Mr T & Mrs C Murphy

Bronte

Inspection report

Lower Lane, Ebford
Exeter
Devon
EX3 0QT

Tel: 01392875670
Website: www.bronte-devon.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 15 and 16 June 2016.

The service provides accommodation and personal care for up to 20 older people. On the day of this inspection there were 12 people living there.

The service was inspected on 19 June 2015 when we found a number of serious concerns. The service was rated as 'inadequate' and we placed them in 'special measures'. The special measures framework is designed to ensure a timely and coordinated response where we judge the standard of care to be inadequate. Its purpose is to:

•Ensure that providers found to be providing inadequate care significantly improve

•Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

•Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example to cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

We imposed a condition that the service must not admit any further people until we were satisfied that all breaches of compliance had been addressed and the service was safe. We carried out another inspection on 4, 5 and 11 February 2016 when we found some actions had been taken, but these were not sufficient to ensure the service was fully compliant. The rating of the service remained 'inadequate'.

We carried out this inspection to check if improvements had been made. During this inspection we found the providers and staff had worked hard to address the previous breaches to ensure that people's needs were met. Improvements had been made in all areas and the service was fully compliant. The service will now be removed from special measures but we have rated the service as 'requires improvement' because it is too early to be certain the service will maintain full compliance in the future. We will continue to monitor the service until we are satisfied the good practice found during this inspection has been embedded and maintained.

People living in the home, staff and visitors told us the service had improved significantly over the last year. There was a cheerful and lively atmosphere with lots of smiles and friendly conversations between people living in the home, visitors and staff. Comments included "They really do try hard. I have no problems at all" "No trouble here. I like it here. I am very happy" and "The staff are all very, very kind. They are all marvellous."

One of the providers is the registered manager of the service and the other provider is responsible for the day to day management of the service and is referred to in this report as the duty manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Safe procedures had been followed when recruiting new staff. Checks and references had been carried out before a new staff member started working in the home. This meant that new staff were suitable for the job they had applied for and there was a robust recruitment process in place. Staffing levels had increased since the last inspection. There was an extra member of staff on duty each day therefore we found the staffing levels were adequate to meet people's needs. People received assistance when they needed it. People told us there were sufficient staff on duty at all times to meet their needs. Comments included "It's much better now."

Staff had undertaken a wide range of training since the last inspection and were able to tell us what they had learnt and how they had put it into practice. Staff attended weekly training sessions to gain a qualification known as the Care Certificate. We saw evidence of regular, planned, one to one supervision sessions for staff. Each staff member had a named supervisor and the records showed staff had received at least three supervisions since the previous inspection. This meant staff now had support to discuss how their role was going and to plan for their training needs.

Medicines were administered safely. Medicines were administered by staff who had received suitable training. Safe procedures were followed when recording medicines. Medicines administration records (MAR) were accurate. There were no unexplained gaps in the medicines administration records. Audits of medicines had been completed and appropriate actions taken to monitor safe administration and storage. The service had ensured the management of prescribed topical creams and lotions was safe.

Staff had received training on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). DoLS applications had been submitted for most people living in the home. There had been improvements in the way the service assessed people's capacity to give consent, or to make important decisions about their care and treatment. The care plans explained to staff about each person's capacity to make decisions and ensured staff gained people's consent before providing care. We observed staff seeking consent before carrying out care tasks.

Staff had sufficient information to ensure people received care that met their individual needs. New care plans had been drawn up in consultation with the resident, some family members, the deputy manager, the duty manager and the registered manager. The new care plans had been completed and were in use. The information was up to date and gave a person centred picture of each person including their individual needs and preferences. Staff knew about each person's needs and were meeting them in a person centred way in practice. They had been regularly reviewed to ensure the information remained current. This meant staff were now working with up-to-date information to assist them in providing safe and effective care for individuals.

Risks to people's health had been fully assessed and regularly reviewed. People who were identified as being at risk of choking had been referred to the local speech and language therapy team and appropriate actions had been taken to minimise risk. The records contained assessments and regular reviews relating to all potential risks, for example falls, pressure wounds, malnutrition, dehydration and weight loss. The staff had sought specialist advice and treatment where necessary and equipment had been provided to reduce

risks.

Staff had worked hard to identify people's social needs. There was clear evidence in the care plans to show staff had discussed with people the things they enjoyed doing. Two activities organisers visited the home each week to provide a variety of activities such as games, arts and crafts. During an activities session on the first day of our inspection there was lots of smiles, laughter, singing and clapping. Staff also spent time on a one-to-one basis with people, for example by accompanying them to go for a walk. People could choose to join in as they wished and were able to socialise in a way that suited them.

