Braunton Residential Home Ltd

Braunton

Inspection report

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Ratings

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

Overall summary

Braunton is a residential care home which is registered to provide care for up to eleven older people requiring assistance with personal care. The home is family run and situated in a quiet residential area of Yeovil. The home specialises in the care of older people but does not provide nursing care. There is a registered manager who is responsible for the home. 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 and associated regulations about how the service is run.

The service was last inspected in March 2015. During that inspection we identified seven breaches where legal requirements were not being met. This meant that the service was rated "Inadequate" overall and in the areas of "safe", "caring" and "well-led". The areas of "effective" and "responsive" also required improvement. From March 2015 to the time of this inspection the service had been

Summary of findings

the subject of a whole service safeguarding process and quality monitoring. This resulted in a voluntary agreement from the service with commissioners not to admit any further people to the home until improvements had been made. We also looked at the minutes from these meetings. After the March 2015 inspection, the provider wrote to us with an action plan to say what they would do to meet legal requirements in relation to the breach.

We undertook this inspection on 13 October 2015 to carry out a comprehensive inspection and to check that they had followed their action plan and to confirm that they now met the legal requirements made at the previous inspection. At the last inspection in March we found there were breaches relating to care and treatment not being provided in a safe way as risks were not adequately assessed. People were not always protected against the risks of infection which was not well managed. The Mental Capacity Act 2005 framework was not being followed and arrangements to assess people's mental capacity were inadequate. People were not always treated with dignity and respect or involved or enabled in their care planning and reviews. The systems and processes for assessing and monitoring the quality of the service were not adequate or people focussed and there were not enough staff to meet people's needs.

During this inspection on 13 October 2015 we found that the registered manager and staff team had worked hard to meet the legal requirements. Although these breaches had been met there were still some other areas that required further improvement to ensure the service continues to improve. These areas for improvement were bed rails risk assessments, medication audits practical manual handling training, end of life care planning records and accessing advocates for people in relation to best interest decision-making.

On the day of the inspection there was a calm and relaxed atmosphere in the home and we saw staff interacted with people in a friendly and respectful way. People were encouraged and supported to maintain their independence. They made choices about their day to day lives which were respected by staff. People told us they felt safe living at the home. Comments included "Yes, we are safe here" and "I'm lucky to be here, I'm well looked after." Relatives said "Staff helped to get [my relative] more mobile and to gain their confidence back after a long stay in hospital" and "For our family we believe [our relative] is in good, safe hands. Their needs are being met and I feel that there is a family approach of looking after the residents."

Although people and their relatives felt the home was a safe place for them to live we found some elements of care provision did not ensure safe care. There were no bed rail risk assessments to ensure the safe use of bed rails.

Practical manual handling training was not robust enough to be effective and keep people safe. Staff had good knowledge of people including their needs and preferences. Staff were up to date with mandatory training and there were opportunities for on-going training and for obtaining additional qualifications.

Improvements were required in the application of the Mental Capacity Act and accessing advocacy services in relation to best interest decision making.

There were no records to show how people wished to be cared for at the end of their lives to ensure people's needs would be met.

There were not always effective quality assurance processes in place to monitor care and plan ongoing improvements. The service had not identified the areas for improvement which we raised. However, there were systems in place to share information and seek people's views about the running of the home. People's views were acted upon where possible and practical and feedback was used to drive forward further improvements

People said they would not hesitate in speaking with staff if they had any concerns. People knew how to make a formal complaint if they needed to but felt that issues would usually be resolved informally.

People were well cared for and were involved in planning and reviewing their care. There were regular reviews of people's health and staff responded promptly to changes in need. People were assisted to attend appointments with appropriate health and social care professionals to ensure they received treatment and support for their specific needs. However, comments from health professionals mentioned that management were sometimes communication with management was difficult due to a defensive attitude.

Summary of findings

People's privacy was respected. Staff ensured people kept in touch with family and friends. Relatives all said they were always made welcome and were able to visit at any time. People were able to see their visitors or take calls in communal areas or in private.

People were provided with a variety of activities and trips. People could choose to take part if they wished. Attention was given to people's likes and preferences which were respected and staff had time to sit with people on a one to one basis doing things people wanted to do or chatting. One person said "

There was a new management structure in the home which provided clear lines of responsibility and accountability. The registered manager had worked hard to involve staff in making people the focus of their improvements and wanted to provide good care for people who they knew well.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

We found that action had been taken to improve the safety of the service. This meant that the provider was now meeting the legal requirements made at the last inspection.

