

Century Care Limited

# The Brambles Rest Home

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	<b>Requires Improvement</b> 
Is the service effective?	<b>Requires Improvement</b> 
Is the service caring?	<b>Good</b> 
Is the service responsive?	<b>Good</b> 
Is the service well-led?	<b>Requires Improvement</b> 

# Summary of findings

## Overall summary

This unannounced inspection took place on 30 July 2018.

The Brambles Rest Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates 32 people. At the time of the visit there were 25 people who received support with personal care. Nursing care is not provided at this service.

The service was managed by 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.

At the last inspection in January 2016, the service was rated 'good'.

At this inspection in July 2018 we found shortfalls in relation to medicines management, safety checks, staff training and development, and good governance management. We found breaches of Regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because medicines management practices in the home were not robust and staff had not received up to date training and competence checks. Emergency lighting inspections had not been undertaken in line with regulations. The governance and quality assurance systems were not effective in ensuring the shortfalls were identified and rectified before the inspection. You can see what action we told the registered provider to take at the back of the full version of the report.

Improvements were required to the management of medicines in the home. People told us they received their medicines as prescribed and some staff had been trained in the safe management of medicines. However, we noted that further improvements were required to ensure people's medicines were robustly managed. Medicines audits were not effectively identifying shortfalls and areas of improvement. There were shortfalls in the medicines storage practices and the management of 'as required medicines' were not robust.

Some of the staff had received induction and training. However, there were significant shortfalls in staff training and competence checks in various areas. The training policy needed to be reviewed to ensure it was up to date with current regulatory requirements.

The registered manager and registered provider used a variety of methods to assess and monitor the quality of care at The Brambles Rest Home. There were checks in various areas such as medicines administration, health and safety and infection prevention and control. However, we found the internal audit and quality assurance systems needed to be improved in areas such as medicines management staff training to ensure

they could effectively identify areas of improvement and any shortfalls to the quality of the service. There were policies and procedures in place. However, some of these needed to be reviewed to ensure they were in line with current guidance and regulations. There was no evidence on how the registered provider had checked that registered manager was compliant with regulations. They informed us of the plans they are introducing in respect of this.

We received positive feedback from people and their relatives regarding the quality of care and staff approach. Views of a professional we spoke with were also positive. People who lived at the home told us that they felt safe. There was mixed feedback about the staffing levels in the home from visitors and visiting professionals. Visitors and people who lived at the home spoke highly of the registered manager and the care staff.

Staff knew how to report concerns to safeguarding professionals however 15 out of 19 did not have up to date safeguarding training. Accident and incidents had been recorded and medical attention had been sought where required. Recruitment checks were carried out to ensure suitable people were employed to work at the home.

Risk assessments had been developed to minimise the potential risk of harm to people who lived at the home. These had been kept under review.

The staff who worked in this service made sure that people had choice and control over their lives and supported them in the least restrictive way possible. People's consent to various aspects of their care was considered and where required some deprivation of liberties (DoLS) authorisations had been sought from the local authority. Some improvements were required to ensure all mental capacity assessments were decision specific. We made a recommendation about mental capacity practices and the registered manager started to act to address this.

Risk associated with fire had been managed and fire prevention equipment serviced in line with related regulations. However, improvements were required as there was no up to date emergency lighting inspection report. Risks of infection had been managed. The environment was clean, and adaptations and decorations had been used to suit the needs of people living in the home.

Care plans were in place detailing how people wished to be supported. People and their relatives were involved in care planning. People's independence was promoted. There was a policy on how to prevent discrimination and promote equality and diversity.

The provider had sought people's opinions on the quality of care and treatment being provided. Relatives and resident's meetings and surveys had been undertaken to seek people's opinions however these had not been analysed and feedback on the outcome of the survey had not been shared with people.

We observed that regular snacks and drinks were provided between meals to ensure people received adequate nutrition and hydration. People's nutritional needs were met. Risks of malnutrition and dehydration had been assessed and monitored. Comments from people who lived at the home were all positive about the quality of meals provided.

We found people had access to healthcare professionals and their healthcare needs were met. Relevant health care advice had been sought so that people could receive the treatment and support they needed. Health and safety concerns were identified and rectified.