At the last inspection we found improvements were needed to make sure quality assurance systems were effective in identifying shortfalls in the service offered. At this inspection we found more robust quality monitoring had been put in place. The providers had implemented a new system of checks including a manager monthly service review, regular audits, spot checks and completed a quality assurance survey. They had also attended various training events to update their knowledge. They told us their aim was to ensure the quality of the service continues to improve.

Staff demonstrated a positive and caring manner. They were cheerful, friendly, smiling and welcoming. We saw staff communicating well with people seeking consent and explaining the care they were offering, for example moving and handling procedures. Staff understood the importance of treating people with dignity and respect, for example by drawing curtains and shutting doors when carrying out personal care. People told us the staff were always kind and caring.

At this inspection we found actions had been completed to improve the security of the premises. During this inspection we saw the risk of unannounced visitors had been addressed. The providers had carried out risk assessments on all exits from the home to ensure people were protected from harm.

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

People were safe. However systems to ensure people are safe have not yet been proven to be consistently maintained.

Risks to people's health and safety were managed effectively.

Safe recruitment procedures had been followed before new staff began working in the home.

Medicines were securely stored and administered safely.

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

Is the service effective?

Good

The service was effective.

People were supported by staff who had received regular supervision and appraisal to monitor their practice or identify areas where further training or guidance may be necessary.

People's capacity to make decisions about their lives had been considered or assessed. Applications had been submitted for people whose liberty may be restricted. They had taken adequate steps to ensure any restrictions to people's liberty were managed in line with current legislation.

People were offered a choice of meals and drinks that met their needs and preferences.

Is the service caring?

Good

The service was caring.

Staff supported people in a caring and respectful manner.

Staff understood the importance of providing care in a manner which protected people's privacy and dignity.

People were appropriately cared for at the end of their lives by competent and well-trained staff with the support, advice and

treatment of relevant health professionals.

Is the service responsive?

Good

The service was responsive.

Care plans gave sufficient and up to date information about each person's needs to ensure that staff had clear instructions to follow.

People's social needs were met. People were supported to receive a range of activities suited to their individual needs and preferences.

Is the service well-led?

Requires Improvement

The service was well-led

There were systems in place to monitor the quality of the service and seek people's views. However, these had only recently been put in place and therefore we cannot yet be certain these will be fully effective, or will be maintained for the foreseeable future.

The provider and registered manager had begun to update their own learning and development needs and had a better understanding of current legislation or good practice standards in relation to people's care needs.

Bronte

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 review the rating of the service under the Care Act 2014.

This inspection took place on 15 and 16 June 2016 and was unannounced. It was carried out by two social care inspectors.

Before the inspection we reviewed the information we held about the service. We looked at the information we had received from the service including statutory notifications (issues providers are legally required to notify us about) or other enquiries from and about the provider.

During our inspection we spoke with one of the providers, seven people living in the home, four visitors and four staff. We also spoke with one health and social care professional who knew the service. We looked at the care records of four people living in the home.

We also looked at records relevant to the running of the service. This included staff recruitment files, training records, medication records, and quality monitoring procedures.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found breaches in Regulation 12, Safe care and treatment, and 13, Safeguarding service users from abuse and improper treatment (Health and Social Care Act 2008 (Regulated Activities) Regulations (2014). The providers and staff had worked hard since the previous two inspections and the improvements we found during this inspection were now effective and ensured that people were no longer at risk of harm. However, the improvements have only recently been put in place and we cannot yet be certain these will be sustained. Therefore we have rated the safety of the service as 'requires improvement' and we will monitor the service to ensure they continue to provide a safe service.

Staff had received training and information on all areas of risk and knew how to keep people safe from harm. They were able to tell us about what they had learnt and how they put it into practice. Staff were knowledgeable about managing the risk of choking, pressure sores and medication management and safeguarding processes to ensure that people were safe. People told us they felt safe living at Bronte. One person told us "No trouble here. I like it here. I am very happy."

At the last inspection we found staff had not received adequate training or information to enable them to recognise potential abuse or know how to report suspected abuse. Since the last inspection staff had received training on safeguarding adults and knew how to recognise and report any suspicion of abuse. This meant the risk of people suffering harm or abuse had reduced significantly. Staff assured us they felt confident they could speak with the providers if they had any concerns and the providers would listen, take their concerns seriously and take appropriate action. They showed us information on the office wall about local reporting procedures if they felt the providers had not taken the right actions.