However, the service was not always safe. Some people were at risk because assessments of one aspect of their risks had not always been completed.

The provider had systems in place to make sure people were protected from abuse and avoidable harm. People told us they felt safe living at the home and with the staff who supported them.

People were protected from the risk of abuse because staff were trained and knew how to recognise it and report it.

Requires improvement

Is the service effective?

We found that action had been taken to improve the effectiveness of the service. This meant that the provider was now meeting legal requirements made at the last inspection.

However, the service was still not always effective. People were at risk of receiving care that was not effective because some practical staff training was not delivered by a qualified trainer.

The service was not always pro-active in accessing advocates for people in relation to best interest decision making meaning that decisions may not always be made in people's best interests although staff had a good understanding of people's legal rights and the correct processes had been followed regarding the Deprivation of Liberty Safeguards.

Staff had a very good knowledge of each person and how to meet their needs and people could be confident that they received appropriate care and treatment.

Requires improvement

Is the service caring?

We found that action had been taken to improve the caring of the service. This meant that the provider was now meeting legal requirements.

Staff were kind and compassionate and treated people with dignity and respect.

People were consulted about their care regularly, listened to and their views were acted upon.

Good

Is the service responsive?

We found that action had been taken to improve the responsiveness of the service. This meant that the provider was now meeting legal requirements.

Good

Summary of findings

People were involved in planning and reviewing their care. They received personalised care and support which was responsive to their changing needs.

People made choices about all aspects of their day to day lives. People took part in social activities, trips out of the home and were supported to follow their personal interests.

People shared their views on the care they received and on the home more generally. People's experiences, concerns or complaints were used to improve the service where possible and practical.

Is the service well-led?

Requires improvement

We found that action had been taken to improve how the service was managed but some areas that required improvement had not been identified by the home's own policies and procedures. The service was not completely well led.

There were not always effective quality assurance systems in place so that all areas for improvement were identified and addressed and the service took account of good practice guidelines.

Staff did not always work effectively in partnership with other professionals to make sure people received appropriate support to meet their needs.

There was an open culture within the staff team and they and people living at the home felt they could voice any concerns and that they would be heard.

There were clear lines of accountability and responsibility within the management team which meant people living at the home and staff knew who to go to and what management roles were carried out by whom.

Braunton

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 13 October 2015. Before the inspection we reviewed the information we held about the service. This included previous inspection reports, reports commissioned by the home, statutory notifications (issues providers are legally required to notify us about), other enquiries from and about the provider and other key information we hold about the service.

During our inspection we spoke with the registered manager, three staff, six people living at the home and received feedback from three relatives and three health professionals.

We also looked at records relevant to the running of the home. This included staff recruitment files, training records, care files for four people living at the home, medication records, maintenance records, complaint and incident reports, surveys and audits.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Braunton in March 2015 we found that staffing was not arranged to ensure people received consistent care and support. Risks were not adequately assessed and described based on individual need. Risks relating to infection control were not adequately managed and the home was not clean.

At our 13 October 2015 inspection we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements made at the last inspection.

Whilst people told us they felt safe we identified an additional area which placed some people at risk. Although a risk of falls requiring the use of bed rails had been identified by the home for two people there were no risk assessments about the practical use and appropriateness of the use of bed rails as a preventative measure for those individuals. For example, staff had not considered the risk of entrapment, or the possibility the person might try to climb over the rails. One person had fallen whilst shuffling to the end of the bed rails and sustained an injury. There was no bed rail risk assessment to show whether the use of bed rails was appropriate for that person to keep them safe or whether another method should be used to minimise risk. Bed rails had been provided to another person after they had fallen when getting out of bed. Their care plan file included a consent form showing the person had agreed to allow the staff to use bed rails on their bed. However, again there was no risk assessment in place showing that the risks associated with bed rails had been considered.

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

We observed medicines being administered at midday. The member of staff checked the medication administration records (MAR) carefully before dispensing the tablets into named pill pots. All medicines to be administered midday were removed from their packaging and placed into individually labelled pill pots at the same time, instead of removing the tablets for just one person, administering them, and then returning to the MAR charts to confirm each medicine had been administered, which is good practice and would reduce the risk of error. There had been no medication errors at the service but we saw some unexplained gaps in the records for the previous evening. We checked the blister packs and saw the tablets had been removed and therefore it was likely the tablets had been administered but the member of staff had forgotten to sign the MAR charts. The registered manager was aware and had reminded staff to sign following medicine administration. The registered manager said they would do this from now on. We observed the member of staff administering the medicines to each person and saw this was carried out carefully, giving each person time to swallow the tablets. The member of staff spoke with each person, offering them drinks and making sure the person was comfortable and happy to take the medicines. We observed the staff member returning to complete the MAR chart after administering the medicines to each person.