On the day of inspection people were not offered meaningful daytime activities. However, there were plans

of activities and activities that had been offered before the inspection. We were informed that the activities co-ordinator was away on the day. People were supported to continue to access their community to reduce social isolation.

People who used the service and their relatives knew how to raise a concern or to make a complaint. The complaint's procedure was available, and people said they were encouraged to raise concerns. However, records of complaints received in the home were not made available to us on the day of the inspection. The provider informed us they had not received a complaint since our last inspection.

Staff told us there was a positive culture within the service. Staff we spoke with told us they enjoyed their work and wanted to do their best to enhance the experience of people who lived at the home. We received positive feedback from two visiting professional and relatives of people who lived at the home.

We saw evidence where the registered manager and staff had considered best practice.

## 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** ●

This service was not consistently safe.

There were shortfalls in the safe management of medicines including training in medicines administration.

Risks to the health, safety and well-being of people who lived at the home were assessed and plans to minimise the risk had been put in place.

There were mixed responses in relation to staffing levels in the home. People, their relatives and professionals felt the service was safe. Feedback was positive.

Staff knew how to protect people from abuse and some had received safeguarding training. Risks of fire had been managed and equipment had been serviced regularly.

### Is the service effective?

**Requires Improvement** ●

This service was not consistently effective.

Staff had received induction and supervision. However, there were significant shortfalls in staff training in various areas that the provider deemed necessary for the role.

People's consent was considered before they received care. However, mental capacity assessments were not always decision specific.

The environment was adapted to meet the needs of people living at the home.

People's health needs were met, and specialist professionals were involved appropriately.

### Is the service caring?

**Good** ●

The service was caring.

People and their relatives spoke highly of care staff and felt they were treated in a kind and caring manner.

People's privacy and dignity was protected. Staff knew people and spoke respectfully of people they supported.

People's needs were adequately assessed to ensure their needs were identified and planned for.

### Is the service responsive?

Good ●

The service was responsive.

People had plans of care which included essential details about their needs. They had been reviewed regularly.

There were plans for day time activities to occupy people. However, we were not activities provided on the day of inspection.

There was a complaints policy and people's relatives told us they felt they could raise concerns. Records of complaints were not present for us to review.

People had been supported to plan for their end of life care.

### Is the service well-led?

Requires Improvement ●

The service was not consistently well led.

Policies for assessing and monitoring the quality of the service were in place. However, the systems and processes had not identified areas where improvements were required.

We found shortfalls relating to medicines management, staff training and audit systems in the home.

There was evidence of joined up working with other agencies and a commitment to resolve shortfalls identified.

There was a registered manager in post and people gave positive feedback about the manager and the staff.

# The Brambles Rest 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection visit took place on 30 July 2018 and was unannounced.

The inspection team consisted of one adult social care inspector.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. This provided us with information and numerical data about the operation of the service.

Before the inspection we reviewed the information we held about the service. This included safeguarding alerts and statutory notifications sent to us by the manager about incidents and events that had occurred at the service. A notification is information about important events, which the provider is required to send us by law. We also contacted health and social care professionals who worked alongside the service and spoke to one visiting health professional during the inspection. We also reviewed the information we held about the service and the provider.

We spoke with a range of people about the home including six people who lived at the home, one visitor and four care staff. In addition, we also spoke with the senior carer, registered manager, the maintenance person and one of directors who owned the home. We also spoke to two visiting health care professionals.

We looked at the care records of five people who lived at the home, staff training records and three recruitment records of staff members and records relating to the management of the service such as service certificates, maintenance records and health and safety checks.

## Is the service safe?

### Our findings

We looked at the arrangements in place for managing people's medicines. There were policies and procedures which defined and described the service's responsibilities in relation to medicines. People and their relatives were satisfied with the way medicines were managed. Senior staff who were designated to administer medicines had completed medicines awareness and administration training. However, they had not been competence tested. In addition, we found all other care staff had not received training in relation to medicines awareness or administration. These staff assisted people with medicines such as topical creams and with thickening powders. This meant that the provider had not ensured that all staff involved in the administration of medicines had received appropriate training and checked if staff had achieved the right level of competence to manage medicines safely following their training.

