Brendoncare Foundation(The)

Brendoncare Woodhayes

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?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

Brendoncare Woodhayes is registered to provide accommodation for 25 people who require nursing and/or personal care. There is a registered manager who is responsible for the home. A registered manager is a person who has registered with the CQC 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 Brendoncare Foundation has ten care homes which include Woodhayes.

At the last inspection carried out on 9 August 2013 we did not identify any concerns with the care provided to people who lived at the home. Prior to this inspection in April 2015 we received some concerns from two sources about lack of staff and concerns about the quality of care. We found that although people using the service, who were able to comment, felt the service was safe we found this was not always the case. Although there were enough staff to meet people's basic needs there were not enough staff available to meet people's

Summary of findings

needs fully in a person centred way. Care was delivered which focussed on tasks and time frames. People did not have their individual emotional, social and mental health needs met.

Care plans did not provide adequate information for staff to be clear about how to meet people's needs or reflect the care provided. One person with complex needs had no care plan and staff relied on verbal knowledge. Nursing updates in general were communicated through a communal handover sheet. Care planning did not involve people using the service or their representatives.

On the day of the inspection the home was busy. Staff were unable to spend any time with people other than during tasks. There was a high level of people with complex needs. For example, 10 people required two staff and a hoist to mobilise and six people required assistance with feeding. However, we saw staff were managing to meet people's basic needs such as assisting people to get up in a timely way and ensuring their hygiene needs were met. Staff were kind and interacted with people in a friendly and respectful way.

There was an activity programme three days a week for 18 hours assisted by a care worker for four allocated hours. Although this provided a range of activities and was well organised this only met the needs for people who were able to or chose to attend these activities. Care staff had little time to offer engagement and stimulation for people such as chatting, going into the garden or to the nearby shops or to spend time with people in their rooms. This was despite isolation being highlighted as a risk in some people's care plans. People who chose to or required assistance mainly in their rooms did not have their emotional and mental health needs met.

Staff had a good understanding of people's legal rights, and understood the correct processes regarding the Deprivation of Liberty Safeguards and use of restrictive measures intended to keep people safe.

The provider had systems in place to make sure people were protected from abuse and avoidable harm. Staff had received training in how to recognise and report abuse. All were clear about how to report any concerns. Staff spoken with were confident that any allegations made would be fully investigated to ensure people were protected.

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 not involved in planning and reviewing their care. Some relatives had requested to see care plans but this had not happened. The home was changing the care plan format but this was taking some months and there was poor recording in care plans generally. This meant staff would not know how to care for people in a person centred way by referring to care plans.

However, there were regular reviews of people's health and staff responded promptly to changes in need. Nurses were knowledgeable about people's needs and health professional advice was sought appropriately. People were assisted to attend appointments with appropriate health and social care professionals to ensure they received treatment and support for their specific needs.

Staff had good knowledge of people including their needs and preferences but did not have time to ensure care records reflected these or that information was used to ensure these needs were met. Staff felt frustrated that they did not have enough time to meet people's needs.

Staff were well trained and training was up to date or booked, there were good opportunities for on-going training and for obtaining additional qualifications. However, staff did not receive formal one to one supervision sessions on a regular basis. This did not ensure that any issues were monitored or discussed formally.

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

There was a management structure in the home which provided clear lines of responsibility and accountability.

There were some effective quality assurance processes in place to monitor care and plan on-going improvements. Some of the issues above had been identified in audits but had not improved. This had been shared by the registered manager with Brendoncare head office.

There were systems in place to share information and seek people's views about the running of the home.

Summary of findings

People's views were acted upon where possible and practical. However, although the registered manager was aware of some of the issues raised above there had not been sufficient improvement.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe. There were not enough staff available to ensure that people's individual needs were met in a person centred way.

The provider had systems to make sure people were protected from abuse and avoidable harm.

Staff were aware of how to recognise and report signs of abuse. They were confident that action would be taken to make sure people were safe if they reported any concerns.

People were supported with their medicines in a safe way by staff who had appropriate training.

Is the service effective?

