Runwood Homes Limited

Bramwell

Inspection report

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

Summary of findings

Overall summary

This inspection took place on 15 and 16 November 2016 and was unannounced. Bramwell provides accommodation and personal care for up to 93 people with or without dementia and people with physical health needs. On the day of our inspection 79 people were using the service. The service is provided across two floors with passenger lifts connecting the two floors. Each area of the home was open so that people could access any of the communal areas in the service.

The service had 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 2008 and associated Regulations about how the service is run.

The risks to people's health and safety were not always properly assessed and steps to reduce risks were not always taken. People were cared for in an environment that was not always clean.

There were not always enough staff to meet people's needs in a timely way. People felt safe living at the care home and staff knew how to protect people from the risk of abuse. People received their medicines as prescribed and they were safely stored.

People were cared for by staff who felt well supported and received a range of training relevant to their role. We found the Mental Capacity Act (2005) (MCA) was being used correctly to protect people who were not able to make their own decisions about the care they received.

Sufficient quantities of food and drink were provided and people were generally positive about the quality of food. People received support from health care professionals such as their GP and district nurse when needed.

People were positive about the relationships they had developed with staff and felt well cared for. People were able to be involved in the planning and reviewing of their care and we saw they were able to make day to day decisions. People were generally treated with dignity and respect by staff.

There was a risk that people may not receive care in line with their changing needs because information about them was not always up to date or available. A range of activities was provided for people. However, people spent long periods of time without any activity or stimulation. Complaints were handled appropriately and in a timely manner.

The systems in place to monitor the quality of the service were not fully effective and did not always result in improvements being made. There was a positive and transparent culture in the home, people who used the service and staff felt able to raise any issues with the registered manager. There were different ways people could provide feedback about the service and their comments were acted upon.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people's health and safety were not always assessed or well managed.

Some areas of the home were not effectively cleaned which exposed people to the risk of infection.

There were not sufficient numbers of staff to meet people's needs.

People felt safe and there were systems in place to reduce the risk of abuse.

People received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People were cared for by staff who received appropriate training and support.

Where people lacked the capacity to provide consent for a particular decision, their rights were protected.

People had access to sufficient food and drink and staff ensured they had access to healthcare professionals.

Is the service caring?

Good

The service was caring.

People felt well cared for and there were positive relationships between people and the staff who cared for them.

People and relatives were able to be involved in care planning and decision making.

People's privacy and dignity were respected by staff, however people did not always receive their own clothes back from the

laundry.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive person-centred care and staff did not always have accurate, up to date information about people needs.

The provision of activities had improved, however people were not always supported to take part in stimulating activity.

People felt able to complain and there was an appropriate response to any complaints received.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality monitoring systems that were in place did not always result in improvements to the service people received.

There was an open and transparent culture in the home.

The registered manager displayed clear leadership and was held in high regard, however they did not always receive the support they needed.

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Detailed findings

Background to this inspection

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

We visited the service on 15 and 16 November 2016, this was an unannounced inspection. The inspection team consisted of two inspectors, a specialist advisor with experience in falls management and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During our inspection we spoke with eight people who used the service, six relatives, six members of care staff, the deputy manager, the registered manager and a representative of the provider. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at the care plans of six people and any associated daily records such as the food and fluid charts and incident records. We looked at three staff files as well as a range of other records relating to the running of the service, such as audits, maintenance records and six medication administration records.

Requires Improvement

Is the service safe?

Our findings

Risks to people's health and safety were not always appropriately assessed and steps not always taken to minimise any risks. The people and relatives we spoke with provided mixed feedback about how staff supported people to stay safe. One person told us that they had fallen several times. A relative said, "[My relative] is hoisted now and I see them doing it, so [my relative] is perfectly safe." However, another relative told us that they had noticed bruises on their loved one's body and felt that this was because staff had not followed safe procedures when assisting them to change position.