We found medicines storage practices were not robust. There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They were stored in a controlled drugs cupboard or secure safe, access to them was restricted and the keys held securely. However, there were no arrangements for checking the daily room temperatures for the medicines storage rooms. The effective monitoring of temperatures would ensure that temperatures in medicine storage areas are kept at the recommended levels to prevent medicines from being compromised. We spoke to the registered manager who informed us that they would resolve this immediately.

We looked at how people medicines such as thickening powders were managed. We noted that each person had their own stock of thickening powders. There were records where staff were meant to record when they had used the powders to thicken people's drinks. However, staff had not recorded the quantity they had given. This is important to demonstrate that people are supported in line with the guidance provided by professionals to prevent risks associated with swallowing difficulties and aspirating. We also noted that staff who administered the thickening powders had not received staff training around the use of thickeners in line with current guidance.

The registered manager had undertaken medicines audits however; this was in the form of a medicines count only. Medicines audits are meant to include all aspects associated with the ordering, receiving, security, storage, administration of medicines including staff training and competence checks. As a result of the audit arrangement we found the above shortfalls that had not been identified by the provider and the registered manager before our inspection. We spoke to the registered manager and the director regarding updating their practices in line with current best practice such as National Institute of Clinical Excellence (NICE) guidance on managing medicines in care homes.

We found some people had specific protocols for the administration of medicines prescribed as 'when required' and 'variable dose' medicines (PRN). However, we found this was not consistent throughout the medicines records we checked. For example, we found one person who was prescribed a Glyceryl trinitrate spray (GTN) did not have a protocol. In addition, the protocols in place at the home needed to be reviewed to ensure they adequately support staff and that they were available at the point medicines were



administered. The protocols are important to ensure staff are aware of the individual circumstances when this type of medicine may need to be administered or offered. The organisation's policy required that all people with PRN medicines should have PRN protocols. This meant that the provider had not consistently followed their own policy to ensure the safe management of medicines.

On the day of the inspection we observed staff administering medicines safely. They were kind and patient with all the people they administered medicines to. The staff took time to explain to the people what the medicines were for. However, before the inspection we had received an incident where a person had been given medicines that belonged to another person in error. The incident was investigated by the local safeguarding team and they substantiated allegations of neglect in relation to medicines administration. They informed us staff had not checked that it was the right medicines for the right person before administering. Staff should check each person's medicines with their individual records before administering them. This would ensure the right person gets the right medicine. Medical advice was provided by a visiting GP and they concluded there was no significant impact on the person. We spoke to the registered manager and the owner regarding this error and they informed us that the person involved was a new admission to the home and the medication administered was that what came with this person. They added that refresher training had been arranged for all staff who administered medicines and that lessons had been learnt. This was a robust response to the incident.

Medicines such as pain patches and topical cream charts were safely managed. The registered manager was working collaboratively with the chemist to improve the processes for ordering medicines. Records were kept for medicines that were awaiting disposal and medicines for disposal were kept securely. Arrangements had been put in place to ensure unwanted medicines were disposed of monthly.

There were shortfalls in the safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Maintenance records showed some safety checks and servicing had been undertaken in the home including the emergency equipment, fire alarm, call bells and electrical systems testing. Some maintenance checks had been done regularly and records had been kept. Faults and repairs had been highlighted and had been addressed. However, we noted that the emergency lighting inspections were overdue by five months. We alerted the provider and the registered manager to this and they informed us that the checks had been done and they would send us the records to prove that. However, the records sent to us after the inspection were similar to the expired records we had reviewed during our visit. We were unable to rely on these records. Therefore we made contact with the electrical contractor. We could not be assured that the emergency lighting inspections had been carried out in line with regulations. We wrote to the provider and asked them to ensure this was undertaken and to submit the evidence to us.

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

We looked at how risks to people were assessed and whether their safety was monitored and managed so they can stay safe and their freedom respected. We found accidents and incidents had been recorded. Support had been sought from emergency services and health professionals where this was required. Accident and incidents had been analysed to identify patterns and trends. Post falls observations had been recorded and any support given following a fall.

Serious incidents that happened in the home had been reported to the safeguarding authority in line with the local safeguarding guidance. This meant people could be assured the registered provider and the staff

would raise safeguarding concerns to allow independent investigations by relevant authorities.

Risk assessments had been undertaken in key areas of people's care such as, falls, nutrition, skin integrity and moving and handling as well as behaviours that could pose a risk to self and others. Plans of care were in place including guidance on how to reduce the risks.