Some people were prescribed medicines on an “as required” basis, for example, paracetamol for pain. There was no clear guidance in each person’s records to explain when these should be offered, or how to recognise signs and symptoms that might indicate the medicines should be offered. We asked staff if they knew what each medicine was prescribed for and they said they were not sure about every medicine, although from their experience they knew many of the medicines. They knew people’s needs well including where they generally had pain and required medication for example. The registered manager told us they would re-instate forms they had used in the past to ensure staff had easy access to information about each medicine, including what they were prescribed for, possible side effects, and how and when they should be administered. People told us they got the right medication when they needed it.

Medicines were stored securely in a locked metal cabinet. No controlled drugs were stored in the home at the time of this inspection, although suitable storage facilities were in place if controlled drugs are prescribed at any time in the future. Most tablets were supplied in weekly blister packs. Some tablets that could not be supplied in blister packs were supplied separately in packets .

People told us they felt safe at the home and with the staff who supported them. Comments included “Yes, we are safe here” and “I’m lucky to be here, I’m well looked after.” Relatives said “Staff helped to get [my relative] more mobile and to gain their confidence back after a long stay

Is the service safe?

in hospital" and "For our family we believe [our relative] is in good, safe hands. Their needs are being met and I feel that there is a family approach of looking after the residents."

Care plans contained risks assessments about all aspects of each person's physical and mental health and personal care needs. For example, there were details about one person at risk of becoming depressed and how to manage this. Daily records then monitored how they were feeling. The care plans contained risk assessments for moving and handling. People at the home at the time of this inspection did not require assistance to move using hoists or stand aids and were generally independent or required assistance from one care worker for support. Some people used walking frames or a stick and needed some assistance from staff to help them get out of their chairs. Therefore people were assessed as being at a low risk for moving and handling and required minimal assistance. People said the staff helped them when they needed assistance and they understood when to ask for help due to their assessed risks.

There were risk assessments for the risk of falls. These were detailed using a new format since the last inspection. There was a summary of any falls with full details recorded in the accident book. We saw the registered manager assessed how falls could be minimised. For example, one person who was usually independently mobile had become unwell which affected their understanding cognition. Staff were monitoring any confusion and had discussed with the family the use of bed rails and the possibility of using a pressure mat to keep them safe. Daily records showed the person had been more settled with appropriate medication to treat their condition and the restrictive measures had then been re-assessed as the risk had reduced. Staff had also increased the frequency of checks at night.

Another person was assessed as at high risk of falls due to reduced vision. They had not had any recent falls and the risk assessment instructed staff to ensure they supported them to wear their glasses and had the support of one care worker when in the garden, using the front door and fire doors. Risk assessments also included whether people were able to use a call bell or not and how often they required supervision or checks and these were done and recorded.

Risks of abuse to people were minimised because the provider made sure prospective new staff were checked to make sure they were suitable to work at the home. We looked at the recruitment files of three staff who had started working there since our last inspection of the service. These contained evidence of checks carried out to ensure job applicants were safe to work with vulnerable adults. References had been taken up from previous employers and from people who knew the applicants well enough to give an opinion of their suitability for the job. Staff we spoke with confirmed their recruitment process was thorough and they had not been allowed to start working with people until all checks and references had been completed and were satisfactory.

Staff told us, and records we saw confirmed that all staff received training on how to recognise and report abuse. Staff told us policies and procedures on how to recognise and report abuse were held in the office on the ground floor, and this included contact information for relevant agencies. They were confident they could raise any concerns with the registered manager and these would be listened to and sorted out satisfactorily.