During our visit we observed that practical steps were not always taken to minimise the risk of people sustaining injuries. For example, one person was at high risk of falling and had fallen multiple times. We saw that they were wearing slippers which were too big and impeded their ability to walk safely. Staff were directed to check the person's whereabouts every 30 minutes. However, this was not being done and staff were unaware of the need to carry out this check. Another person's falls risk assessment noted that they had difficulty in getting out of bed. However, no steps had been put into place to reduce the risk of the person falling from their bed. Following a fall, people were closely monitored for 24 hours to check for any signs of injury and to try and reduce the risk of them falling again. However, the effect the fall may have had was not always discussed with the person or their relatives.

Risk assessments had not always been accurately completed which meant that the correct level of risk was not identified. For example, one person had sustained multiple falls but this had not been taken into account in subsequent reviews of the risk assessment. This meant that no further measures had been put into place to support the person. Another person's assessment of the risk of their skin breaking down directed staff to consider providing an airflow mattress which would provide pressure relief whilst in bed. This had not been put into place, we raised this with the registered manager who told us they would consider whether this would be appropriate. We saw that this person's skin had broken twice in the month prior to our inspection.

Risks to people's health and safety were not properly assessed or well managed which meant there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people and relatives we spoke with felt that the building was well maintained. One relative said, "Anything you report gets fixed, no problem." We saw that the building was generally well maintained and action was taken when anything needed repairing or replacing. A range of safety checks were carried out on a regular basis, such as fire alarm tests and checks of the hot water temperatures.

People were exposed to the risk of infection because areas of the home were not effectively cleaned. Cleaning staff were using the same cloths to clean sinks and toilets in different people's bedrooms. This meant there was a risk of cross contamination between different bedrooms. There were kitchenettes in each of the six areas of the home and we saw that these were not effectively cleaned. Some work surfaces and cupboards in the kitchenettes were damaged or heavily stained and the floors were sticky. In addition, place mats were being used that were heavily stained and could not be effectively cleaned. We saw one person

placed their food directly on to a placemat and try to eat from it which exposed them to the risk of infection. The provider took action during our inspection to dispose of some items that could not be effectively cleaned. In addition, the provider commissioned a contractor to upgrade some of the kitchenettes.

Cleaning staff completed a work schedule, however this did not provide specific detail about each area that needed to be cleaned. For example, there was no breakdown of cleaning tasks to be completed in the dining areas. We saw that the undersides of tables and chairs contained food residue, drinks marks and chewing gum which had not been cleaned. There was insufficient capacity in the laundry which meant that people's clothes sometimes got mixed up and not returned to them. In addition, there wasn't sufficient space to store any soiled items before they could be washed.

People were exposed to the risk of infection which meant there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that communal lounges and bathrooms were generally clean. People's bedrooms were cleaned on a regular basis and the bedrooms we saw were clean. The people we spoke with told us they felt the home was clean. One person said, "It's very clean here." Another person said, "They do a grand job with cleaning." The relatives we spoke with also felt that the home was kept clean and hygienic. One relative said, "It always looks nice here."

The provider was undergoing a programme of installing soap and paper towel dispensers in bedrooms to promote better hand hygiene at the point of care delivery. We observed staff wearing personal protective equipment, such as disposable gloves, to protect people and themselves from the risk of infection. The care staff we spoke with told us they generally had access to sufficient supplies of equipment. However, two staff told us they did not always have sufficient wet wipes available.

We received mixed feedback about whether there were sufficient staff to meet people's needs. One person said, "They seem to cope alright in here." We were also told, "They're always short staffed." Another person told us that staff had recently taken 30 minutes to respond when they had pressed their bedroom call bell. The relatives we spoke with also provided mixed feedback about staffing levels. One relative said, "There's never enough (staff) – finding someone when [my relative] needs the loo can be a trial." Another relative commented, "I think they're getting a few more staff in now."

During our visit we observed that there were not always sufficient staff to provide the support that people required. For example, there were many occasions during our inspection where the lounge areas were left unattended for periods of up to 40 minutes. People who were at risk of falling were present in the lounges during these times. There were six units in the home and each had two care staff on duty, apart from one unit which had one member of care staff. Many people required two members of staff to provide personal care and support. This meant that, when a person required the support of both staff there were no other available to support other people. The registered manager told us that staff were flexible and could work across different areas of the home to provide support. However, we observed that this system was not working effectively at the time of our inspection.