Requires improvement

The service was not always effective. People using the service and/or their representatives were not involved in their care planning and some people were not cared for in accordance with their preferences and choices.

Staff had general knowledge of each person and how to meet their needs. Staff received on-going training which meant they had the skills and knowledge to enable them to provide effective care to people. However, they did not always have the time to do so.

The service was meeting the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Is the service caring?

Requires improvement

The service was not always caring. However, staff were kind and compassionate and treated people with dignity and respect.

People were not consulted, listened to and their views acted upon on a day to day basis in relation to their care planning. Care did not actively encourage independence in a person centred way.

Where people had specific wishes about the care they would like to receive at the end of their lives these were not always recorded in the care records with involvement from family as appropriate. This did not ensure that all staff knew how the person wanted to be cared for at the end of their life.

Is the service responsive?

Requires improvement

The service was not always responsive. Care plans were not working documents for staff and did not clearly reflect people's care needs and daily care. One person did not have a care plan at all. The arrangements for sharing information about how to meet people's needs with the staff team was not robust.

Summary of findings

People did not always receive personalised care and support which was responsive to their changing needs. However health needs, such as assessments, appointments and relating to medical conditions or infections were generally well met and involved appropriate health professionals. There were good wound care outcomes but records were not robust.

People were not supported to follow their personal interests reflecting their needs and preferences. Emotional, leisure and mental health needs were not met in a person centred way. However, there was a well organised activity programme run by a part-time activity co-ordinator which able participants enjoyed.

People's experiences, concerns or complaints were responded to but not always used to improve the service.

Is the service well-led?

Requires improvement

The service was not always well led. There was an open culture promoted

within the staff team but some of the issues we identified had also been identified by the service but there had been no improvement. For example, staffing levels, care planning and reviewing people's social and emotional needs.

Records did not ensure that people's hydration and nutrition was monitored in a robust way.

Staff worked in partnership with other professionals to make sure people received appropriate health support to meet their needs.

Brendoncare Woodhayes

Detailed findings

Background to this inspection

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

This inspection took place on 20 and 21 April 2015. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. It was carried out by an inspector and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the home. At the time of this inspection there were 19 people living at the home. Some people were living with a degree of short term memory loss and/or dementia and were not able to comment directly on their experiences. During the day we spoke with 14 people who lived at the home and six relatives who were visiting or by telephone. We were assisted by the deputy manager as the registered manager was on leave during our inspection. We fed back our findings to them on their return. We also spoke with six members of staff, the deputy manager, activities co-ordinator and administrator. We looked at a sample of records relating to the running of the home such as audits, training and personnel files and five care files relating to the care of individuals.

Requires improvement

Is the service safe?

Our findings

The service was not always safe. Although people using the service, who were able to comment and relatives visiting those people felt the service was safe, we found this was not always the case. We had received some information of concern about staffing levels not being sufficient for the number and needs of people living at the service. There were 19 people using the service at the time of this inspection. Staffing levels were calculated using a Brendoncare dependency formula. At the time of our inspection there was one registered nurse with four care workers in the morning and three care workers during the afternoon shift. At night there was a registered nurse and two care workers.

On the day of the inspection the home was busy. Staff were unable to spend any time with people other than during tasks. There was a high level of people with complex needs. For example, 10 people required two staff and a hoist to mobilise and six people required assistance with eating. Staff said these tasks alone took at least 20 minutes per person. We saw staff go from one task to the next. The nurse was unable to assist with providing personal care as they were doing the medicines round for an hour and a half and then dealing with clinical issues. Lunch was quite early at 12.00 not long after some people had finished their morning coffee and biscuit. Staff said this was partly to give time to enable them to assist people in the dining room first and then those people who required assistance in their rooms.

There were enough staff to meet people's basic needs such as ensuring people were assisted with hygiene needs and getting up in a timely way. However, there were not enough staff available to meet people's needs fully in a person centred way. Care was delivered which focussed on tasks and time frames. In the afternoon there were three care workers. There was again no time to spend with people as there were 10 people to assist with continence using the hoist as well as those who required one person to walk to the toilet or go for a lie down. One relative said often incontinence pads were not checked or the person was not comfortable in between re-positioning task times. We saw two people who had slipped off their pillows in bed who were unable/did not use the call bell. Staff would not see them as staff were not visible upstairs especially in the afternoon.