The providers and staff had taken action to improve people's safety. At the last inspection we found although risk assessments had improved and had been completed for health risks such as skin damage and pressure sores, constipation, weight loss, dehydration, choking, or falls, these documents were not yet in use. During this inspection we found the new care plans and risk assessments now contained detailed information about each person's individual needs. Staff had been involved in completing the care files for people and they were now in day to day use. Where risks had been identified, plans to address the risks were now clear and staff were able to tell us how they managed risks for people. Environmental risk assessments had been completed, for example relating to the use of fire exit doors and findings were related to a monthly service review to ensure the service continued to be safe for people.

Where people had been assessed as 'at risk' there was a clear care plan detailing how staff should minimise and manage that risk. For example, care plans contained completed risk assessment tools for nutrition, skin integrity and hydration. One person had a sore area. This had been referred to the GP and was being monitored by the community nursing team. Staff knew how to manage the risk and told us what aids and monitoring they used. They understood the importance of a nutritious diet to aid healing and there was a pain management plan in place. The person told us they were comfortable and were happy with their care.

Care plans contained body maps, detailing where risks were and regular monitoring of progress. For

example, how a wound was progressing/healing, where to apply topical creams and lotions and why. All prescribed creams and lotions were named and labelled with their opening date to ensure safe application. Where people were at high risk of developing pressure sores their risk assessments showed staff what equipment to use such as creams and specialist pressure relieving mattresses and cushions and these were in place. At the time of the inspection no-one was receiving care in bed and people were all able to mobilise themselves in bed therefore not requiring staff to regularly turn them. There were no people suffering from pressure sores.

People who were at high risk of falls had been identified using a recognised tool and detailed individual monthly reviews were in place. For example, one person had hit a door frame whilst mobilising. Their care plan detailed how to assist this person to avoid the incident happening again. Accident forms were completed and reviewed to ascertain any common patterns in falls and actions for staff to take were documented. Since the last inspection the incidence of falls had been very low and there had been no injuries resulting from falls.

At the last two inspections we found the home had failed to take suitable action to protect people from the risk of choking. This had now been addressed. People who had been identified as being at risk of choking had been referred to the local speech and language therapy team (SALT). The assessment recommendations had been shared with staff including the cook and clear instructions about how to minimise the risk were in the care plan and displayed in the kitchen. The cook was able to tell us who required a special diet such as 'fork mashable' and 'puree' and told us how they made these meals as tasty and appetising as possible. If people liked particular meals such as fish and chips, the cook tried to incorporate the foods people liked in a way that met the SALT recommendations such as soft sandwiches and soft chips and flaked fish. Pureed meals were presented with individual purees for meat and sides. Risk assessments were in place to show how the staff had assessed the risk of choking, the level of risk and any preventative measures that should be put in place. Care staff told us about the people who were at risk of choking, and how their food was prepared in line with guidance from the SALT team. The care plans also provided detailed information on how to support people to minimise the risks of choking.

Where people were at risk of weight loss this was highlighted in the care plans. The staff now used a recognised Malnutrition Universal Screening Tool (MUST) l to assess risk and this was included in the care plans. People were weighed regularly using a weighing chair which enabled them to weigh each person safely and accurately. Where weight loss or gain had identified a risk to a person's health, adjustments to their diet had been agreed with them, and progress towards a safe weight was monitored. For example, one person at risk of weight loss had been given foods they could pick up easily with their fingers. Staff knew the foods they liked and placed them in easy reach to enable the person to 'graze' throughout the day. Staff told us how they prepared snacks to put on the table at night and knew the person had enjoyed them when they found crumbs in the bed in the morning. The cook told us how they ensured a high calorie diet and offered food the person liked. Care plans included an NHS information sheet about 'simple ideas to help improve your food intake'.

Where people were at risk of weight loss or dehydration input/output charts were completed by staff. However, some records appeared to show long periods between meals and drinks, particularly at night. Staff said they did not always document when the person had refused or had assistance from family or night staff. They assured us some people were often awake during the night and were offered drinks and snacks regularly throughout the night. The records had not been totalled each day to monitor overall input. The senior care worker assured us they would record totals immediately and ensure staff, including night staff recorded intake consistently. By the second day of our inspection we saw all staff had been given instructions on recording and totalling all food and fluid intake.