There were not always enough staff available to provide any support people required at mealtimes For example, at breakfast time on the second day of our visit we observed that two people did not receive the support they needed as staff were busy elsewhere. This resulted in one person trying to eat their cereal with their fingers and another person struggled to eat their porridge, eventually spooning it onto a placemat. A third person required some support to place their cereal on a spoon and raise it to their mouth. This support wasn't provided as staff were busy serving other people which meant the person spilt a lot of milk over their

clothing. At lunch time on the first day of our visit one person struggled for 45 minutes to eat their lunch and by the time staff had the opportunity to give any support they said, "This has gone cold now hasn't it." The staff member took the food away which meant that the person did not eat their meal. The staff member then brought the person's dessert and the person ate this without assistance. At lunchtime on the second day of our visit there were management and activity staff present who supported staff to assist people with their meals. We saw this had a positive impact and people had a much more pleasant mealtime experience.

We looked at the workload of the care staff and we saw that in addition to delivering care and support to people, staff had other roles in the service. In the afternoon staff were tasked with returning laundry back to people's bedrooms. They also needed to prepare the evening meal such as cheese on toast or soup and then serve the meal and clear the dining room afterwards. Some staff told us that they could not always take their break or find the time to complete their paperwork due to being busy. Staff felt that it would be beneficial to have more staff working at peak times such as mealtimes.

There were not sufficient numbers of staff available to support people which meant there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had taken steps to protect people from staff who may not be fit and safe to support them. Before staff were employed the provider requested criminal records checks, through the Disclosure and Barring Service (DBS) as part of the recruitment process. These checks are to assist employers in maker safer recruitment decisions.

The people we spoke with told us they felt safe living at Bramwell. One person said, "It feels safe here. I don't worry about things." Another person told us, "I feel safe now. " The relatives we spoke with also felt their relations were safe. One relative said, "I think [my relative] is very safe. It feels right here." Another relative commented, "[My relative] is very safe – 100% safe."

Information about safeguarding was displayed in the service and staff received training and developed to understand their role in protecting people from abuse. Information had been shared with the local safeguarding authority when any incidents had occurred. Staff told us that they had confidence that the registered manager would take the appropriate action should they report any concerns to them.

Some people living at the home could at times demonstrate behaviour that was difficult for staff to manage. The staff we spoke with told us they could generally manage this and were able to keep people safe, however they told us that no specific training was provided to develop their knowledge in skills in handling difficult situations. People's care plans described the type of challenges that they could present to staff. However, there was limited guidance available to staff about individual approaches that could be used to safely support people to reduce any distress.

The people we spoke with were satisfied with how their medicines were managed and administered to them. One person told us, "They stay with me while I take them." Another person told us, "They trust me to take them alone and leave me them." The relatives we spoke with were also complimentary about the way in which medicines were managed. One relative said, "They always wait with [my relative] (while they take their medicines)."

Medicines were administered and stored safely and there were systems in place to ensure that people's medicines were ordered in a timely manner. We observed a member of staff administering medicines and saw they followed appropriate procedures when doing so. Medicines were stored securely in locked trolleys and kept at an appropriate temperature. Staff correctly recorded the medicines they had administered to

people on their medication administration records.

Good

Is the service effective?

Our findings

The people and relatives we spoke with provided mixed feedback about the competency of care staff. One person said, "Sometimes they don't seem to know things and are always in a rush." Another person told us, "I think the staff are very good, very professional." A relative commented, "Generally they seem capable. New staff are not always dementia aware." Another relative told us, "Some we've known for a long time now and have confidence in them. Night staff tend to be agency so they're less aware of residents."

People were cared for by staff who received a range of training relevant to their role, such as first aid and dementia awareness. The staff we spoke with told us they were given training that was helpful and relevant to their role, although some staff felt that the training did not always suit their preferred style of learning. During our visit we observed staff utilising the training they had received, for example by supporting people to transfer from a chair to a wheelchair safely. Staff also received training relevant to people's health needs which was delivered by community healthcare professionals.