People were supported by sufficient numbers of staff to meet their needs. This had not been the case at the previous inspection. During our visit there were three care staff on duty plus the registered manager in the morning and two care staff and the registered manager in the afternoon. Staff rotas reflected the higher staffing level. The care staff also carried out cooking and laundry. Staffing levels had increased since the last inspection. Care workers no longer had to take sole responsibility for ensuring the home was clean. There was now additional assistance from a staff member whose duty it was to carry out daily cleaning, including deep cleaning for two hours each weekday morning. Care staff only had to carry out cleaning over the weekend. All areas of the home were clean and hygienic. This had not been the case at the last inspection and we saw the home had worked hard to ensure infection control and hygiene was high on the agenda. A recent staff meeting discussed infection control. A staff member now had a lead role in infection control carrying out weekly audits and random checks. The service had invested in a new bathroom and bath, deep cleaned the bath hoist and installed new flooring. A relative said "The rooms are kept clean and very tidy and they are also welcome to have their own personal belongings in there." Comments in the recent family satisfaction questionnaire were also positive about cleanliness which had been a breach at the previous inspection.

Requires improvement

Is the service safe?

There were enough staff on duty to support people with a wide range of activities both inside the home and out in the community. We saw staff sitting with people either individually or in small groups, and staff supporting people to move around. Staff gave people the time they needed and they gave people support at the times people preferred. People told us there were enough staff. Comments included “As far as I am concerned you get all you need here,” and “Yes, there are enough staff.” Staff also told us the staffing levels had improved since our last inspection. They told us “Now there are more staff it’s brilliant! The home is clean. Care is given when people want. We can sit and talk to people now.” At the last inspection the home had been accepting a high level of people who required day care or short term respite care. The registered manager told us how they had re-evaluated this and there were now minimal short term or day care people being cared for at the home. There was only one person at a time receiving day care over three days. This meant that there were enough staff to meet the needs of the people living at the home safely. At the time of this inspection one person was receiving day care and had been visiting for some time so staff knew their needs well.

Requires improvement

Is the service effective?

Our findings

At our comprehensive inspection of Braunton in March 2015 we found that staff were not following the Mental Capacity Act 2005 for people who lacked capacity to make particular decisions and there was not a proper process to safeguard people's rights.

At this 13 October 2015 inspection we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements made at the last inspection.

During this inspection we found people did not always receive effective care and support from staff who had the skills and knowledge to meet their needs in relation to practical manual handling training. There were issues with the quality and implementation of the practical element of the manual handling training offered. Although staff had received some moving and handling training the practical element had been provided by the registered manager who agreed they had not had up to date training on moving and handling for some time. They were also not qualified as a "train the trainer" in this topic. One staff member did not use a safe means of assisting one person to stand up. Another health provider had previously told us they were concerned that staff did not seem fully competent in using mobility equipment when transferring someone to hospital. The registered manager agreed to review staff training practical provision on safe moving and handling to ensure they were following current good practice guidance and keeping people safe.

This was a beach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us they had received a range of training on all required health and safety related topics, and also safeguarding, Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS). One member of staff said the registered manager was very happy to support them to gain further knowledge and qualifications, for example they had asked if they could gain a level four diploma in health and social care and this had been agreed. Another member of staff said "Yes, the training is OK. It was very helpful – I have learnt a lot." There was an improved handover for staff who were able to tell us how they cared for people in line with their care plans. Staff said "We have a good handover and go through each person. Updates are in the diary and we go through a folder to ensure we are up to date."

Staff had received training on safe administration of medicines. This had included watching a DVD and training provided by the registered manager. One member of staff told us they had also received training on this topic provided by their previous employer. The registered manager said they would also look into sourcing training from an external expert such as the pharmacy to ensure they kept up to date.

At the last inspection, people's consent to care and treatment had not been sought in line with legislation and guidance as set out in the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty (DoLS). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

The registered manager and staff team had now received refresher training in the MCA and DoLS. Staff were able to demonstrate an understanding of seeking people's consent and involving them in decisions. Appropriate DoLS applications had been made depending on people's mental capacity. The registered manager was able to explain what this meant for people and understood and carried out appropriate "best interest" meetings with people and their families. For example, consent was sought for the use of preventative measures following falls and for shingles and flu vaccines. This did not include consent for night checks and the registered manager said they would now include this rather than automatically put them in place. They described how they respected people's wishes and had discussed this them. Staff had also noted when one person's do not resuscitate status had not been completed by an external health professional without the person's involvement despite them having capacity and had ensured this was done with the person and their GP.