Where people were at risk of constipation or diarrhoea care plans guided staff to encourage people to drink plenty of fluids. Plans now included monitoring of fluid intake levels to make sure people were not at risk of dehydration.

Where people required equipment to help them to move safely there were now moving and handling assessments in place. There was good information in the care plans to instruct staff on how to use the equipment safely. For example, one care plan said the person needed to be assisted to move with the use of a hoist and sometimes depending on how they felt, could weight bear. Staff knew the person preferred to use the sling hoist as it was more comfortable. The care plan detailed how to ask the person how they felt before mobilising and at present they were doing well and had been able to access the garden with assistance. Another person had a detailed care plan about how they could weight bear and stand up using a frame for short distances but used a standing hoist to stand up for washing.

Staff were seen to safely support people who had restricted mobility. Care plans detailed how people had been assessed for moving and handling and what actions staff needed to take to ensure people's and staff safety. Throughout the inspection we observed staff supporting people who had poor mobility in an unrushed and reassuring way.

At the last inspection we found medicines were not always administered safely. We found staff had received training on medicine administration since out last inspection. Medicine administration records had been completed after each medicine had been administered and there were no unexplained gaps. Where people needed assistance with their medicines, assessments had been carried out and consent had been obtained for staff to administer medicines. Staff understood when to offer medicines that were prescribed on an 'as required' basis. Medicines were stored securely in a medicine trolley that was locked when not in use. There were secure storage facilities for controlled drugs, and for medicines that needed to be stored in a refrigerator. We looked at the recording of medication fridge temperatures. These were within normal levels but the forms did not detail what these were. The senior care worker said they would include the normal range details on the form.

We observed a member of staff administering medicines at lunchtime. They demonstrated good knowledge of each person's medicines and followed safe practice by checking the medication records before removing medicines from the packaging and giving to the person. There were efficient systems in place to make sure stocks of medicines were replenished regularly by the local pharmacy. Out of date or unwanted medicines were returned to the pharmacy each month.

Recruitment procedures had improved since the last inspection. One new member of staff had been employed and we found their recruitment process had been robust. Their recruitment file contained evidence of each stage of the recruitment process. This included references from previous employers and people who knew them well. The provider had also carried out disclosure and barring service (DBS) checks. The DBS checks people's criminal record history and their suitability to work with vulnerable people. Interview notes had not been retained. The provider assured us they will keep a record of all areas discussed in interviews in the future.

The ratio of staff to people living in the home had increased. The staff rota showed that either the registered manager or duty manager were working in the home each day, plus a senior care worker, two care staff, one cook, and an activities person on three or four afternoons each week. There was a care worker at night and a sleeping care worker on site who could be called for assistance at any time. This had clearly resulted in staff being less rushed. People living in the home, visitors and staff told us they were confident there was always enough staff on duty. Comments included "It's much better now." We also saw that staff had time to sit and

chat with people, provide activities, and accompany people for walks and to medical appointments. One person had previously expressed a wish to go to church regularly. The staff had encouraged the person to get ready in the mornings and now they were attending regularly with a friend. Therefore people's social needs were now able to be met in an individualised way. The provider said they would continue to monitor people's dependency and staffing levels in line with increasing admissions in the future.

The majority of people living at the service required one care worker to assist them and few people needed help at night, therefore dependency was low. The staff appeared cheerful, relaxed and welcoming and visible around the home. One person did not ring their call bell but sat in their door way for assistance. Staff ensured they checked this person regularly and we did not see anyone having to wait very long for assistance. People had access to call bells and on the days of the inspection call bells were responded to in a timely manner. A visitor told us, "They are very good; if [person's name] is going out they make sure they are ready in good time and not rushed."

The building was well maintained and safe. The decorations and furnishings were in good order. The gardens had been neatly maintained and provided places for people to walk or sit.

Cleaning staff were not employed. Cleaning tasks were carried out by the care staff. All areas were clean and free from odours. We spoke with a person during a visit from one of their family. They assured me the room was kept clean on a daily basis, and the staff also carried out regular 'deep cleaning' when all the furniture was pulled out and the whole room cleaned thoroughly.

At previous inspections we found external doors were sometimes left open and this meant staff were unable to monitor people entering or leaving the premises. During this inspection we found many external doors were locked and tied with special tapes approved by the fire service. This meant people were able to leave the premises in an emergency, although they were unable to leave freely if they wished. The provider told us the tapes were intended as a temporary measure and they were planning to install alarms on all exits to enable people to go out if they wished, while at the same time ensuring staff were aware of people entering and leaving.