The staff we spoke with told us they felt well supported by their line manager and the registered manager. There was a system in place which ensured that staff received regular supervision and an annual appraisal of their work. One member of staff said, "I feel like I can really talk to the manager about anything." New members of staff were provided with an induction into working practices at Bramwell as well as being able to shadow more experienced staff. Staff were also supported to complete the Care Certificate which enables staff to develop key skills to provide effective care.

People were supported to make decisions about their care and provided consent to the care being delivered. One person said, "They do ask me and explain what we're going to do next. They're very nice." Another person said, "Yes staff do ask first before doing anything." The relatives we spoke with also felt that staff asked their loved one for consent prior to giving any care or support. One relative commented, "I always hear [my relative] get asked first."

Where people lacked the capacity to make a decision the provider followed the principles of the Mental Capacity Act (2005) (MCA). The 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. We saw that assessments of people's capacity had been carried out when required and decisions made in their best interests.

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 and hospitals 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 registered manager had made applications to the local authority and ensured that staff were made aware of the outcomes. There was a good awareness amongst staff about how the MCA and DoLS

impacted upon the care they provided to people.

People provided positive feedback about the quality of food and said they were given enough to eat and drink. One person said, "It's very good food. There's usually something I fancy or you can ask for something else. Sometimes there's a fruit bowl in the lounge or we can ask for a bit." Another person told us, "There's more than enough food here. I've put on weight. I eat most things."

During our visit we observed that people enjoyed the food and were provided with extra portions if they were still hungry. People were provided with drinks at mealtimes and throughout the day as well as a variety of snacks such as fruit and biscuits. The catering manager told us that they were looking to make the menu more flexible so it could be more easily adapted to individual tastes. Kitchen staff planned menus to ensure a balance of nutrients was provided as well as catering to people's preferences.

There was a list of people who required specialised diets such as soft food and low sugar alternatives in the kitchen which were catered for. This matched the information that was in people's care plans about their dietary requirements and how their food should be prepared. The staff we spoke with told us people were provided with sufficient amounts of food and drink.

People told us that they had access to various healthcare professionals when required. The relatives we spoke with also confirmed that their loved one was able to access healthcare services with the support of staff. One relative told us, "They were good at getting the doctor out when [my relative] had a mystery infection." Another relative said, "[My relative] has seen the optician here and has the NHS chiropodist coming."

People received support and advice from visiting healthcare professionals on a regular basis. A GP and district nurse visited people during our inspection. People also had access to specialist services such as the dietician and continence advisory service. For example, staff were concerned about one person losing weight and had received advice to provide the person with a higher calorie, fortified diet. Staff had ensured that this guidance was put into the person's care plan and it was being followed in practice.

Good

Is the service caring?

Our findings

People were told us that they felt well cared for and that they had developed positive relationships with staff. One person said, "They're very nice. Some of the young ones are super." Another person told us, "They are very good to me." The relatives we spoke with felt that staff were caring and treated their loved one with kindness and compassion. One relative told us, "The carers go that extra mile for them – you often see them sing or dance with people." Another relative commented, "They're very kind and respectful."

We observed that staff cared for people in a kind and compassionate way and responded well when people became upset or distressed. For example, one person became upset and staff sat with them and held their hand which provided comfort and reassurance. Staff also noted when people wanted their own space and responded appropriately. One person communicated through their body language and hand gestures and we saw staff respect their wishes when they informed staff they wished to be left alone. Staff also tried to act spontaneously and take opportunities to engage positively with people. For example, we saw occasions when staff were supporting people and sang along to the music that was playing which people enjoyed.

The staff we spoke with told us that they enjoyed spending time with people and valued the relationships they had developed. Staff understood people's preferences about how their care should be delivered and put this into practice. People's religious and cultural needs were catered for by staff. For example, religious services were provided in the home on a regular basis. People were provided with food appropriate to their culture or religion where this was requested. People were asked if they had a preference of the gender of staff who provider personal care and their wishes were respected.