However, improvements could be made in relation to ensuring people had access to independent advocates

Is the service effective?

when some decisions were being made. For example, one person's family was making a decision on a person's behalf. Although this had been discussed, the person living at the home was clearly not happy with the decision and records were not up to date about their involvement and mental capacity status to make this kind of decision. The registered manager did not have hard copies of family's power of attorney and had not been pro-active in accessing an independent advocate for that person. They contacted an advocate during our inspection and an appointment was made to involve the person and discuss the decision making. Where people expressed a wish to develop relationships this was not facilitated fully. Best interest discussions had been recorded about the relationship but some aspects had not been dealt with. The registered manager commented, "Luckily they did not raise the issue again" rather than look at ways to meet those people's wishes in a safe way.

People were supported by staff who had undergone an induction programme which gave them the basic skills to care for people safely. Staff we spoke with confirmed they had a good induction at the start of their employment. Training was then ongoing and the staff matrix showed they were up to date. The registered manager was aware that staff required dementia care training and they sent us confirmation of this being booked for the near future.

Staff received regular one to one supervision meetings to discuss their needs and discuss competency and any issues. For example, one person had requested training which was being sourced. Staff told us they felt well supported. There had been a change in the management structure and job roles since our last inspection. Staff felt they knew what their roles were. There was no longer a deputy manager but two team leader roles who were now responsible for supervising other care staff, care planning and reviews, for example. The registered manager sent us details of staff roles and confirmed that these had been communicated to staff in writing detailing changes. The service employed two agency staff. These staff worked regularly at the home and knew people well. The registered manager was ensuring they had the correct training and working with the agency in relation to completing the Care Certificate, a nationally recognised training source.

People's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes. Information on each person's likes and dislikes, and any food allergies had been obtained before they moved in. For example, if they liked their food really hot, what foods they disliked and information about special diets or supplements. Care plans contained clear instructions to staff about food allergies and staff were able to tell us about these.

Each morning staff spoke with each person to find out about their food preferences for the day. This meant people were informed about the meals offered and were able to agree suitable alternatives if they did not like the main meals offered. A record of the foods chosen was kept in the kitchen. On the day of our inspection people were offered a choice of sausages or fish fingers, with sliced potatoes and vegetables. The meals were attractively served and looked appetising. Tables were laid and looked attractive with the meal time being a sociable affair. Staff went around to each person to offer sauces, and checked they were happy with their meals. We saw people enjoyed the meal and cleared their plates. People were offered a choice of puddings. Staff were attentive throughout the meal. Drinks and a fruit bowl were available throughout the day and people said they could ask for tea or coffee or a snack when they wished which we saw happening.

People told us they enjoyed the meals provided. Comments included "The food is very good" and "We have a choice of breakfasts including cereals, toast, porridge or cooked breakfasts. We have some beautiful soups in the evenings, all home-made." One person told us how they liked tea in their room with a friend sometimes and this happened as described in their care plan. A recent family satisfaction form included comments from relatives such as "I think [my relative] eats really well" and one person had commented during a residents' meeting that meals were lovely and they really enjoyed them.

People's health needs were met. People told us they could access relevant health professionals when they needed to. There were many examples where people had a short term health issue which had been well managed. Staff had identified the need and contacted the appropriate health professional. One health professional told us how they had worked with the staff team to ensure they could administer a medication safely. The staff had sought advice appropriately and received training so they felt confident they could meet that person's health need with support from the health professional.

Good

Is the service caring?

Our findings

At our comprehensive inspection of Braunton in March 2015 we found people were not always treated with dignity and respect and their privacy was not ensured. People were not involved in decisions about their care and their views were not sought or recorded on their care plans.

At this 13 October 2015 inspection we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements made at the last inspection.

During this inspection we observed staff being attentive to people's needs and speaking with people in a gentle, friendly and empathic manner. We saw staff interacting with people in a caring way. When staff offered support they either knelt in front of the person or sat beside them to gain eye contact. They made sure the person understood what they were saying, and offered choices such as "Would you like..?" and waited for a response before providing support. People told us they were supported by kind and caring staff. Comments included "They are very good – very kind. They are very nice "and "The staff are not bossy – they are very kind. All the staff are good." Relative comments about the way care was provided included "It is a lovely and friendly home. I am made to feel really welcomed by all the staff and owners in the home" and "The staff are really good and talking to [my relative] about the home brings a smile to their face! They are wanted and cared for there." One relative said "Although [X] has progressive dementia, they speak highly of the staff who kindly wash and dress / undress her each day, and lovingly assist her to take a little gentle exercise each day."