Fire alarm systems were regularly checked and serviced. Where problems were identified we saw evidence to show actions had been taken promptly to rectify the issues.

Good

Is the service effective?

Our findings

At the last two inspections we found breaches in Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014); Need for consent, and Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014); Staffing. Staff had not received adequate training, supervision or support. People's capacity to consent to care or treatment had not been assessed or recorded and consent was not always sought from people before care and treatment was provided.

At this inspection we found staff had received training on the Mental Capacity Act (MCA) and the new care plans included information about each person's capacity to make decisions. People and/or their advocates had been consulted and they had signed a form in agreement with their care plans. Care plans showed staff had considered the need to seek agreement for procedures to be carried out in a person's best interest.

Staff were observed seeking consent before carrying out tasks and explaining the procedures they were about to carry out, for example when offering to assist a person to move, and asking a person if they wanted their medication. Staff we spoke with had understood the importance of gaining consent and what to do if people could not consent. They confirmed they had recently received training on the MCA.

The provider told us they had submitted Deprivation of Liberty Safeguards (DoLS) applications for most people living at the home. Care plans showed how they had reached the decision to apply for DoLS authorisations and there were mental capacity assessment forms completed, and care plans contained evidence of application documents. Therefore we were certain the key requirements of the Mental Capacity Act 2005 were fully understood or carried out.

The level of training for staff had improved significantly. New staff had undergone an induction programme and were working towards a nationally recognised qualification known as the Care Certificate. On the first day of our inspection both of the providers were attending training. One provider also attended training on the second day of our inspection.

Staff also told us they had received training almost every week on a variety of topics. For example, on the day before our inspection some of the staff had received training on challenging behaviour. Staff told us there was another training session later in the week for those staff who had been unable to attend the training the previous day. In the last year staff had received training on all essential health and safety topics including fire awareness, first aid, moving and handling, infection control and administration of medicines. In addition they had also received training on topics relevant to the health and personal care needs of people living in the home. These included dementia awareness, ageing, vision and dementia – common eye problems, palliative care, equality, diversity and inclusion, and privacy and dignity.

Staff told us the training had been delivered in a variety of ways suited to all learning styles. For example, some training had been provided through external courses, from visiting trainers, by watching DVDs and completing workbooks, and they had also received training during staff meetings. The provider gave us a copy of their training matrix showing the topics covered and dates staff had attended the training. This

showed almost every member of staff had received each of the training topics provided. Staff told us that if they missed a training session they were usually offered another date.

At the last two inspections we found the providers had failed to ensure staff received appropriate supervision, training or professional development. During this inspection we found there was now a robust supervision programme in place. Named senior care workers had been allocated named staff to supervise. There were clear forms for recording supervision sessions. These detailed previous discussions, any safeguarding issues, training needs and professional development and the role of the key worker. A member of staff who had been given the lead responsibility for staff training described how the staff team had responded positively to the training and felt they were progressing well. They told us "Three new staff are attending the care certificate training and I can see improvement in their skills." They also explained how they monitored the training sessions staff had attended. They told us the experienced members of staff were happy to pass on their skills and knowledge to less experienced staff. This meant staff now received adequate support and their competence and training needs were monitored.

People could see health care professionals when they needed to. Staff said they knew who to call and had made appropriate referrals such as to the SALT team. Health professionals who had responded to a recent questionnaire from the providers had given positive responses about the service. One professional had said "On every visit I have found Bronte to be a quiet, pleasant place with a calm atmosphere. I wish to complement staff on their welcoming approach to visitors. Staff generally have an excellent knowledge of each resident in the home. Well done."

At the last two inspections we found people were at risk of missing medical appointments as the systems for recording and planning medical appointments were not fully effective. There had been an issue previously about staff escort availability for people going out for hospital appointments resulting in some being missed. Now, named staff were assigned as escorts in the daily diary and hospital appointments were attended. One person was due to go for a planned operation. Staff were clear about the actions they needed to take to prepare the person for the hospital stay and operation and the provider was escorting them to the hospital with the necessary documentation kept in the daily diary.