Care workers also did the afternoon tea and cake round. They then had to go back and assist those six people with their drinks by which time they needed to prepare for supper. We spoke to two relatives who also said staff did not have time to spend with people encouraging food and fluids. They felt they had to be available to assist as staff were not and sometimes people missed coffee or snacks. Staff also told us this and added that some people were slow to eat and drink saying "We are very short staffed".

Staff said if anything different to the usual happened such as a recent themed lunch requiring more people to be assisted to the dining room and back and clearing up then time was very short. They said they did not have time to get involved with activities or chatting. The local shops were very close but staff were unable to offer a trip out. More able people were able to attend a monthly trip out however. One person's daily record said "staff could not get X down in time for activity, will try another day." Records showed this did not happen again and the person did not attend another activity.

People did not have their individual emotional, social and mental health needs met. On both days we identified five people on the first floor and one person on the ground floor who chose to or needed to spend more time in their rooms. We went to see these people every hour or so and each time they were alone during the day. They had not seen any staff unless there was a task being performed or a drink which was reflected in their records. One person confined to bed said "It's not a wild life but I would like to see people more". Another person said they preferred to spend time in their room but it would be nice to have someone to chat to. In each person's care plan it stated the person was at risk of isolation, sometimes also due to depression, anxiety or dementia and this should be monitored. Three people were unable to use the call bell due to their condition; one person said they would not ring theirs as staff were busy. Daily records did not mention the isolation part of the care plan other than tasks. Staff said they did not have time, or time to update the old care plan format to a new one which had been brought in four months ago.

This was in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's risk were well managed, their health needs were assessed and met by staff and other health professionals

Requires improvement

Is the service safe?

where appropriate There were risk assessments in people's care records relating to skin care and mobility. There were no people with pressure sores at the home. Where someone was assessed as being at high risk, appropriate control measures, such as specialist equipment, had been put in place. Where people had been assessed as being at high risk of pressure damage to their skin, they had the identified pressure relieving equipment and they was contact with the local district nursing and tissue viability team.

Emergency plans and procedures were in place. These included personal emergency evacuation plans and what staff should do in an emergency. Accidents and incidents were recorded showing details of the incident and what action had been taken to minimise future risk.

Staff recruitment was robust to ensure people were protected from the risk of harm or abuse. The service ensured new staff had full checks and references in place prior to commencing employment. This included gaining references from their last place of employment and reviewing any gaps in employment history. A new registered nurse was about to start and would be shadowing an experienced nurse until they felt competent.

The provider had systems in place to make sure people were protected from abuse and avoidable harm. Staff confirmed they had received training in protecting vulnerable adults and knew who they should report any concerns to. Staff were aware there was a policy and procedure they could refer to and were confident any safeguarding concerns they raised would be appropriately dealt with. People who were able to comment told us they felt safe living at the home and with the staff who supported them. People's comments included "My possessions and I are safe."

People were supported with their medicines in a safe way by staff who had appropriate training. The treatment room and medication storage was well organised. People were able to manage their own medicines following a risk assessment if they wished. At the time of the inspection, five people managed their own medication and there were processes in place should people wish to do so including storage options in their rooms. We saw medication administration records and noted that medicines entering the home from the home's dispensing pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises.

Medicines were given to people at appropriate times for individual people as required. Staff were competent and confident in giving people their medicines. They explained to people what their medicines were for and ensured each person had taken them before signing the medication record. The medication record was complete, no gaps and clear records showing medicine patch rotation for example. The nurse said medication rounds took an hour and a half in the morning (a trolley was not used but each person was visited individually). Lunch time round took half an hour and tea- time was another hour. The nurse said "It's all about time issues, that's all".

A medicine fridge was available for medicines which needed to be stored at a low temperature. Some medicines which required additional secure storage and recording systems were used in the home. These are known as 'controlled drugs'. These were stored and records were kept in line with relevant legislation. The stock levels of these medicines were checked by two staff members at least twice each day. Checks showed stock levels tallied with the records completed by staff. People were satisfied the staff had received the correct training and their medication was received at the correct time.