The registered manager also told us how they had discussed the previous report with people living at the home taking into account that they may have felt anxious so involved family using appropriate communication levels. People and family now felt involved in how the home was run and in their care. One family friend had written to the home commenting, "All is well at Braunton. [X] was so happy when they played a game with staff. They have gained weight and look well and happy." They particularly wrote about how [X] was now eating in the dining room with others which was real progress and that they felt confident the staff and the manager cared about them.

When staff spent time with people it was not only task related but spent in a meaningful way. In the morning a member of staff sat with a group of people and offered nail care and hand massage. There was friendly conversation, smiles and laughter and people were clearly enjoying the attention from the member of staff. In the afternoon we saw a member of staffing sitting with a small group of people playing a board game. The member of staff offered gentle encouragement and advice according to each person's individual needs, for example explaining the game and scores as the person had reduced vision. The smiles and friendly chatter showed the member of staff had offered the right level of support to each person to enable them to engage fully in the activity and to enjoy it.

People made choices about where they wished to spend their time. Most people chose to sit in the lounge, but their wishes were respected if they wanted to spend time in their rooms. Care plans explained people's wishes regarding social interaction. Care was taken to ensure people's dignity and privacy. Care plans had been well written to reflect this giving clear details such as [X] does not like being seen by staff partly clothed and is very private. There were also clear instructions on how one person's beliefs impacted on their day to day choices which were respected. The registered manager said since they had reduced day and short term care there were less visitors and coming and goings. They had created a screened area in the dining room and if people were receiving a telephone call they asked people to ring back and assisted people to return to their rooms if they wished to take the call. Friends and family were welcomed. Relative comments included "[X] has been a resident at Braunton for some two years now and feels very much part of the family spirit at Braunton" and "Our family visit regularly and always receive a warm welcome from management and staff, usually being offered tea and biscuits while we spend time with [X]."

There was also information about how people interacted with other people living at the home to ensure any altercations were minimised and identified. For example, staff knew who liked to sit with whom and encouraged people's relationships.

There were ways for people to express their views about their care. Each person had their care needs reviewed on a regular basis and summarised at the end of each week, which enabled them to make comments on the care they

Good

Is the service caring?

received and view their opinions. Residents meetings were held regularly. The meeting minutes included information about anyone who may want to speak to staff in private and any changes that had arisen from discussion. For example, ideas for meals and outings were put forward and acted upon. One person had expressed a wish to go to a theatre show. The registered manager had put up a poster and was organising a group trip for those who wanted to go.

People's views were also sought through questionnaires and from families. A recent questionnaire had been sent out in the summer and was being collated. Where comments were received the registered manager noted any action taken at the bottom. For example, one person had been refusing a hair wash and there had been a discussion about how to help them keep feeling nice in a way that suited them. A member of staff described how they sat with people regularly to discuss their care plan. They said they read the care plan to the person to make sure they agreed the content and this was recorded. Where possible the person was asked to sign to agree their care plan.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way.

Good

Is the service responsive?

Our findings

At our comprehensive inspection of Braunton in March 2015 we found people's needs assessments and care plans contained limited information about people's likes and dislikes, background and interests. People told us then they would like more activities and things to do. People were unsure how to make a complaint and their views about the service had not been sought.

At our 13 October 2015 inspection we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements made at the last inspection.

Most records were comprehensive but one risk assessment had not been updated although appropriate actions were being taken to keep them safe, and the end of life care records required improvement. We found that the care plans did not contain information about people's wishes in relation to end of life care. The registered manager said that "We would probably not do end of life care again." Future planning around end of life care was not clear. For example, there was no information about what future plans were for people who may go on to require end of life care who were already living at the home or whether they would have to move. One relative said "I know [X's] condition will worsen as time goes by but as long as I have a say they will stay there at a home where they are wanted and cared for."

One person had strong religious beliefs which staff were knowledgeable about but their care plan gave no information about their wishes for end of life care. The registered manager said they had people's end of life wishes recorded but had taken it out of the care plans. They said the information about people's end of life wishes had been archived and they would ensure it was put back therefore we have not made this a breach of regulation. People had information about their do not resuscitate status in their care plans. These had been reviewed by staff to ensure they reflected people's wishes and had been correctly completed by the GP.

People received care that was responsive to their needs and personalised to their wishes and preferences. People were able to make choices about all aspects of their day to day lives. One person told us how they enjoyed staying up late to watch films and having lie-ins if they weren't going out. Other people told us how they could sit where they wanted, in the lounge or in their rooms and make choices about their clothes, activities, food and visitors, for example.