At the last two inspections we found people were not offered an adequate choice or variety of food at mealtimes. An additional cook had been employed. In total two cooks were employed and between them they cooked the main meals seven days per week. The cook told us about each person's likes and dislikes and dietary needs and these were displayed on the cupboard and in a kitchen file reflecting their care plan. The cook spoke with people each day in the morning to let them know the meals offered and agree any alternative they wanted. For example, some people preferred traditional Chinese food. The cook was preparing a special Chinese meal for one person during our inspection. There were two choices of main meal every day or people could choose something off the menu. For example, a relative had brought in some rhubarb and the cook had included some rhubarb crumbles and pies. All meals were made fresh and homemade such as cakes, profiteroles, beef curry and cottage pie. One person sometimes liked a vegetarian meal and often had a bit of both meals on offer. The cook said they had a good food budget and were able to buy the things that people liked such as food from a particular supermarket and a sausage slice that was a favourite. Where people required a high calorie diet the cook enhanced food with whole milk for example, and one person liked melted chocolate in their warm milk drink which they had.

We observed a lunch time. Staff were kind and attentive, sitting discreetly with people to offer assistance and chat. Most people ate at individual tables which were laid up attractively with tablecloths, napkins, condiments and flowers. Staff offered drinks and snacks regularly throughout the day with drinks available in the communal lounge and within reach in people's rooms. One person enjoyed a second helping of beef

curry. In the evenings people were offered bedtime drinks and also snacks such as cakes, sandwiches or whatever the person wanted. People told us they enjoyed the meals. Comments included, "I like the food, I'm well looked after and I love the cakes." The cook said, "Things are a lot better. The staff are happier and working as a team." They told us that the appointment of a second cook had made a big improvement as it meant the care staff no longer had to cook the meals on the days the cook was not working. The two cooks worked together to draw up menu plans and to ensure people were offered a choice of meals that met their nutritional needs and preferences.

Good

Is the service caring?

Our findings

Staff treated people in a caring, dignified and respectful manner. The staff sought people's consent before providing any care or support. While they assisted people they explained the procedures they were about to follow and there was friendly conversation, smiles and laughter. Staff were attentive to people's needs and people responded well to staff. The atmosphere in the home was relaxed and friendly. One visitor said, "The staff all appear happier in their work. It's lovely to see."

Staff respected people's privacy. All rooms at the home were used for single occupancy. People could spend time in the privacy of their own room if they wanted to. Bedrooms were personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. Staff knocked on doors and waited for a response before entering. We noted that staff never spoke about a person in front of other people at the home which showed they were aware of issues of confidentiality. Staff addressed people using their preferred name and they were discreet when offering people assistance with personal care needs.

Throughout the day we heard staff chatting with people, and people were smiling and laughing. We saw a member of staff sitting with people during an activities session, holding their hands, encouraging and supported them to join in. Staff told us they enjoyed having more time to sit and chat to people, for example talking about topical news events. A person who lived in the home said "The staff are all very, very kind. They are all marvellous

During lunchtime staff sat with those people who needed assistance with their meals. They provided individual attention, taking time to communicate with the person and check they had finished each mouthful before offering more food. We also saw one person who was able to eat independently but needed support and encouragement from staff regularly during the meal. Staff kept a watchful eye to make sure they were eating the meal. When the person stopped eating staff offered support in a discreet manner. The care plan detailed that the person was reluctant to accept help and told us how they ensured the person ate enough regularly. We heard staff asking people "Would you like a bit more?" "Would you like to try…?" "Is that alright?" and "Do you need some more water?" While staff were assisting people with their food and their medicines they carefully explained the food or medicines they were offering and checked the person was happy before proceeding.

When staff assisted a person who needed assistance to move from their chair to a wheelchair they used a fleece blanket to protect the person's dignity during the procedure. Staff checked what people were doing before showing visitors to their room and visitors were able to visit in private or in the communal areas. A visitor told us "They are very kind here."

Staff demonstrated a good knowledge of people's needs and the care plans reflected what the staff told us. For example, care plans stated what each person could do for themselves and what they needed staff help with. One person could manage to wash their face and upper body themselves but needed help to hold their mug and cutlery. Staff understood each person's likes and dislikes and individual needs such as

whether they needed their glasses for watching TV as per their eye care assessment and if someone liked to use continence pads for security. One person on a fork mashable diet had specific details in their care plan such as what drink they preferred and how to make a favourite snack safe for them to eat. We then saw them having these items. The care plans contained a daily routine for each individual which was flexible but had been discussed with the person and their key worker. Another person's care plan stated how they liked the light on all day and the door and window open. This was happening. Staff told us they felt they knew people well and that, "Things were really coming together. It's a pleasure to work here now."

Treatment Escalation Plans (TEP) were in place for people near the end of their lives and we saw these had been completed following discussion with the person, or with their next of kin. Care plans now contained information about each person's wishes for their care at the end of their lives.