People who lived at the home told us they felt safe living at The Brambles Rest Home and with the way staff supported them. Comments from people who lived at the home included, "The carers, they're absolutely brilliant. I'm dependent on them and I'm not frightened of anything. I feel secure", "The people are very nice, they look after you with care" and, "I feel safe here and if I didn't they would know about it." Comments from relatives included, "[my relative] has only been here for a few days but I am happy and feel confident with their safety" and, "They're very careful when they give [my relative] assistance."

A visiting professional told us, "I think people are safe, the registered manager involves us at the right time and without delay at times overcautious in a right way." And, "I would recommend a relative of mine to live here."

The registered manager had procedures in place to minimise the potential risk of abuse or unsafe care. Staff spoken with expressed a good understanding of safeguarding and protection matters. They were aware of the various signs and indicators of abuse. They were clear about what action they would take if they witnessed or suspected any abusive practice. Some staff confirmed they had received training and guidance on safeguarding and protecting adults however some had not received training.

We found lessons had been learnt from previous safeguarding incidents. For example, lessons had been learnt to ensure staff sought medical attention in a timely manner where people were suspected to have had a fall. Records we saw showed that any falls with head injuries were reported to medical professionals. This meant people could be assured they would receive timely care.

We looked at the risk assessments in place concerning fire safety and how people would be supported in the event of an emergency. Each person had a personal emergency evacuation plan (PEEPS). This provided staff with guidance on how to evacuate people in the event of an emergency. We saw the service had contingency plans in place and a building evacuation plan. We saw there were clear notices within the premises for fire procedures and fire exits were kept clear. Records showed that staff had been involved in fire safety practice drills. On the day of the inspection the overall fire risk assessment for the service could not be located. Following the inspection, the registered manager and the owner submitted the records to us.

We found there were plans in place to respond to any emergencies that might arise and staff understood these. The provider had devised a continuity plan. This set out emergency plans for the continuity of the service in the event of adverse events such as loss of power, accommodation or severe weather.

People we spoke with and their relatives told us they felt that there were adequate staff numbers during the day and at night. However, before this inspection we had received concerns from a visiting relative and a visiting professional regarding staffing levels. We checked how the provider determined the number of staff required. There was no staff dependency tool in place in the home to help determine if the number of staff were adequate and in line to people's needs. Comments about staffing included; "There's always somebody there, there's always someone around," "They do come if you buzz but sometimes you do have to wait if they are busy," "I've never had to wait." And; "They always try and get to you." All visitors we spoke with told us there was always staff about when they visited. Comments from staff included, "There are enough of us

and we help each other, if we are struggling the manager will help."

During our inspection visit, staffing levels during the day were observed to be sufficient to meet the needs of people who lived at the home. There were three care staff, a chef, a cleaner and a senior carer. However, there were two care staff for the night shift. We noted that four people in the home required support from two people. We spoke to the registered manager and the director about the feedback on staffing levels and they informed us they had been no concerns around staffing and that people are able to use the call bells in the home if they required support. They informed us they had not established formal procedures for determining dependency levels. A formal assessment of dependency would demonstrate how the provider ensures that there are adequate numbers to meet people's needs in a timely manner.

We looked at recruitment processes and found the service had recruitment policies and procedures in place, to help ensure safety in the recruitment of staff. We reviewed the recruitment records of three staff members and found that safe recruitment procedures had been followed. We saw the required reference and character checks had been completed before staff started to work at the service and these were recorded. The files also included proof of identity and Disclosure and Barring Service (DBS) checks. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. There were disciplinary procedures in place at the service.

The building was clean with hand sanitising gel and hand washing facilities available around the premises. Risks of infections had been managed and infection control audits had been undertaken.

We found equipment had been serviced and maintained as required. For example, records confirmed gas appliances, moving and handling equipment and electrical equipment complied with statutory requirements and were safe for use. Water temperatures had been checked to ensure people were protected from risks of scalding.

