BM Care Warwick Limited

Bromson Hill Care Home

Inspection report

Ashorne
Warwick
Warwickshire
CV35 9AD

Tel: 01926651166
Website: www.bromsonhill.co.uk

Date of inspection visit:
01 December 2016

Date of publication:
12 January 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Bromson Hill Care Home on 1 December 2016. The inspection visit was unannounced. Bromson Hill is divided into two separate floors and provides personal and nursing care for up to 32 older people, including people living with dementia. There were 26 people living at the home when we inspected the service.

A requirement of the service's registration is that they have a registered 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 and associated Regulations about how the service is run. There was not a registered manager in post at the time of our inspection visit. The previous registered manager had left the service several months before our inspection; a new manager had been appointed and had been in post for eight weeks. They intended to apply for registration as soon as their probation period had ended. We refer to the newly appointed manager as the manager in the body of this report.

People received medicines as prescribed to maintain their health and wellbeing. People were supported to access healthcare from a range of professionals inside and outside the home and received support with their nutritional needs. This assisted them to maintain their health.

People were protected against the risk of abuse as the provider took appropriate steps to recruit staff of good character, and staff knew how to protect people from harm. Safeguarding concerns were investigated and responded to in a timely way to ensure people were supported safely.

There were enough trained and supervised staff to care for people effectively and safely, and meet people's individual needs.

People were supported to access healthcare from a range of professionals inside and outside the home and received support with their nutritional needs. This assisted them to maintain their health.

The provider, manager and staff understood their responsibilities under the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure people were looked after in a way that did not inappropriately restrict their freedom. The manager had made applications to the local authority where people's freedom was restricted, in accordance with DoLS and the MCA requirements. Decisions were made in people's 'best interests' where they could not make decisions for themselves.

Staff knew people well and could describe people's care and support needs. Staff treated people with respect and dignity, and supported people to maintain their privacy and independence.

Care staff treated people with respect and dignity, and supported people to maintain their privacy and independence. People made choices about who visited them at the home. This helped people maintain

personal relationships with family and friends who were important to them.

Care records were up to date and provided staff with the information they needed to support people responsively. People were supported to take part in social activities and pursue their interests and hobbies.

People knew how to make a complaint if they needed to. Complaints received were investigated and analysed so that the provider could learn from them. People who used the service and their relatives were given the opportunity to share their views about how the service was run.

Quality assurance procedures were in place to identify where the service needed to make changes; where issues or improvements were identified the manager took action to continuously improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were enough staff available to care for people effectively and safely. People felt safe living at the home. People were protected from the risk of abuse, as staff knew how to safeguard people from abuse. The provider recruited staff of good character to support people at the home. Medicines were stored and managed safely, and people received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

Staff completed induction and training so they had the skills they needed to effectively meet the needs of people at the home. People received food and drink that met their preference and cultural needs, and supported them to maintain their health. Where people could not make decisions for themselves, people's rights were protected. Important decisions were made in their 'best interests' in consultation with people that were important to them and health professionals.

Is the service caring?

Good

The service was caring.

Staff treated people with respect and kindness. Staff knew people well, and respected people's privacy and dignity. Staff supported people to maintain their independence. Family members and friends were welcomed to the home, which helped people maintain relationships that were important to them.

Is the service responsive?

Good

The service was responsive.

People described staff as being responsive to their wishes. People were supported to take part in interests and hobbies that met their needs. People were able to raise complaints and provide feedback about the service, which was acted on by the

provider.

Is the service well-led?

Good

The service was well led.

There was not a registered manager at the home, however, the manager was accessible to people who used the service, their relatives, and members of staff. People were asked for their feedback on how the service could be improved, and feedback was acted upon. Quality assurance procedures identified areas where the service could improve, and the manager took action to improve things in response.

Bromson Hill Care Home

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 was 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 1 December 2016. The inspection was unannounced. The inspection was to follow up on a previous inspection on 1 December 2015 at the home, where 'safe' and 'responsive' had been identified as requiring improvement. This inspection was conducted by one inspector, a specialist advisor, and an expert-by-experience. An expert-by-experience is someone who has personal experience of using, or caring for someone who has used this type of service. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported us had experience and knowledge in nursing care.