The service had completed a quality assurance survey involving people, their advocates, stakeholders and health professionals. They asked people using the service if they felt the staff were polite and thoughtful, if staff respected their privacy, and if they were happy with the way staff treated them. All of the responses were positive.

There was also a 'dignity and respect' spot check process done regularly by the provider. This looked at how staff interacted with people at random times. For example, one person had become distressed and staff had been quick to reassure them. Another care worker had noticed a person was becoming more confused when having lunch and so they were now assisted discreetly. This ensured that staff were vigilant about how they cared for people in a kind and respectful way.

Good

Is the service responsive?

Our findings

At the last two inspections there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's care was not person-centred. Care needs had not been fully assessed, monitored or reviewed and people had not been fully consulted or involved in drawing up or agreeing how their care needs should be met. The providers had received support and advice on care planning from the local authority's quality improvement team (known as (QAIT). New care plans had been drawn up after an assessment of each person's needs, and these provided information on all areas of needs. However, we found they had not been implemented and therefore staff did not have sufficient information about each person's health and personal care needs or any risks associated with these. At this inspection we found the new care plans were in place, were person centred and detailed and being used daily by staff to inform their care. They had been drawn up with a significantly increased level of information about each person's care needs. This meant staff now had clear and adequate information on each person's health and personal care needs.

People were now involved or consulted in drawing up their care plans and people and/or their advocates had signed to say they agreed with their care plans. Records showed that staff also discussed care with relevant advocates to help them further inform the social needs care plan for example. Where people needed staff to support them with tasks such as bathing, washing and dressing the person's preferred method of support was clearly explained. Staff understood each person's needs and they were able to explain to us the assistance each person needed. People had signed various parts of the care plan to indicate they had been involved in drawing it up and agreed to the content of the plan. We asked people if they had been involved and consulted. Most said yes although one person said "I am not sure about a care plan. I can't remember."

The care plans explained clearly each person's likes, dislikes and preferences in all areas of their daily routines. Information was neatly filed and indexed making information easy to find. Staff told us they were confident the new care plans provided them with all the information they needed about each person's care needs. Comments included "Residents get all the help they need."

Staff were responsive to people's changing needs. For example, they made appropriate referrals to health professionals in a timely way. One person had reduced hearing. A note in the daily diary and their care plan stated, "Inform the district nurse." This was done the next day and an appointment made. Another person's care plan said the person had requested a GP and they had been seen promptly.

Staff were able to tell us about each person's individual support needs. For example, some people wanted to look after their own laundry as far as possible. A member of staff described how they supported a person to maintain independence with their personal laundry by chatting to them, giving reassurance, and by agreeing how their laundry would be washed and returned to their room. They understood the reasons why this was important to the person.

At the last inspection people's social needs had not been assessed or reviewed. An activities organiser

visited the home for one hour three times a week. At this inspection we found new activities organiser had been employed for two afternoons each week in addition to the existing activities co-ordinator. Between them they provided a wide range of activities to suit most interests. The staff told us that on the days when the activities organisers did not visit they provided activities including going out for walks with people in the garden or lanes nearby. Some people also went out to local clubs each week.

There was now a programme of activities to suit people. There was a lovely atmosphere in the home throughout the inspection. We heard people laughing, clapping and singing. People were enjoying a session with a drama therapist and later care staff sat with people chatting in the lounge having drinks and watching the Queen's birthday celebrations. Each person had an individual activities record showing they were engaging with activities regularly and doing what they liked to do. For example, people had been able to access the garden, attend art sessions making crafts which were displayed around the home and spend time with staff.

One person had enjoyed sitting in the staff office chatting with staff. Another person had enjoyed a singing session and sitting with a care worker watching a TV programme they liked. One care worker said, "[Person's name] is really loving all the extra activities. Things are happening and it's great to see everyone happy." Another care worker said, "[Person's name] used to stay in their room a lot but now they hear the activities going on and it's really nice that they want to come out and spend time with us." We saw people being engaged rather than sleeping or on their own for long periods. Care plans also included details about who was important to people and who they liked to keep in contact with.

Residents meetings were held every three months and were held in the lounge. We saw the minutes of each meeting held approximately every three months. The minutes showed people had been consulted, made suggestions, and actions had been taken to address these, for example suggested menu changes.