## Is the service effective?

### Our findings

People's assessed needs, preferences and choices were not always met by staff with the appropriate qualifications, skills, knowledge and experience. We looked at how the provider supported staff to ensure they had up to date training. Some staff had received national vocational qualifications in health and social care. In their PIR the registered manager wrote 'Staff receive regular supervision and training which helps them to care for people effectively. Staff attend outside training and cascade to other staff members. The manager attends regular safeguarding champion training sessions from LCC and has recently completed a trainer's programme to deliver safeguarding training in house. Regular update and safeguarding through staff meetings and supervisions, e-learning.' Our findings showed that this was not always happening. There were significant shortfalls in various areas of training that the provider had deemed necessary for the roles staff were employed to perform. For example, 16 out of 19 staff did not have up to date safeguarding adults training, 10 staff had not received fire safety training, 14 had not received mental capacity training and 12 staff had not received health and safety training. In addition, there were significant shortfalls in other training that the provider had deemed mandatory for the role such as dementia care, medication awareness, nutrition, infection control and end of life care. The shortfalls in training meant that care staff had not received or updated their training to ensure their practice and knowledge was up to date. This had an impact in some of the practices in the home for example medicines management.

Records we reviewed and our conversation with the registered manager and the owner also demonstrated that they were aware of the training shortfalls. We also noted that the shortfalls had been highlighted by visiting professionals in July 2017. This meant the shortfalls had not been rectified in a timely manner and that the provider had failed to follow their own policy on training and development.

The director informed us that they are in conversation with staff regarding the importance of keeping up to date with their training and to ensure that staff prioritise this.

Staff had received supervision and appraisals regularly and in line with the organisation's policy. Records we reviewed showed various topics had been discussed during the supervisions including safeguarding, infection control and medicines management among other topics.

There was a failure to ensure that all staff had received such appropriate support, training, professional development, as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 so that they can receive care and treatment when this is in their

best interests and legally authorised under the MCA. The authorisation 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. A significant number of DoLS authorisation requests had been submitted to the local authority. Some of the requests had been authorised. The registered manager was regularly checking progress of the other applications. We saw evidence that people's consent in various areas been sought in all care files we looked at.

The registered manager had completed mental capacity assessments. However, the mental capacity assessments in the records we reviewed were not always decisions specific. The registered manager showed us one example of a decision specific assessment however this needed to be consistent in all decisions. We also noted that best interest's records had not been kept. We noted that best interest's decisions were recorded in people's daily notes. This made it difficult to identify what best interest's arrangements were in place for a person where people lacked capacity to make specific decisions.

There was an up to date policy in relation to seeking consent and mental capacity. We spoke to the registered manager regarding their responsibilities in respect of mental capacity assessments and best interest's records. They started to take appropriate action to ensure the shortfalls were rectified during the inspection.

We recommend that the provider and the registered manager seek advice and guidance from a reputable source, about the application of mental capacity principles.

People who lived at the home and their relatives told us they felt their needs were effectively met. Comments included, "Yes our staff seem to know what they are doing", "Yes, they seem to know when to call the Doctor", "Yes, I'm happy here they will send for the doctor anytime."

We observed that people's needs, and choices were considered during the delivery of care. For example, we saw people being asked what they wanted to eat and where they wanted to sit. People told us they could get up anytime they wanted and chose to spend time in their bedrooms if they wanted to.

Staff knew how to protect people against discrimination, including in relation to protected characteristics. There was a policy on how protect people against discrimination and harassment as well as a policy on equality and diversity. These policies were important in demonstrating how the registered provider implemented or applied human rights principles (fairness, respect, equality, dignity and autonomy) to the service. Information on how to report concerns was readily available in prominent places within the home. However, this was not adequately supported with up to date training in areas such as equality and diversity. Three out of 19 staff had up to date training in equality and diversity.

Staff completed a range of assessments to check people's abilities and review their support levels. For instance, they checked individual's needs in relation to mobility, mental and physical health and medicines. Specific requirements for each individual had been identified. For example, they identified those people who required assistance with moving, soft diet, people who were at risk of falling and people who were at risk due to their vulnerability. Assessments and all associated documentation were personalised to each individual who stayed at the home. Care plans and risk assessments had been reviewed and dated. This ensured a person-centred approach to care reviews.

We reviewed how people's individual needs were met by the adaptation, design and decoration of premises.

We saw people who lived at the home had access to a garden that was enclosed and safe for people to use. In addition, there were two lounges for people to spend some time in a quiet sitting area for people to sit with their visitors if they needed privacy. We observed that people moved around the building freely. We saw some people had brought their own personal items that helped personalise their bedrooms and made it homely for them.