We reviewed the information we held about the service. We looked at information received from statutory notifications the provider had sent to us and commissioners of the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are representatives from the local authority who provide support for people living at the home. Before we conducted our inspection we were aware of a number of recent concerns at the home, including the change of manager, which had resulted in the local authority not placing anyone new at the home for the time being. We took these concerns into consideration when we reviewed people's care.

Some people had limited verbal communication skills, and so we spent time observing how they were cared for and how staff interacted with them so we could get a view of the care they received. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with six people who lived at the home and two people's visitors or relatives. We spoke with six members of staff including the manager, two nurses, one of which was the deputy manager, members of care staff, the chef and the activities co-ordinator.

We looked at a range of records about people's care including four care files, and other records relating to people's care, for example, medicines records and fluid charts. This was to assess whether the information needed and the care offered to each person was available.

We reviewed records of the checks the manager and the provider made to assure themselves people received a quality service. We also looked at personnel files for three members of staff to check that safe recruitment procedures were in operation, and that staff received appropriate support to continue their professional development.

Good

Is the service safe?

Our findings

All the staff knew and understood their responsibilities to keep people safe and protect them from harm. People and their relatives told us the home felt like a safe place to be. One person said, "Oh yes I'm safe, I know it's safe here." Another person said, "There's no risk here."

The provider protected people against the risk of harm and abuse. The provider notified us when they made referrals to the local authority safeguarding team where an investigation was required to safeguard people from harm. They kept us informed with the outcome of the referral and actions they had taken. Staff attended safeguarding training regularly which included information on how staff could raise issues with the provider. Staff told us the training assisted them in identifying different types of abuse and they would not hesitate to inform the manager if they had any concerns about anyone. They were confident the manager would act appropriately to protect people from harm. One person said, "If I was worried I'd talk to a manager or the nurse on duty, we've got familiar staff now."

Staff told us they would escalate their concerns if they did not feel they had been responded to appropriately. The manager understood their obligations for managing safeguarding concerns and reported them to the CQC and the local authority.

People were protected from the risk of abuse because the provider checked the character and suitability of staff prior to them working at the home. For example, criminal record checks, identification checks and references were sought before care staff were employed to support people. Nurses also had their registration checked before working at the home.

The manager had identified potential risks relating to people who used the service, and care plans had been written to instruct staff how to manage and reduce potential risks to each person. Risk assessments were detailed, and reviewed regularly. Risk assessments gave staff clear instructions on how to minimise risks to people's health and wellbeing. For example, one person was at risk of falling, and could injure themselves. There were plans for staff to follow in how the person should be assisted to move around, and what equipment should be in place to minimise the risk of them falling. In another person's care records we saw they were at risk of falling out of bed. Measures had been put in place to prevent the person from falling in this way, with the use of a rail to the side of their bed. The appropriate risk assessments were in place to ensure this was the least restrictive method of assisting the person to make sure they were unable to fall from their bed. The person told us, "They ask me if I want to stay in bed and put panels on the side so I don't fall over."

The provider had taken measures to minimise the impact of some unexpected events happening at the home. For example, emergencies such as fire were planned for, so that any disruption to people's care and support was reduced. There were clear instructions for staff to follow in the event of emergencies. Records showed personal emergency evacuation plans (PEEPs) were in place for each person who lived at the home. They gave instructions about the assistance people would need to safely evacuate the building in the event of an emergency.

We observed there were enough staff to care for people effectively and safely. Call bells were answered promptly and people were supported to eat and drink when they needed support. Staff were available at all times in the communal lounge area of the home. In addition to the nurses and care staff, the manager was available to cover care duties if required. The activities co-ordinator also spent most of their time in the lounge area, and was available to assist people if they needed support. One relative said, "There are enough staff always, though sometimes [Name] waits a little while, but it's okay."