People were able to be involved in making decisions and planning their own care. People also confirmed that staff respected their decisions and encouraged their independence. One person said, "They let me come and go as I want and sit anywhere. I do as much as I can myself." Another person commented, "They let me choose my bedtimes and getting up and I dress myself in what I want." The relatives we spoke with told us that they were able to be involved in care planning and decision making where it was appropriate. One relative said, "We have reviews so I'm happy they keep me informed on things. I know I can see the care plan any time." Another relative told us, "They do talk to us about [my relative's] care. We get review meetings."

Our observations showed that people were encouraged to make day to day decisions. For example, we saw that people were offered a choice of dining room to eat their meals in. When one person appeared unsettled, staff helped them to walk to a different dining room. People were also offered the choice of whether or not to take part in the entertainment that was provided on the second day of our inspection. Some people chose not to participate and this was respected. Where required, staff adapted their approach to ensure that people with communication difficulties were also able to make decisions. For example, staff presented the meal choices visually as well as verbally and this meant people were able to make their own decisions.

We saw from the care plans we looked at that people's likes and preferences about their care had been

taken into account. For example, there was detail in relation to how and when people preferred to have a bath or a shower and what products they preferred to use. The information included detail about what the person could do without assistance and what they would need support with. People were provided with information about how to access an advocacy service; however no-one was using this at the time of our inspection. An advocate is an independent person who can provide a voice to people who otherwise may find it difficult to speak up.

People told us they were treated with dignity and their privacy was respected by staff. One person said, "They usually knock and let me say 'come in' or I open the door. They'll close my curtain." Another person told us, "They always knock me first. The curtains get drawn when I'm dressing." The relatives we spoke with also confirmed that staff treated people with dignity and respect. One relative said, "I see staff always treating people properly."

We saw that staff mostly treated people in a respectful and dignified manner when they spoke with them and always addressed them by their preferred name. However, some people reported that they did not always get their own clothes back from the laundry and that they had been given other people's clothes to wear. During our visit, we observed one person wearing ill-fitting clothes which did not appear to be theirs. People had access to their bedrooms at any time should they require some private time. Visitors were able to come to the home at any time and had access to several private areas to spend time together with their loved one if required.

Requires Improvement

Is the service responsive?

Our findings

The people and relatives we spoke with provided mixed feedback about whether they received the care and support required. One relative said, "Since [the registered manager] took over, [my relative] looks cleaner, their nails are done nicely. There have been some staff changes – they seem to have a kinder attitude now and I see them spending time with the residents." Another relative commented, "I have to do [my relative's] nails and they're always quite dirty underneath – just lack of care." Another relative told us, "[My relative] needs one-to-one time really but doesn't get it."

During our visit we observed that staff were not always made aware of people's needs and did not always provide responsive care. For example, staff knew that some people required regular changes of their position in order to relieve pressure on their skin. However, this support was not always provided when required. A review of one person's care plan indicated that they needed support from staff to regularly change their position. However, staff were not aware of this and were not providing the support which left the person at elevated risk of developing another pressure ulcer. Another person regularly declined staff assistance to change their position, however we observed that staff did not try alternative techniques to persuade the person to stand or move to another chair.

People did not always receive responsive care and support during mealtimes because staff did not always respond to people's needs and requests. We observed that one person was provided with a meal that they had not asked for, due to a miscommunication between staff. The person was not able to inform staff but became distressed and did not eat any of the meal. However, staff did not offer the person the other meal choice and instead presented their pudding. Because the person was already distressed this meant they did not eat anything. We also observed times when staff did provide responsive care and met people's needs. For example, one person was confused having just woken up and staff spent time sitting with them and reassuring them whilst they adjusted to their surroundings again.