Staff supported people to eat their meals. The atmosphere was calm and caring and people were able to eat their meals at their own pace. All people appeared to have enjoyed their meal and had eaten very well. Staff offered a choice of drinks. They encouraged individuals with their meals and checked they had enough to eat. Staff gave people an alternative if they did not like the meals on offer.

Comments about the food were positive. One person who lived at the home said, "The food is quite good" and, "I would recommend the food, we get plenty here." People told us they had two choices of hot meal at lunch time and sandwiches in the evening. A menu was on display in the home. The care records we reviewed had a section that noted any special dietary requirements such as specialist cutlery, plate guards or the need for a soft diet. Staff recorded in care records each person's food and fluid likes and dislikes. This was good practice to provide preferred meals to increase their nutritional intake. People were weighed regularly. We found staff assessed people against the risks of malnutrition and made referrals to dieticians and speech and language therapists (SALT) where appropriate.

People were supported to live healthier lives, have access to healthcare services and receive ongoing healthcare support. Care records we looked at contained information about other healthcare services that people had access to. Staff had documented when individuals were supported to attend appointments or received visits from for example, GPs and district nurses. Documentation was updated to reflect the outcomes of professional health visits and appointments. We observed a GP and a district nurse visiting during the inspection. They informed us the staff were proactive in involving specialist professionals and that they would seek advice if ever they were unsure about people's conditions. This meant that people could be assured they would have access to specialist professionals if they needed them.

## Is the service caring?

### Our findings

During our inspection visit we observed people were relaxed, happy, smiling and comfortable. We confirmed this by talking with people. For example, comments included, "The care here is very good." "The staff here are kind and patient," "They treat people here with respect, I have no bad word to say about them.", "It's very nice, they are very good to me." And, "It's not like your own home but staff are really nice." Comments from relatives included, "I am impressed with the staff so far, they are welcoming and attentive."

A visiting professional told us, "Staff care, and they lead by example in protecting people's privacy. I have seen them challenge professionals not to examine people in the lounge to protect their privacy."

We observed staff engaged with people in a caring and relaxed way. For example, they spoke to people at the same level and used appropriate touch and humour. People were well groomed, and staff took time to sit down with people and talk about their past experiences and interests. We observed people being treated with kindness and respect. Staff were patient and took time to give explanations to people.

Staff had a good understanding of protecting and respecting people's human rights. When we discussed this with staff, they described the importance of promoting each individual's uniqueness. There was a sensitive and caring approach, underpinned by awareness of the Equality Act 2010. The Equality Act 2010 legally protects people from discrimination in the work place and in wider society.

We observed people being as independent as they could be in accordance with their needs, abilities and preferences. We observed people being encouraged to do as much as they could for themselves. For example, we observed people eating independently. Staff explained how they promoted independence, by enabling people to do things for themselves. One staff member said, "We encourage people to do as much as they can before we assist them."

Staff maintained people's privacy and dignity throughout our visit. For example, we saw staff knocked on people's bedroom doors before entering. Staff also addressed people by their preferred names. Care records that we saw had been written in a respectful manner. Staff we spoke with described how they ensured people's dignity was maintained when they assisted them with their personal care tasks. For example, they informed us they would ensure people's curtains and doors were closed when they receive assistance with personal care.

We noted a caring and inclusive atmosphere when people were together in groups. People were sitting together enjoying each other's company. From our observations it was clear that the service acknowledged and supported the relationships people had forged with each other and with staff.

Staff said they made sure information about people was kept locked away so that confidentiality was maintained at all times. We saw that all personal documentation including care plans and medicines records were locked away and this meant that only authorised staff accessed people's records.

Relatives told us the management team encouraged them to visit at any time. They said this gave them the freedom to access the home around their own busy schedules. We observed staff welcomed relatives with care and respect. For example, they had a friendly approach and one relative said, "They always make you feel welcome and will offer you a drink and something to eat."

We saw people were supported to express their views on matters that were important to them and were also involved in making decisions about their care as far as possible. Records we reviewed showed how people had been involved in the review of their care records. The registered provider had information details that could be provided to people and their families if advocacy was required. We saw evidence to show an advocate supported one person. This ensured people's interests would be represented and they could access appropriate services outside of the service to act on their behalf if needed.