Each person had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. This information was used to inform the care plans. For example, one person had reduced vision. Staff were observed using large dominoes, commentating through the game and ensuring the person wore their glasses. The registered manager told us they had re-done all the care plans and were using a new format since the last inspection. Care plans were personalised to each individual and contained information to assist staff to provide care in a manner that respected their wishes. For example, care plans included details about people's medical conditions and staff had researched conditions and added information such as Parkinson's and heart disease and what that meant for people. There was information about people who were living with dementia and how this manifested so staff could offer appropriate support such as discreet prompting to maintain continence and involving them in household tasks and using diversion if they became anxious.

There was clear information about people's preferences, likes and dislikes in a personalised way. For example, one person often felt cold and the care plan instructed staff to ensure then had warm clothes on which they did. Another person liked to sit at the dining table with their visitors which we saw. There was good information about how people liked to practice their faith and staff were able to tell us about each person's preferred choices and how they respected them.

Staff demonstrated a good understanding of each person's needs, preferences and personality. For example, one care plan said the person needed to keep their feet up to reduce swelling. We saw they were sitting in the lounge and their feet were not raised. We spoke with a member of staff who explained they regularly reminded the person to put their feet up but the person often chose not to follow their advice. However, they were confident that other treatment such as compression stockings and medication as well as short periods with their feet raised had been beneficial. Their description of the care provided showed they

Good

Is the service responsive?

respected the person's wishes while at the same time they had kept a close watch on the person to make sure their condition had not deteriorated and the person's health remained stable.

Other than the example above, the staff responded to changes in people's needs and sought appropriate health advice. Staff told us there was good teamwork. They felt there was a strong staff team and they all wanted to provide the best possible care for people. They sat down at least once a month to discuss the care plans with each other and with people receiving the care. Comments included "We all chip-in and make sure the care plans are up-to-date" and "I think we are working well as a team now." One person had had infections which had been managed well with GP support. The care plan monitored how they were progressing and how the infection had affected their behaviour. Another person had become increasingly anxious and staff had contacted relevant people to assess the person. They had then monitored the effectiveness of their new medication. Another person had had difficulty swallowing their medication so the staff had asked the GP to change to an easier tablet with success. Healthcare professionals who provided feedback said the staff contacted them to discuss issues with individuals' healthcare and acted on any advice given. One person told us "I am pretty healthy. If I need the doctor I am sure they will call them."

Care plans contained good information about people's skin pressure area status and used body maps and bath skin checks to monitor skin integrity. For example, no-one at the home had any skin pressure damage or required dressings. Body maps noted changes to skin such as redness or blemishes and progress was monitored in the daily records showing what actions staff should take. Staff had been responsive and called the district nurses if there were any changes. For example, one person had had an insect bite treated successfully.

Staff were responsive to issues such as weight loss. People had been nutritionally assessed and a care plan devised to ensure their nutritional status was monitored. There were records of monthly weights and advice sought from dieticians where needed, for example to request build up supplements or provide high calorie foods.

People were able to take part in a range of activities according to their interests. Staff told us they had made significant improvements in the range of activities offered since our last inspection. In the entrance hallway there was a calendar for the current month showing some of the group activities planned, including musical entertainments. There was a notice board with photographs of parties, outings and activities that had been provided during the summer months. There had been a party for the Queen's longest reign, a VJ Day party and apple scrumping. One member of staff described how people had decided during a residents' meeting they wanted to go on more outings. They had a trip to a local pub for a meal and this had been very successful so they were in the process of planning more outings.

A member of staff told us they tried to offer a range of different activities throughout the day to suit each person. They said sometimes people did not want to spend a long time doing activities, but liked short sessions. For example, in the morning they had a 15 minute quiz. This was just enough for people to participate and enjoy. They also told us some people liked to watch the television in the mornings. They chose the programmes they wanted to watch.

During our inspection we saw staff sitting with people either individually or with groups of people offering a range of activities including nail care and hand massage, board games, or just sitting and chatting with visitors, other people living at the home or staff. Care plans showed how staff had spent time one to one with people in their rooms playing scrabble or reading the newspaper. They monitored whether people were at risk of feeling low or feeling socially isolated and supported them.