The care plans we looked at did not always provide sufficient guidance to enable staff to understand people's needs, or the information that was provided was out of date. One person's care plan indicated that they could become agitated and become verbally aggressive towards staff and other people living at the home. In the event that this happened, the person's care plan advised staff to leave them to calm down and try again later. However, there was no further guidance available to staff regarding other techniques they could use to support the person. The staff we spoke with told us they often struggled to provide personal care for this person. We saw that some sections of care plans contained detailed and person-centred information. For example, one person lived with diabetes and there was detailed information about how this impacted on their daily life and signs and symptoms that the person may be unwell.

The people and relatives we spoke with provided mixed feedback about the provision of activities, however there was acknowledgement that it had improved in recent months. One person said, "We've had dancing and singing. There are not things on every day, just now and then. I'd love animals here." Another person said, "I spend a lot of time on my own. But I join in if there's anything on like we were making Christmas cards yesterday. Weekends we don't have anything to do." A relative told us, "It has definitely improved here

– we see lists of what's planned now." Another relative commented, "They did a fireworks night last week with fireworks outside and hot dogs for tea. All the staff helped out and they made sure the food went to everyone not joining in. The summer fayre was brilliant – a great team effort."

During our visit a singer visited and their performance was greatly enjoyed by a large group of people. In addition, the weekly coffee morning took place in the café area and various activities were carried out. There was a schedule of activities which took place during the week, however there was no activity provision at weekends. We saw that staff did not always have the time to carry out smaller, one to one activities with people and there were long periods of time when people did not have any stimulation. People were not always provided with equipment for self-directed activities. For example, one person enjoyed dusting and cleaning and we saw them running their hand along the top of furniture and hand rails. However, they were not provided with a cloth to do some dusting with, which may have provided them with a more purposeful and enjoyable activity. Another person enjoyed reading the newspaper and magazines, however they had not been given any reading material during our inspection.

People told us they felt they could raise concerns and make a complaint. One person said, "I would speak to the management, they are very friendly." The relatives we spoke with also felt able to make a complaint and knew how to do so. Several relatives told us they had complained about the laundry and clothes either going missing or being ruined. We were told that the registered manager had responded well when complaints had been made. One relative said, "Mostly it's laundry and ruined cardigans but they always act when we've mentioned anything. It's been better since [the registered manager] has been here." Another relative said, "Staff were called away and [my relative] fell. The carer was retrained and I had it all explained to me by the manager."

People had access to the complaints procedure which was displayed in the home and was also provided to people on admission to the home. We reviewed the records of the complaints received in the 12 months prior to our inspection. Each complaint had been investigated and responded to in a timely manner. The registered manager had offered to meet with each complainant to discuss their concerns in more depth. The outcome of each complaint was clearly recorded and apologies were offered where the quality of the service had fallen short of people's expectations. The registered manager also made efforts to improve the quality of the service for everyone following each complaint.

Requires Improvement

Is the service well-led?

Our findings

The systems in place to monitor the quality of service people received were not always effective in bringing about improvements. The registered manager undertook a monthly audit which included aspects of the service such as the environment, infection control, care planning, complaints, accidents, staff files and training. However we found these audits were not always effective in identifying issues and bringing about improvements. For example, the most recent audit in relation to the satellite kitchens in each unit had not identified any concerns. During our visit we found there were a number of issues with the cleanliness of the kitchens and inappropriate fridge temperatures.

Where improvements had been identified as being required, these were not always made in a timely manner. A consultant employed by the provider had undertaken a full review of the service based on the five key questions, is the service safe, effective, caring, responsive and well led. This review had identified areas which needed improvement and an action plan had been put in place. The action plan specified who would make the improvements and by when, however we saw that the improvements were not being signed off by the due date and so it was unclear as to whether they had been carried out. One of the actions was to evaluate all care plans by 31 October 2016 and ensure that they met the current needs of the people they were written for. This had not been signed off as completed on the date we visited and we found that care plans still did not meet the current needs of the people they were written for.

Despite having audits and reviews carried out by a range of external and internal people, there was a lack of a central action plan for the registered manager to work towards. Instead there were several action plans in place, none of which were effective in bringing about the required improvements. We found a number of breaches of regulation during our visit which showed the systems in place to monitor, assess and bring about improvement were not fully effective. In addition, records relating to the care provided to people, such as repositioning records and body maps, were not always completed accurately or kept up to date. Confidential records were not always securely stored. On a number of occasions we saw that the staff offices had been left open and unattended which meant that people's records could be accessed by anybody in the building.