We asked the manager how they ensured there were enough staff to meet people's needs safely. They told us staffing levels were determined by the number of people at the home, and by the needs, or dependency levels of each person. We saw each person had a completed dependency tool in their care records, which assessed how much care and support they required. The manager used this information, along with auditing information and staff feedback, to determine the numbers of staff that were needed to care for people safely and effectively. The manager told us they were currently reviewing how many staff members were needed on the night shift at the home, because currently there were only three members of staff working at night. One staff member was a nurse, and there were two members of care staff. This meant that one floor of the home was supported by one member of staff, rather than two members of staff. Ideally it would be beneficial to have two members of staff available to support people on each floor, so that people who needed two members of staff to assist them to move around had support readily available.

We asked the manager about the number of staff vacancies at the home, they told us they were currently recruiting for additional members of staff and they had already filled some vacancies for nursing staff. The home used agency staff to fill any vacancies whilst recruitment was on-going. One person told us agency staff were not ideal, as they didn't always know people well and understand their needs. However, the manager told us agency staff only worked alongside more experienced members of staff, so that they had the support and knowledge of permanent staff available to them. On the day of our inspection visit we noted there were two members of agency staff, the agency staff worked with experienced care staff at all times. One relative commented on the improvements since permanent staff had been recruited to the home saying, "Now they're getting more full time nursing staff they get to know the residents and residents get more one to one support, it's better."

We observed medicines being administered. Staff who administered medicines were trained nurses, and had received specialised training in how to administer medicines safely. Nurses confirmed this included checks on their competency and regular refresher training. Each person at the home had a medication administration record (MAR) that documented the medicines they were prescribed and when each dose should be given. MAR records contained a photograph of the person so that staff could ensure the right person received their medicines. This was important as the home could use temporary or agency staff to administer medicines who might not know the people there. Daily checks were undertaken by nurses to check people received their medicines as prescribed, and medicines were stored safely.

On the day of our inspection visit we found the manager (who was a registered nurse) was training a new member of staff to give people their medicines. The training involved the new member of staff working alongside the manager to observe their practice. Because of the training of the new member of staff the morning medicines round took longer than usual to complete. This meant that some people did not receive their medicines until after 10.00am. The MAR records stated the morning medicines were given at 8.00am. We brought this to the attention of the manager, who agreed that the actual time people received their medicine would be recorded in the future, if the medicines were time sensitive, or a gap was required between doses of medicines. This would prevent people from receiving their medicines without an appropriate gap being left between doses, which would put people at risk of receiving too much medicine.

People told us they received their medicines when they needed them. One person said, "I have my medicines at 8.00 o'clock, some at dinnertime and some in the evening. I'd know if I didn't get them." Some people received medicines that were prescribed on an 'as required' (PRN) basis, such as pain relief. This meant the medicines should only be given when people were in pain. There were protocols (plans) in place to give staff information on when they should give people these types of medicines. One person told us they always received their pain medicine when they needed it, saying, "They give me paracetamol if I'm in pain."

Good

Is the service effective?

Our findings

The provider had processes in place to ensure that when staff started work at the home they had training to support them in providing effective care for people. New staff completed an induction to ensure they understood their role and responsibilities. The induction included a week of training in all areas the provider considered essential and a period of working alongside more experienced staff. The induction was being updated to include the Care Certificate at the time of our inspection visit. This is based on a set of minimum standards for care workers, and provides staff with a certificate at the end of the induction period to recognise their skills and abilities. Staff told us in addition to completing the induction programme; they had a lengthy probationary period to check they had the right skills and attitudes to support people effectively.

Staff told us the manager encouraged them to keep their training and skills up to date. The manager maintained a record of staff training, so that they could identify when staff needed to refresh their skills. Staff told us each member of staff received an individual training programme tailored to their specific job role. For example, nursing staff received specialist training in medicine administration and wound care which assisted them in keeping their professional registration up to date.