## Is the service responsive?

### Our findings

The people who lived at the home made positive comments about the staff team and the care and support they received at the service. Their comments included, "I like to read, sometimes we have things going on and I enjoy the entertainers" and, "They will get me a newspaper daily, so I can keep up with the news", "I don't do much, but I am offered a chance to join in." And, "I listen to the radio, I like watching certain programmes, I like the sport."

The registered manager informed us that people were offered various activities of their choice. They said, "We have a good relationship with the local church that facilitate some people to attend the coffee mornings and continue to follow their faith. The yellow bus comes and picks up people for social outings." They also added that people had access to armchair exercises from another activities provider contracted by the provider.

People had access to various activities to occupy their time. There was a dedicated activities co-ordinator who assisted with activities five days of the week. In their PIR the registered manager wrote, 'We have introduced an activity coordinator to provide regular activities for our service users to enjoy. Activities include arts and craft, story group, board games, dominos, and dancercise. We also have regular entertainers for service users and their families to enjoy. We celebrate service user's birthdays and have recently had an article in the Lancashire Evening Post celebrating a service user 100th birthday. We hold an annual summer barbecue in July and a Christmas party in December.' We saw a list of planned activities. People were supported to continue to access their community to reduce social isolation. However, on the day of the inspection we observed no activities taking place in the home. We were informed that the activities co-ordinator was on holiday. We would however expect alternative arrangements to be in place to ensure continuity.

We checked how the provider ensured that people received personalised care that was responsive to their needs. The care plans were comprehensive and person centred and contained details on how people preferred to be cared for. Although the care records were comprehensive, we found the handwritten records were not always legible. We noted that this had been noted by a visiting professional and a they suggested for the home to consider computer generated records. We spoke to the registered manager about this and they informed us that they are considering the recommendation. This would ensure that information and guidance about people's care is easily readable.

The care records had been developed, where appropriate, with contributions from each person and their family. They identified what support they required. People and their relatives told us they had been consulted about support that was provided before using the service. People's needs had been assessed before they started living at The Brambles Rest Home. This was to ensure that the home and staff were able to meet people's needs before they decided to admit them into the home. We also noted that people's care records contained their life histories which had been written by their family members. This meant that people could share memories that they cherished and allowed staff to know what people valued.

The provider had been responsive to the needs of people who lived at the home. For example, staff were aware of the need to support people who may wish to manage their medicines. There were signs in the home which reminded people to use call bells and not to attempt to walk if they were unsteady. The signs read; 'Call don't fall'. This was a response to the risks of falling.

The provider had used technology to support people to receive timely care and support. For example, there was a call bell system which allowed them to summon support from staff from wherever they were in the building. There was also a working broadband and a telephone system that was easy to use and accessible to staff and people who lived in the home.

People were supported to maintain local connections and important relationships. People were also actively encouraged and supported to maintain local community links. The registered manager informed us that people had been assisted by local volunteers to attend church and continue with their lifestyles.

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. We discussed with the director and the registered manager and they showed awareness of the requirement. People had care plans on how they could be assisted with their communication, this included records of referrals to opticians. We found various pictorial messages and signage in the home to help people with sight and cognitive impairment to ensure they could communicate effectively. The provider would now need to consider establishing a policy to ensure they can be consistent in their approach.

People we spoke with knew how to make a complaint or raise concerns and felt comfortable to do so if needed. We saw people were encouraged to do so by information that had been posted in the home. People were confident to speak up. The service had a complaints' procedure that was made available to people on their admission to the service. Copies were on view in the service and had been written in a format that enabled people who used the service to understand the procedures. The procedure was clear in explaining how a complaint should be made and reassured people these would be responded to appropriately. Contact details for external organisations including social services and CQC had been provided should people wish to refer their concerns to those organisations. We asked for records of previous complaints received in the home however, these were not provided to use at the time of our inspection. We were informed that no complaints had been received since our last inspection.