Requires improvement

Is the service effective?

Our findings

The service was not always effective. Staff gave a variable account of whether they had receivedone to one supervision sessions and records were not always available to support this. Records showed staff supervision sessions had last been done for some staff in October and November 2014. Fifteen staff had received supervision and 14 care workers and nurses had not. The quality of supervision notes was varied although the format was good. These included what was going well, not so well, workplace observations and training needs. However, where there had been previous disciplinary action the supervision notes did not discuss the issues. Staff said they had had informal chats. This did not ensure that any staff competency issues were dealt with appropriately to ensure people received appropriate care.

This was in breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provision of lunch in the dining room was a social occasion with lovely laid up tables and condiments. The kitchen staff were aware of which people had specialist diets such as fork mashable. There were eight of the 19 people eating in the dining room which was a lovely environment. There were napkins and condiments. There was a varied rolling menu offering two main meals. Staff had asked people what meal they would like to see on the menu and some meals were labelled with a name as the title. It was not clear whether people were happy to have their name printed on the menu. The food was served at the table from a hot trolley by kitchen staff. There was a range of desserts and drinks on offer although no water was available on the table. Holidays were celebrated with special meals and recently an Indian themed lunch had been put on for people at the home and their relatives.

People who were able to comment said they always had more than sufficient to eat and the food was always hot when it should be. People could choose to have their meals in the dining room or in their bedrooms. One person said, “Today there were only three of us for breakfast in the dining room so the others must have had breakfast in their rooms.” One person said “I always have breakfast in bed which is very nice”. Several people made reference to having bacon and eggs for breakfast which they enjoyed.

The Mental Capacity Act 2005 (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. Deprivation of Liberty Safeguards (DoLS) provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. Staff had a good understanding of people’s legal rights. The service was meeting the requirements of the MCA and the DoLS. The correct processes had been followed regarding DoLS relating to use of restrictive measures intended to keep people safe. For example, risk assessments relating to the use of pressure mats to alert staff when people moved and the use of bed rails included best interest decision making processes to ensure they were being used appropriately in the person’s best interests.

Staff knew what actions they would take if they felt people were being unlawfully deprived of their freedom to keep them safe. For example, appropriate applications had been made to appropriate authorities for assessment about specific restrictive decision making such as preventing a person living with dementia from leaving the home, to maintain their safety. Staff practice and records showed staff were gaining consent before carrying out tasks. At times some care workers did not knock and wait for a response before entering people’s rooms which we fed back to the manager. This had been noted before and there were signs to remind staff around the home.

Staff received on-going training to make sure they had the skills and knowledge to provide care to people. A number of staff had attained a National Vocational Qualification (NVQ) in care or a Diploma in Health and Social Care. There was a training matrix to make sure staff

training was kept up to date. For example, 12 staff had been flagged up as due manual handling training. This was booked for May 2015 and done as a practical session in-house as one staff member was trained as a trainer. Those training sessions which were due as indicated on the training matrix had been booked such as safeguarding and control of substances hazardous to health. Staff were able to access external relevant training and opportunities were on the office notice board. For example, some training relating to end of life care had been sourced from

Requires improvement

Is the service effective?

Hospiscare. One person said “The staff are very good here” and another person said “The staff are always smiling”. Some staff had also attended training in dementia care and managing hearing aids.

People saw health and social care professionals when they needed to such as GPs, dentists, podiatrist and speech and language therapists. One person said “Yes, we can see the dentist, doctor, chiropodist, whatever you need.” Records showed people had seen health professionals appropriately.

The home was well maintained and provided a pleasant and homely environment for people. As an older building requiring regular maintenance there was a re-decoration programme on-going. For example, the sash windows had recently had a complete refit and refurbishment showing high investment in the fabric of the home. There was adequate space for people to move around as they wished. People’s bedrooms were lovely and personalised. Some areas were particularly good for people living with dementia such as bathroom colourways to enable people to interpret their environment more easily. For example, the toilet seats and edges of the room were highlighted so people could navigate where they were.