Staff used their skills to effectively assist people at Bromson Hill. For example, we observed staff used appropriate moving and handling equipment and techniques when they assisted people during our inspection visit. We saw one person being moved using a hoist and 'handling belt'. The person was not anxious or worried, which showed they had confidence in the staff. Staff explained to the person what they were intending to do, and offered the person reassurance. The person's privacy was maintained, and the transfer was completed safely. One person told us, "They [staff] have to use a hoist with me, and my wheelchair. They use it (the hoist) properly."

We observed how staff supported people during the lunchtime meal. The majority of people ate their lunch in their room, and were served their meal on a tray. Some people ate their meal in their room with the assistance and support of staff where they needed this. Staff told us this was according to each person's preference, and they could eat where they chose.

Some people ate their lunch in the dining room, and other people ate in the lounge area with a tray whilst they watched television. The dining room was calm and was laid with cutlery, flowers and table clothes where people could enjoy their meal with friends and relations. There was a relaxed atmosphere in the dining room, which was attended by sufficient staff to assist people to eat their meal. Where people needed assistance, staff supported people with their meal at their own pace and waited for people to finish before offering them more food.

Most people told us they enjoyed the food. Comments from people included; "The food tastes good", "Yesterday we had roast lamb. We always have a roast on Sunday", "The food is very good, it's like living in a cafe here", "We get enough food" and "Meals are enjoyable." Only one person said they would like the food to improve. They explained the chef had spoken to them about what was available for them to eat.

People were offered food and drinks that met their dietary needs. Kitchen staff knew people's dietary needs and ensured they were given meals which met those. For example, some people were on a soft food diet, were vegetarian or required Halal food. Information on people's dietary needs was kept up to date in their care records, and included people's likes and dislikes. The chef told us, "The staff here keep me up to date with people's dietary needs and if anything changes." They added, "I know people well."

A daily menu of the food on offer was displayed on the notice board at the home, so that people could choose each day what they wanted to eat. People were able to choose from a range of options and staff asked people for their food choices before their meal was prepared. One person said, "The chef comes up to ask me which meal I want, and I press the buzzer at night for different things." Where people were unable to make decisions themselves staff made choices based on the individual's likes, diet, cultural and religious backgrounds. We saw people could chose alternative foods if they did not like what was on offer at the mealtime. For example, on the day of our inspection visit we saw one person had a prawn salad, which was prepared especially for them. Another person ate a fish curry with rice in their room, according to their dietary needs.

Food and drinks were available throughout the day to encourage people to eat and drink as much as they liked. People and their relatives could help themselves to fruit, biscuits and drinks, which were readily available in the communal areas of the home. One relative told us, "Snacks are always there, and we help ourselves." People also had drinks taken to their room several times each day. We saw drinks in people's bedrooms were in easy reach. One person told us, "I had tea at 1 o'clock this morning; I only waited about 10 minutes."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager was able to explain to us the principles of MCA and DoLS, which showed they had a good understanding of the legislation. Mental capacity assessments were completed when people could not make decisions for themselves. Staff demonstrated they understood the principles of the MCA and DoLS. They gave examples of applying these principles to protect people's rights, for example, asking people for their consent and respecting people's decisions to refuse care where they had the capacity to do so. Where people could not make decisions for themselves, records confirmed important decisions had been made in their 'best interests' in consultation with people that were important to them and health professionals.

The manager reviewed each person's care needs to assess whether people were being deprived of their liberties. Where people required a DoLS application to be made, the manager had made the appropriate applications to the local authority in accordance with the legislation.

Staff and people told us the provider worked in partnership with other health and social care professionals to support people. Care records included a section to record when people were visited, or attended visits, with healthcare professionals. For example, people were able to see their GP, dietician, chiropodist and dentist where a need had been identified. The manager told us the doctor visited the home each week to

see people there, but also came when they were required, if someone needed to see the doctor more quickly than the weekly visit. One person told us, "There was no emergency, but the doctor came out really quickly last week, when I needed it." A relative told us, "[Name] has their feet done regularly by the chiropodist." One relative told about how responsive the staff team were when their relative became ill, saying "If they are concerned about an infection, they always ring us and get the doctor out." We found changes were made to people's care following advice from medical professionals.

