completed for a night visit which showed that they had checked to make sure call bells were within reach of people; that drinks were available; MAR records were completed with no gaps; hourly checks had been carried out and that people's monitoring charts had been completed. Where poor practice was observed, for example, if monitoring charts had not been filled in, the registered manager immediately addressed this with the member of staff concerned.

The registered manager told us they felt well supported by the provider who had worked closely with them to put in place a comprehensive set of audits to monitor the safety and effectiveness of the service. We saw that the audits led to sets of actions with a designated person identified as being responsible to complete each task.

There had been several changes of registered manager over the past three years which had unsettled people, however things had now stabilised. A relative told us, "This is the third manager we have had in two and a half years, it's all been a bit unsettling, but I think things are getting better now."

Staff told us they found the registered manager supportive and felt listened to. One staff member said, "[registered manager] always has time for you; always interested, they will always come and offer advice and guidance." People and relatives were also positive about the new registered manager. One relative told us, "[registered manager] is very approachable, they'll always listen if we've got a problem, I would absolutely recommend this home."

The registered manager was a qualified nurse and told us that they regularly attended courses to continue to develop professionally. We were advised that they had just completed a course on phlebotomy along with the lead nurse so that people who used the service could have blood tests processed quicker which could lead to improved outcomes for people's health and wellbeing.

We found that the registered manager was pro-active in developing the service and had already introduced several new initiatives, such as the cognitive stimulation therapy and 'gloup'. They told us that all staff were in the process of being trained as dementia friends and that they were recruiting for a new activities staff member who was going to take the lead on life story work which had been identified as an important aspect to promote person-centred care. The registered manager was also working on forging links with the community and had arranged to deliver a talk on dementia at their local village hall in their role as dementia champion.

The culture of the home provided a warm and friendly environment which focussed on the needs of people using the service. One person told us, "You won't get any negatives from me, this is my home and I'm very protective of it and all the wonderful staff."

Staff meetings were organised so that staff could be included in the running of the service and we saw that these meetings were used to reinforce the values of the provider. We reviewed the minutes of previous staff meetings and saw that the registered manager had used the opportunity to talk about the importance of being open, honest and transparent. Staff were reassured that being open and honest about mistakes made meant they could be learned from.

The service also organised regular resident and relative meetings as a way of obtaining feedback from people and inviting suggestions on ways to improve the service. The meetings were minuted and showed actions that needed to be taken and who was responsible. Relatives and people told us they attended the meetings which they found informative and useful. We looked at previous minutes of meetings and found that the service had taken on board people's comments and responded positively to criticisms. For example, where a relative had complained that their family member's bedroom looked shabby, action was taken and the room was cleaned and painted.

The registered manager told us that they did not send out annual satisfaction surveys to people but instead had an open door policy for people to come and raise any issues or concerns. We saw that the service had listened and taken action in response to people's concerns, for example, regarding food. People had complained that the food was repetitive so the service developed a new menu and the chef walked around the service every day to talk to people and find out what they liked. We observed the chef out on the floor talking to people on the day of our inspection visit.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The Provider had failed to ensure the proper and safe management of medicines.