People had the equipment they required to meet their needs. There were grab rails and hand rails around the home to enable people to move around independently. There was a lift to assist people with all levels of mobility to access all areas of the home and people had individual walking aids, wheelchairs or adapted seating to support their mobility.

Requires improvement

Is the service caring?

Our findings

People were supported by kind and caring staff. However, none of the people who were able to comment said they had been involved in their care planning. Two relatives had repeatedly asked to see an individual's care plan but this had not happened. Records showed no evidence of involvement. The activity co-ordinator had started compiling activity care plans with people and their relatives. However, these had not been completed for everyone and actions had not yet enabled this information to become part of the person's regular care. Two visitors said a family member had been involved with their relative's care plan at the admission stage but they were not aware of any later consultations.

This was in breach of regulation 9 (3) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One care plan in particular had good end of life information to enable staff to care for that person in the way which had been discussed with them and their family. However, two relatives told us they had not felt very welcome at this time especially when asking to stay overnight. One relative said "The carer told us we could not stay the night." However, we were told following the inspection that Brendoncare's policy is that relatives are always welcome to stay overnight with their family, particularly at the end of life. They said Brendoncare would fully support people to meet their needs.

There were no end of life care plans for their relatives. Each care plan had a form completed by a health professional detailing wishes relating to resuscitation. It was noted that one stated the person had mental capacity to make decisions and another said they did not within the same care plan. We fed this back to the deputy manager who said they would audit these forms.

People able to comment said there was a good atmosphere saying, "Not bad, but would not say wonderful", "Calm", "Pretty good, with lots of laughs", "Happy", "Good and friendly", "Friendly", "Family atmosphere, staff come in out of working hours for events", and "Great place". A visitor said, "The atmosphere here is always really nice and welcoming. I never have any worries when I leave here after a visit". Another person said their visitors were always made to feel welcome and sometimes were given a cup of tea.

Staff said they felt frustrated there was not enough time to spend with people but they carried out tasks in a compassionate, caring way. For example, one care worker carefully helped someone style their hair as the hairdresser was not due to visit and the person was going out.

Everyone able to comment said they felt well cared for and the staff were always polite, friendly and respected their dignity and privacy when assisting with personal care by ensuring that doors and curtains were closed. Call bell response time was good for people who could use the bells. One person said it was usually no longer than five minutes with no difference day or night. We noted staff did not always knock on doors before entering bedrooms and whilst some staff did knock, they did not always wait for an answer. Some staff walked straight in and began arranging clothes or opened a wardrobe. There were reminder notices for staff to remember dignity around the home and the deputy manager said they would remind staff of this again. People confirmed that visiting health professionals would visit them in the privacy of their bedrooms, as would their visitors.

Requires improvement

Is the service responsive?

Our findings

The service was not always responsive. The care plans we looked at were not up to date and did not reflect people's needs in a person centred way or encourage independence. Since the beginning of the year the service was moving to a new care plan format. However, we were told only half of the care plans had been completed. When we looked at one completed new care plan we found this person with complex needs had no care plan at all. For example, one person's care plan said they ate in the dining room when they were now bed bound. Care plans did not promote independence by stating what people could do themselves.

Staff were able to explain people's general needs and had good general care knowledge but did not know all the details such as dental care and fluid chart status for example. Sometimes staff were aware of people's needs such as at risk of isolation but were unable to have time to meet these. One relative said they had repeatedly told staff about a person's food allergy but continued to be offered it. Care plans were written in a general way with some meaningless actions such as "ensure staff are trained in moving and handling", "use prescribed creams" without detail within an individual's care plan.

Daily records did not reflect the care plan and were brief such as "all care given" and "all checks done". One care plan said "Done by night staff". Often mental health needs such as dementia and short term memory loss were not included in the care plan so did not inform staff how dementia affected an individual. Keyworker notes were done monthly but did not reflect the care over the last month but stated comments such as "enjoyed food today". One care record had no entries between May 2014 and January 2015. One person's care plan said "at risk of urinary infections" but there was no evidence of monitoring. Within daily records issues were noted such as, seeing a physiotherapist, details of a skin tear, sore arm or groin or chest infection but no further records to show what their status was currently. We could not see any clear wound management plans and a health professional also found this the case when they had visited. One person was stated to be "on and off the toilet" but there was no further detail about actions to take to support them.