Good

Is the service caring?

Our findings

People and their relatives told us staff treated them with respect and kindness. One person described staff as being caring saying, "I'm sure they all are, but you always get your favourites." A relative said, "Relationships here are very good. This is [Name's] home and we like to get to know the staff. They're nice." Only one person made a negative comment about the staff who supported them saying, "They're kind sometimes. I think very highly of some of them, others I don't like them." We spoke with the manager regarding the person's comment who explained they were aware of the persons' preferences. They explained there had recently been some staff changes and new staff were still being recruited to the home.

Staff told us they enjoyed working at the home, because of the interaction they had with people who lived there. We observed how staff interacted with people at the home. Staff communicated with people effectively using different techniques. Staff assisted people by talking to them at eye level and altering their tone of voice to help people understand them. We observed staff touching people lightly on their arms or hands to provide them with reassurance.

People had chosen how they wanted their personal space to be arranged and decorated, so that they felt at home. For example, some people had chosen a specific colour scheme for their room, other people had personal belongings around them such as photographs and ornaments. One person told us, "I've got a lovely room. I've got some of my furniture. They're very good with keeping things clean for me." Another person commented, "The room is the way I like it. I've got my photos, and my younger son who is an artist has done the paintings."

People told us they chose how to spend their time, and staff respected their decisions. They explained they could spend time in the communal areas of the home, or in their bedrooms. We saw most people spent time in their bedrooms during the day. One person said, "I'd rather be in my room and I like the curtains drawn." Another person told us when they liked to go to bed saying, "I'm generally in bed at seven (according to my wishes).The staff help me."

People and their relatives were involved in care planning where possible, and made decisions about how they were cared for and supported. For example, people had information recorded in their records about their religious beliefs, and their personal history, so that staff could support people in accordance with their wishes. Church services and Christmas celebrations had been organised at the home for Christians, to meet their religious preferences. Other denominations and religious festivals were recognised throughout the year with seasonal celebrations.

Another person was unable to speak English well, as English was not their first language. They were able to communicate to staff in short phrases, or answer with single words to some questions. This meant it was important that staff used different communication techniques to involve them in their own care planning. Arrangements had been made to involve the person's relatives, so that they could act as a translator. The person told us, "My relative comes every day." They added, "The staff look after me. I can't understand English. There are no people here who speak my language, it's very difficult." We spoke with the activities co-

ordinator about the limitations this put on involving the person in conversations, activities, and planning their daily care. The activities co-ordinator had recognized the barrier the different language created, and had begun lessons in speaking Punjabi to assist the person. Some well known words in their own language, were displayed in their room, so that staff could try and use the words. We observed later in the day a staff member entering the person's room; they used a greeting in the person's language which demonstrated staff understood how to communicate with the person.

There were a number of rooms, in addition to bedrooms, where people could meet with friends and relatives in private if they wished. People made choices about who visited them at the home. One person told us, "There is no set time for visitors, they come when you want." A family member said, "We come every day."

We saw people and their visitors were offered drinks and snacks and used communal areas of the home to meet which helped them maintain links with family and friends. It was obvious family members felt at ease at the home. One relative commented, "The atmosphere, we find it very homely, we are always welcome and they're always friendly to us."

Staff promoted people's independence and encouraged them to do things for themselves where possible. For example, we observed staff encouraging one person to eat independently. The person was offered the food on a tray with a plate guard which is a device that assists people to gather food on cutlery without assistance from staff. This was according to the person's wishes. We observed the person ate at their own pace, staff checked on them frequently to ensure they did not require support to finish their meal. The manager told us, "We encourage independence. It's about encouraging people to do what they can while they can."
Some people at the home had been consulted about their wishes at the end of their life. We reviewed care records which documented their preferences. Staff told us this was to provide good quality care to people nearing the end of their life, and to respect their cultural or religious beliefs. One person's relative commented on the care their relation had received at the end of their life saying, "We've been really happy here, [Name] has had really good care. They (staff) have been really good."