The lack of effective quality monitoring meant there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were provided with different ways of giving feedback about the quality of the service, although they were not always utilised. Satisfaction surveys were provided to people who used the service which covered different aspects of the service provision. There were also regular resident and relative meetings although we saw that attendance at these was generally poor. The registered manager told us that they operated an 'open door' policy and that people and relatives were welcome to speak with them at any time. We saw that this was the case during our inspection and it was apparent people felt comfortable speaking to the manager.

The people and relatives we spoke with generally felt that there was a relaxed and open atmosphere at

Bramwell. People felt able to speak up and were comfortable speaking with a member of staff or any of the management. One person said, "It is certainly relaxed, I have no problem speaking with anyone." Another person told us, "It can be rather quiet." A relative commented, "It's a pleasant atmosphere." Other relatives we spoke with said, "There's a very good buzz here" and "It's a friendly place."

During our visit we observed that people and visitors to the home appeared relaxed and comfortable in speaking with any member of staff. Staff communicated with each other in a helpful and co-operative manner. The staff we spoke with felt there was an open and transparent culture in the service and told us that they would not have any hesitation in reporting a concern or if they had made a mistake. The registered manager was open to ideas and suggestions made internally but also encouraged the involvement of the wider community in the running of the home. For example, comments and support from healthcare professionals were encouraged. The registered manager and provider responded positively to the feedback we provided as part of this inspection.

Records showed that staff were able to attend regular meetings with the registered manager to discuss any issues and to get updates on changes in the service. We saw the registered manager also used the meetings as an opportunity to test staff knowledge and understanding of practice such as the MCA and DoLS. The registered manager also held an 'open surgery' on a regular basis for staff, people using the service and visitors to have the opportunity to speak with her. One member of staff said, "The manager's door is always open, I can speak to them any time."

The service had a registered manager and they understood their responsibilities. During our inspection the manager was visible in the different areas of the service and spent time assisting and talking to people who used the service and staff. The people we spoke with told us they knew who the registered manager was, with one person saying, "You can have a laugh with them." The relatives we spoke with also felt the registered manager provided clear leadership and direction. One relative said, "She's easy to talk to, she's lovely. Things are a lot better since she's been doing it." Another relative told us, "She's great. Since she's taken over, it's a better place." We were also told, "[The registered manager] is very approachable and is always around. They are in touch with what's going on."

There were clear staffing and decision making structures in place. Staff understood their role and what they were accountable for. We saw that certain key tasks were assigned to designated groups of staff, such as ordering medicines and contacting healthcare professionals. However, the deputy manager and senior care staff were not always able to provide the support that the registered manager required due to being busy providing care and support to people. This had meant that the registered manager was not always able to delegate tasks and sometimes worked additional hours to complete their work.

The provider allocated resources to drive improvements in the service and also in response to our inspection feedback. For example, immediate action was taken to fund repairs and replacements of fixtures and fittings in some of the satellite kitchens across the home. The provider also offered to put into place additional management support from a nearby home. During our visit the provider's dementia lead visited the home and they told us of the work they had done with staff to further improve their understanding of the best ways to care for people living with dementia.

The provider had not always notified CQC of the outcomes of applications made to the local authority to deprive people of their liberty. Providers are required by law to notify us of certain events in the service. Records we looked at showed that CQC had received other required notifications in a timely way.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The risks to people's health and safety were not always appropriately assessed and reasonable steps to mitigate any such risks were not always taken. Regulation 12 (1) & (2) (a) & (b). Steps were not always taken to prevent, detect and control the spread of infections. Regulation 12 (2) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity were not fully effective. Regulation 12 (1) & (2) (a). Records relating to service users were not always accurate, complete and contemporaneous. Records were not always securely stored. Regulation 12 (1) & (2) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet people's needs. Regulation 18 (1).