Staff encouraged people to be as independent as possible. Care plans reflected this. For example, "needs encouragement to wash as will miss bits out. They will select their own clothing." Another person was enabled to be independent with support and the care plan stated that the person may make a mess when getting ready so to clean this up when they were out of the room so they were not embarrassed. Pictorial signs were on toilets and bathrooms, for example to aid people finding them independently even when they lived with a level of dementia. Each person had sat with staff to discuss a room door name plate. These had been personalised to reflect people's interests and enable them to also find their rooms more easily. For example, one plate had pictures of a person's previous career or flowers they liked.

Good

Is the service responsive?

People told us they were confident they could raise any concerns or complaints with the registered manager and they were confident these would be addressed, although they told us they had never needed to make a complaint. There had not been any formal complaints but there was a process and policy to follow. Details of this were in people's rooms for reference and on the notice board. The registered manager said any "niggles" were dealt with at the time and they planned to record these to monitor if there were any patterns in general that needed addressing.

Requires improvement

Is the service well-led?

Our findings

At our comprehensive inspection of Braunton in March 2015 we found that care and treatment was not always provided in a safe way by adequately assessing risks or having enough staff to meet people's needs. Infection control was not well managed, people's consent to their care had not been sought and the Mental Capacity Act 2005 (MCA) was not being followed. Also people were not always treated with dignity and respect, involved in their assessments or enabled to make decisions about their care. At that time we found the systems and processes of assessing and monitoring the quality of the service was not adequate or focussed on the individual needs of the people living there at that time.

At this inspection on 13 October 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements made at the last inspection.

The provider/registered manager has taken steps to improve the service and lead its development, however it is too soon to be able to see if these changes are embedded and sustained and there remain some areas for improvement. Since the last inspection the registered manager had sent us updates of their progress with their action plan. They had worked hard to meet all the requirements raised from the previous inspection in March 2015 and invested in the home to good effect, although there were still some areas for further improvement overall. Some health professionals told us that the service did work with them but that communication with the service was sometimes difficult due to a defensive attitude especially if care needs became challenging for staff. The registered manager was obviously passionate about providing good care and knew people living at the home well. There were only positive comments from people living at the home and family and friends. It was a family business with the provider and registered manager living close by. There had been a change in management since the last inspection. The provider had stepped back from care management and now had a more administrative role. Staff now knew who to go to for advice. The registered manager had delegated other roles such as care planning reviews and supervision and there were clear lines of responsibility, including a new keyworker role. This was a named staff member who would oversee care for an individual.

The registered manager had ensured staff were up to date with training, including MCA and DoLs and implemented learning. They agreed that the quality of practical manual handling training needed improvement to ensure staff were using up to date, good practice from a qualified instructor. There was a range of audits and quality assurance systems which were used to drive improvement. These included care plans, staffing levels, cleanliness, premises, kitchen, and collating feedback. However, the registered manager had not picked up on the issues we raised which required improvement. For example, improvement was needed to ensure the medication audit was robust. It was not so easy to check those medicines that were not supplied in the weekly blister packs. Regular audits had not been carried out to check the amounts of medicines held in the home. This meant it was not possible to check easily that the medicines not supplied in weekly blister packs had been administered as prescribed as numbers were not available. The registered manager was aware that the medication audit needed to be more robust and assured us they would action this.

Staff were regularly supervised and assessed for competency and there were enough staff to meet people's needs. For example, one staff member was to start a higher level qualification. Short term care had been phased out and staffing levels increased which had improved the time available for staff to provide care effectively. Changes also included managing infection control well with a named lead care worker and additional cleaning support.

People all told us the home was well managed saying "Well run? Yes – they know what they have to do." Relatives felt they could talk to the registered manager and staff and felt confident that the home was well managed.

Staff told us the home was well managed. Comments included "It is now well-managed. [The registered manager] has been working very hard" and "[The registered manager] is a strong manager. She is also very fair. We are a team. This is very important."

The home was involving people and their families in their care. There were regular satisfaction surveys, meetings with families and people were involved in their regular care reviews. One relative commented in their monthly review "I accept the review and I have gratitude for the way you care for our dear [relative]." Residents meetings were established and being used to drive forward improvements.

Requires improvement

Is the service well-led?

The registered manager had accessed external agencies for advice and support during the period of improvement since the last inspection. These included an external consultant from the Registered Care Homes Association and worked with a consultancy on care planning. The registered manager had a relationship with two other registered managers for support and discussion. They had plans to network in the wider residential care sector in the near future to ensure they were up to date and to drive improvement further.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: 12 (2) (a) There were no bed rail risk assessments to ensure people were safe. 12 (2) (c) Staff did not receive training from a qualified trainer in practical manual handling.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.