People told us their dignity and privacy was respected by staff. Staff knocked on people's doors before entering, and announced themselves when they entered people's rooms. There were signs on some people's doors which were respected. Some signs directed staff to knock before entering, and to wait to be invited into the person's room. Another sign stated; 'For personal care to have female care staff only.' We observed during our inspection visit that these instructions were followed by staff.

Care staff respected people's privacy when they were moving them. On one occasion a person was being hoisted into a chair, the member of staff made sure the person's privacy was protected as the staff were careful with the person's clothing, so that they were not exposed to other people during the transfer.

Good

Is the service responsive?

Our findings

People told us staff usually responded to their requests for assistance and support quickly. Comments from people included; "Night staff are very good, you've only got to ring, and they bring me a cup of tea", "They see to my needs and pop in three or four times at night", "Staff come if I need them", and "I don't think I've ever been on my own when I couldn't get staff. I've never had to wait for anybody."

Care records gave staff information about how people wanted their care and support to be delivered. For example, care plans included information on maintaining the person's health, their support needs, and their personal preferences. People had a document called 'All about me' completed so that staff had information about the person at a glance. Information in the document included people's likes and dislikes for food, family histories, people's individual communication requirements and their preferences for the gender of staff that they wished to support them. For example, one person had expressed a wish that only female staff support them. We observed on the day of our inspection visit that the person's preference was respected; only female staff supported them with their personal care needs.

Care plans had been recently reviewed and were being improved at the time of our inspection visit. The manager was introducing new care records to include a shortened version of some key information, to be held in a file in the person's room. The new records would include a monthly well-being chart monitoring key indicators regarding their health such as their weight. The records would be used by staff to assist them in monitoring any changes to the person's health.

People were supported to pursue interests and hobbies that they enjoyed, to increase their enjoyment in life. The home employed an activities co-ordinator to spend time with people, and to arrange group activities at the home. People were asked what group activities they enjoyed during regular meetings. A list of planned activities was displayed in the communal areas of the home for people to access. The activities co-ordinator updated people's care records to show what activities people took part in, so that information was available about what people might enjoy in the future. Forthcoming group activities included Christmas celebrations, a carol service and Christmas fair.

People also had a personal activity plan in their care records, so that the activities co-ordinator and other members of staff knew what people enjoyed doing, and could support them with any personal hobbies or interests. Staff provided one to one time to people based on these preferences, including engaging people in conversations, playing games and quizzes and providing them with nail care. One person told us about some recent activities they had been involved with, "We had a singer in the other day (which we enjoyed) and I get magazines from my daughter. I've also got my own TV upstairs, the other night I was watching snooker until 2 o'clock in the morning!"

Some people were supported to go out into the local community regularly. This was either with support from staff members or their families. One person told us, "Sometimes we do. We are going to Banbury before Christmas, and if the weather is nice we can go to a garden centre for coffee and cake."

Staff were able to respond to how people were feeling and to their changing health or care needs because they had a verbal handover at the start of each shift. We observed a shift handover during our inspection, attended by the nurse and care staff. The handover provided staff with information about any changes since they were last on shift. Staff explained the handover was recorded, so that staff who missed the meeting could review the records to update themselves.

There was information about how to make a complaint and provide feedback on the quality of the service available in the reception area of the home. People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to. One person said, "I've no complaints, and when we have the residents meetings we can talk about anything anyway." One relative told us about how the manager had resolved a complaint they made saying, "It was all investigated." They added, "The manager says they are always here if you want to speak to them."

In the complaints log we saw that previous complaints had been investigated and responded to in a timely way. The provider had also acted on the feedback they received in complaints to improve the quality of their service. For example, a relative had complained about the care their relation received. The manager had investigated their concerns and action was taken in response.

Good

Is the service well-led?

Our findings

There was not a registered manager at the service at the time of our inspection visit. The registered manager had left the home several months before we inspected the service. There had been two interim managers before the current manager had been appointed. The new manager had been in their role for 8 weeks; they were applying to become the registered manager.