Another care plan said the person had been "upset a couple of times" but no actions recorded or further information for staff. This person was known to be anxious and require reassurance. The care plan identified long term depression but no actions for staff to take other than "promote wellbeing". This was also the case in another care plan which also did not identify nausea as an issue.

Some important information was lost within review records such as using a certain cream, no nail polish or what sling to use. One review stated "now needs prompting for meals and weight loss". This was not identified in the care plan. Another review said "needs hoist now, in bed" but was not in the care plan. One specialist mattress setting was "lost" within review notes. Another physiotherapist review detailed how to position someone but this was not in the care plan nor was their continence needs. Therefore staff would need to read all the review notes to gain a clear picture of individual care needs. When we spoke to staff they said they relied on verbal handover, daily records and the agency trained handover sheet. This was more detailed than the care plans and appeared to be being used instead of a care plan. Most weight, nutritional and skin care monthly reviews were out of date from January 2015 within the care plans although the managers sent these reports to head office monthly.

This was in breach of regulation 9 (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a wide range of activities organised by the activities co-ordinator who was employed for 18 hours a week over three days. One care worker also had four hours allocated time to assist with activities. There were also volunteers including university students who came to read to people, visiting entertainers and speakers. For people who could or chose to attend, these activities were well organised and people enjoyed them. Large dominoes were said to be very popular along with quizzes, board games and bingo. There was an annual Garden Party and the occasional jumble sale to raise funds for outings. In the summer there were monthly day trips out in a hired vehicle. A relative of a past resident said, "My mother was here for a long time and it was so good that after she died I wanted to give something back so I volunteered to come in each week and do art work with the residents".

However, half people spoken with said they chose not to join in with the activities as they either preferred to stay in their room or were simply not interested in what was provided. Other people were unable to comment due to

Requires improvement

Is the service responsive?

living with dementia. We looked at emotional support, leisure and stimulation provision for six people in particular who spent most of the time in their rooms. These people did not have their emotional or social needs met.

Activities were seen as mainly lounge based, and not provided in an individual way. Care workers said they had no input although the co-ordinator had asked staff to try to spend time with people and record it. The activity co-ordinator felt they were in a task based environment due to lack of time. Activity records were not completed from March and those prior to this showed some people had very little input other than visitors. The activities co-ordinator had started completing social activity care plans for individuals which included excellent information and involved relatives. For example, at risk of isolation and being in a wheelchair for long periods. The plan detailed how they liked a certain radio programme, what books they liked being read to them and for a bird feeder on the window. None of this was happening and this information was not in care plans but kept in the activity co-ordinator's file upstairs where care staff did not have easy access.

During our inspection these six people received no input other than task related. This was despite all of them having at risk of isolation identified within their care plan. Some people also had depression, dementia and anxiety related issues. For example, one person's care plan said they loved to look through old photographs which stimulated conversation. Staff said they did not have time but knew about it and records showed no input. The home's brochure stated "if you have a particular interest then every effort will be made to accommodate it". This was not happening.

This was in breach of regulation 9 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not received many formal complaints however these appeared to be handled well. There was a clear complaints procedure and this was included in the welcome pack for new admissions. People who were able to comments said they had no worries about taking any concerns to the manager or staff. There were clear time frames and process which had been followed and letters of outcomes and acknowledgement sent to the complainants.

Requires improvement

Is the service well-led?