People told us they were confident they could raise any concerns or complaints with the providers or staff and they were confident these would be addressed. For example, one person told us they had written letters to the provider in the past and they were confident the provider had taken appropriate action. Relatives told us they had no hesitation speaking with the providers if they had any concerns.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we found the service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014) – Good governance. At this inspection we found the management of the service had improved. People and visitors told us the service was well-led. However, systems to monitor the quality of the service and seek people's views had only recently been put in place and we cannot yet be certain these systems are fully effective. Therefore we will continue to monitor the service until we are confident full sustained compliance can be maintained.

One of the providers is the registered manager of the service and the other provider regularly manages the service and is referred to in this report as the duty manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The management structure of the service showed a registered manager, a deputy manager and three senior care assistants who each had responsibility for supervising a group of care workers.

At the last two inspections we found the systems to assess, monitor and improve the quality of the service were not fully effective. The provider had previously been slow to take any action in relation to this breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found action had now been taken to address this breach. The providers had received advice, information and documentation from the local authority Quality Improvement Team on all aspects of the management of the service, including effective quality monitoring processes. They had adjusted the documents to suit Bronte and these were finally in place and being used. The audit tool now included checks on many areas of risk including moving and handling audits, risk of choking and falls. A manager monthly service review had been carried out and recorded in full for the last three months and provided detailed evidence of their findings and any actions necessary to improve the service. This meant we now had more confidence the quality assurance system would continue to enable the providers to effectively review and improve the service. However, it is too early for us to be sure that improvements can be sustained and embedded in practice without the continued support of the local authority's Quality Improvement Team. Therefore we have rated this service as 'requires improvement'.

At the last two inspections we found records were not always stored safely to maintain confidentiality. The area previously used as an office was also a corridor linking many of the bedrooms with the lounge and dining room which meant privacy and confidentiality was difficult to maintain. Confidential records and information were not always stored securely. At this inspection we found this had been addressed by converting an unused bedroom into an office. Care plans and daily records were kept in a locked filing cabinet when not in use. The office door was kept locked at all times. Staff were able to hold handover sessions in this room where confidential information could not be overheard.

All accidents and incidents which occurred in the home had been recorded there were now systems in place to analyse trends or consider any actions needed to prevent recurrence. There had been no major accidents

or incidents, since the last inspection. The records of each incident had been clearly recorded and showed that each incident had been taken seriously, investigated, and actions taken to prevent recurrence, even where these were minor in nature.

A fire alarm bi-annual check had been completed including further work to address any issues raised. Also a devices checking audit was in place to ensure all the equipment was in good working order. Staff showed us the provider's workbook where they recorded any maintenance issues. This showed actions were taken in a timely way and issues resolved such as light bulbs or broken fixtures.

A monthly medication audit was now being done. For example, people's medication allergies information had been gathered and shared with the local pharmacy and GP's. Medication stocks had been checked, including liquids and if homely remedies had been used. These are medications agreed with GP's that the service can use for minor ailments bought 'over the counter' in a chemist. One audit had noticed that not all staff had been recording whether one or two tablets had been given for example. Staff had then been reminded to record this. This showed the medication audit was effective in identifying areas for improvement and actions taken.

People were now actively involved in developing the service. They were involved and consulted about their own care needs and signed to agree with their care planning. Any discussions with important people were recorded, for example when relatives had instructions for someone's birthday or if someone needed a new hearing aid. One relative had suggested a contact book in the person's room would be helpful as the person could not always remember who had visited. Staff had put this in place.

People, family and friends, staff and visitors had been asked to complete questionnaires giving their views on the service and their responses had been collated. Overall the responses were positive, although there were some areas where improvements could be made. For example, people were asked "Do you get all your questions answered?" Nine people had answered 'yes' and six people had answered 'usually'. We discussed the responses with a provider who told us they aim to continue to improve the service and hope that the next survey will show this has been achieved. Responses from relatives, staff and professionals who responded to the survey were also positive. Comments included "We have been very happy with the care and attention to detail. The staff are friendly and welcoming. They do their very best with the care they deliver."

At the last inspection the providers had failed to evaluate and improve their practice to ensure the quality of the service was continually improved. The providers' qualifications and training was from some years ago but they were now accessing training and were attending an external training session on the first day of our inspection.

Staff meetings were taking place. The minutes showed a wide range of topics had been covered in the meetings including training needs. The outcome of our last inspection had been shared with the staff and the records showed the staff had discussed and agreed actions to address our findings. Staff were now receiving regular formal support and supervision. One care worker said, "seven months ago it was not so good. Now my English is much better and everything is much better."

As far as we are aware, the home has notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.