The manager told us the provider was supportive to them in their new role, and offered them regular feedback and assistance. For example, the provider visited the service regularly and was available at the end of the phone if the manager needed any support. The manager said, "The provider is always available by phone, we have lengthy meetings and discussions, and they are supporting my improvement plans."

The manager encouraged a culture of openness and transparency and worked in an office alongside the communal lounge area so that they were visible to people and their relatives. People told us the manager was available to speak with. The manager operated an 'open door policy', and people, their relatives and staff told us the new manager was approachable. One person said, "The new manager seems very good; and there is a new nurse." Another person said, "We've got a new manager and they are very good. They seem to get things done, and goes about things in a quiet way."

There was a clear management structure within Bromson Hill to support staff. The manager was part of a management team which included a deputy manager who was also a nurse. Nurses were available to support staff on each shift. Staff told us they received regular support and advice from managers and nurses to enable them to do their work. Staff told us there was always an 'on call' number they could call outside office hours to speak with a manager if they needed to.

Staff had regular one to one meetings with their manager, and team meetings with the manager and other senior team members, to discuss how things could be improved at the home. Staff meetings were planned each month, and included invitations for all staff at the home to attend. An agenda for each meeting was drawn up before the meeting, which staff could add agenda items to. A recent meeting record showed staff had discussed the needs of people in their care, the changes to the management team, training and staff vacancies. Staff told us they had an opportunity to raise any concerns they had, or provide feedback and ideas about how the service could be improved. Where staff had made suggestions, the manager had acted to implement improvements. For example, the manger had introduced 'back to basics' training sessions for staff, to ensure they had all the knowledge they needed to support people at the home.

The provider completed regular checks of different aspects of the service. This was to highlight any issues in the quality of the care provided, and to drive forward improvements. For example the provider conducted regular checks of medication administration, care records, and infection control procedures. Where checks had highlighted any areas of improvement, action plans were drawn up to make changes. For example, a recent care records audit had identified the need for care records to be improved, including the development of monthly well-being sheets to track people's health care needs. These were being actioned and drawn up for everyone at the home when we inspected the service.

People were invited to provide feedback about how the service was run, which was acted on by the provider. The manager told us they encouraged feedback from people, visitors and relatives in the form of regular meetings with people at the home and their relations and an annual survey. There was also a comments book in the reception area. One relative told us, "Yes we have residents meetings. We always attend. I enjoy them; it was on a Saturday so relatives can come." We saw that feedback was analysed and where the provider could make improvements, things were acted upon. For example, in a recent resident's meeting concerns had been raised about the quality of food. The chef had been invited to the meeting to discuss future menu options. The manager also held regular meetings with the chef to discuss the food options on offer at the home. One person said, "The manager was very good at the last meeting, they explained how things were being run and invited the chef to discuss the food."

The manager had introduced some quality assurance procedures at the home, to identify where improvements might be required. For example, the manager had implemented a system called 'resident of the day'. Each day one person was chosen to discuss the quality of the service at the home. The person met with several members of staff including the activities co-ordinator and the chef to gather their feedback. The manager had also introduced a daily meeting with heads of departments to improve the exchange of information at the home.

At our previous inspection visit in 2015 we had identified some people could not always have a bath when they wanted one. This was due in part to the bathing facilities at the home, one of the bathrooms required updating to ensure people could be hoisted safely into the bath. We spoke to the new manager regarding this, although they had only been in post for around 8 weeks they had already identified this as a concern. An improvement plan had been drawn up to update the bathroom on the first floor of the home, to make this more accessible and usable for people. In addition, improvements were being planned to the hairdressing salon, to make this a more enjoyable experience for people to use. This demonstrated the provider took action to continuously improve the quality of the service they provided at the home.

The provider had sent notifications to us about important events and incidents that occurred at the home. The manager also shared information with local authorities and other regulators when required, and kept us informed of the progress and the outcomes of any investigations. Where investigations had been required, for example in response to accidents, incidents or safeguarding alerts, the manager completed an investigation to learn from these incidents. The investigations showed the manager made improvements, to minimise the chance of them happening again.