Our findings

The service was not always well led. The registered manager had been on leave for a couple of weeks and the home was currently managed by the deputy manager. They also had their time split between management and working as a nurse. There were some quality assurance systems in place to make sure any areas for improvement were identified but these had not been addressed in a timely way. For example, a monthly home review in October 2014 and December 2014 signed February 2015 had identified that care plans were not up to date or person centred. A previous documentation audit in May 2014 by head office had also raised those points to be addressed. There had been a staff meeting in November 2014 which had not mentioned these areas in the minutes. A quality audit in October 2014 had also identified the lack of wound care documentation, skin care regimes, lack of person centred care planning, gaps in biographical information about people and lack of keyworker documentation. Action had not been taken to ensure staff received regular meaningful one to one supervision sessions. There were, however, regular staff meetings and manager's meetings across the other Brendoncare homes.

Although the provision of food in general from the kitchen was of a good quality there were issues with whether those people with complex needs were receiving a nutritious, balanced diet. Food and fluid charts for five people mainly showed drinks offered at set times. For example, one person had a drink at 9am and nothing until 12.15pm, then at 3pm. We saw no-one enter the room until then and they were unable to use a call bell. Fluid charts had no optimum level of fluid to achieve recorded and no totals calculated or assessed in relation to the person's needs. This meant staff would not be aware from the records what the ideal amount of fluid was needed for each person. If there was a lack of fluids taken the care plan did not always reflect this and show a clear action plan. One relative said sometimes drinks and nourishment for people unable to eat cake/on a soft diet were missed completely. This was the case with one person during the inspection. They also said if people seemed hungry in the night there was little offered, adding they felt this was especially important if people were eating and drinking very little. They felt they needed to be available to meal times as staff did not have time to spend with their relative. Records supported this in that there were no records on some fluid charts, one person had no chart yet was a risk and there were no records to show if fluids had been offered and refused. At the foot of the supper menu there was a note to the effect that late night snacks were available.

One person had profound weight loss over some months but their food intake chart was no longer being recorded. Weight loss was not mentioned as an issue with actions in their care plan, only in one review note. Staff were unsure whether the person was or was not on a food and fluid chart but one could not be found. The person required assistance with eating and drinking and a fluid chart had not been commenced until March 2015 despite their weight loss being an issue prior to this. Overall, people's weights were monitored monthly and reported to head office although nutritional assessments in people's care plans were often not completed. This was noted by one health professional we spoke to also. They said on their recent visit people's food and fluid charts and nutritional assessments were not completed. Therefore the service was not well led in monitoring and ensuring vulnerable people received adequate food and nutrition consistently.

This was in breach of regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although there was regular reporting to head office about weights and assessments no action appears to have been taken to drive improvement. For example, care plans did not reflect risk areas and inform staff how to manage these risks effectively. However, accidents and incidents including falls were well reported and actions were taken to minimise risk in the future relating to these.

A quality assurance survey to monitor people's experiences and enable feedback had been completed in 2014 although the deputy manager could not tell us what had happened following the survey. The survey included people using the service, relatives and staff. We did not see what proportion of people and relatives this included but it was a largely positive response. However, there were some negative comments and these had not been addressed such as lack of staff, time with residents and communication. The manager had also not picked up some of the issues raised in this report.

This was in breach of regulation 17 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

Without exception people spoke in glowing terms about the laundry service. A couple of people reported a little language difficulty with some staff for whom English was not their first language. One person said that sometimes when staff speak to one another in their own tongue she asks them to speak in English. Most people could identify the registered manager and said they saw her occasionally. One visitor said “The manager is approachable, sensible and easy to talk with”.

Staff comments included “I really enjoy working here. Training is available and we all get on, we just need more time.” Most staff commented on the lack of staff and time with people using the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Care plans did not reflect how care and treatment was designed with a view to achieving people's preferences and ensuring their needs are met. How the regulation was not being met: People were not involved about their care plans and relevant persons were not provided with the information they needed relating to care plans. These were breaches of Regulation 9 (1) (b) and (3) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: There were not enough staff to ensure people's needs could be met in a person centred way. How the regulation was not being met: Staff did not receive appropriate support, supervision and appraisal to enable them to carry out the duties they are employed to do. These were breaches of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

How the regulation was not being met: Quality assurance systems were not robust to ensure they assessed, monitored and improved the quality and safety of the services provided.

Records did not always ensure that people's hydration and nutrition was monitored robustly.

These were breaches of regulation 17 (1) (a) and (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.