Records we saw demonstrated that the provider and the staff had considered people's preferences and choices for their end of life care. For example, there was a policy that asked staff to record where people wished to die, including in relation to their protected equality characteristics, spiritual and cultural needs. The service had worked with a local hospice and signed up to the 'six steps to success to end of life programme'. The programme is based on the six steps described in the route to success in end of life care in care homes. Files we reviewed had plans for end of life. This demonstrated that people and their relatives could be assured they will be offered an opportunity to discuss their advanced care plans and how they wanted to be treated in the event of a life-threatening event.

There was also a policy and guidance on communicating with families and professionals to support people towards the end of their life. Three of the care staff had received training that included guidance on how to support people towards the end of their life. This showed that there were plans to ensure that people were supported at the end of their life to have a comfortable, dignified and pain free death.

## Is the service well-led?

### Our findings

There was a registered manager employed at The Brambles Rest Home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in January 2016 we rated the service overall 'good' and the provider was compliant with all regulations. At this inspection in July 2018, we found improvements were required to sustain the quality of the service. We noted that improvements were required to the governance and the quality assurance processes at the home. We found the service was in breach of regulations in relation to medicines management and staff training. We also made recommendations in relation to mental capacity records. This demonstrated that the management systems at The Brambles Rest Home had not adequately monitored areas of improvement to sustain the quality and ensure compliance with regulations. Following this inspection, we concluded that there had been a decline in the governance systems at the service and that the provider had failed to sustain improvements we noted in January 2016.

We looked at how the registered provider demonstrated how they continuously learnt, improved, innovated and ensured sustainability in the service. The registered manager and registered provider had an established auditing system to assess quality assurance and the maintenance of people's wellbeing. We saw that audits had been undertaken in various areas such as medicines, health and safety and infection control. However, we found shortfalls that had not been identified in these audits. For example, we found shortfalls in the medicines' management practices and mental capacity records. We also found significant shortfalls in staff training and competence checks. Records we checked showed that the provider was aware of the shortfalls failed to address these gaps timely. The audit system for medicines were not robust to ensure all areas relating to medicines management were checked regularly. We found shortfalls that could have been picked up by a robust medicines audit tool. This meant that audit systems in the service had not been effective to identify shortfalls and to ensure improvements were made in a timely manner.

We noted that systems for record keeping were not robust. Some records we requested could not be located for example, minutes of relatives and people's meetings, fire risk assessment, records of complaints received and the emergency lighting inspection record. The registered manager and the owner informed us this had been due to change to their office staff. However, the practices should allow continuity in the home.

The registered manager took immediate action to address some of the concerns we identified during the inspection; however, these shortfalls had not been identified by the providers' quality assurance system and rectified before our inspection.

While in majority of the cases policies in the home had been followed we also found the provider had failed to follow their own organisational policies, for example on policies on medicines management and overall staff training.

The registered manager and staff had a vision to deliver high-quality care and support, and promote a positive culture that was person-centred, open, inclusive and empowering. However, it was not supported by robust audit and quality assurance processes.

Staff we spoke with demonstrated they had a good understanding of their roles and responsibilities. We found the service had clear lines of responsibility and accountability with a structured management team in place. The registered manager was experienced and had an extensive health and social care background. They were knowledgeable and familiar with the needs of the people they supported. Care staff had delegated roles including medicines ordering and catering and domestic duties. Each staff member took responsibility for their role and had been provided with oversight by the registered manager. However, the registered provider had not demonstrated how they monitored the registered manager to ensure they were compliant with regulations. They informed us that they were in the process of introducing a system of auditing the registered manager's audits. This would ensure they can demonstrate how they are providing oversight on the registered manager's compliance with regulations and holding them accountable.

The provider had failed to maintain good governance. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We received positive feedback about the management and leadership of the service. People told us, "The manager is very good she is always about and will help you with anything", "The manager is approachable I can talk to her about anything." Staff were complimentary about the registered manager. They told us, "[Name] is good as a manager, she will support you with anything and listens to you." And, "It's a great place to work here, I like it." They told us they were supported to develop their skills to undertake their jobs effectively.

Staff we spoke with told us they felt the registered manager worked with them and supported them to provide quality care. For example, we only received positive comments from staff and people and they included, "She was the first person who spoke to me this morning with a big smile on her face." "She's always popping in and out of the lounge."

Similarly, we received positive feedback from a visiting professional. They said, "The manager is knowledgeable and will inform us of any concerns that they have with people and they follow guidance that we provide."

We checked how people who used the service, the public and staff were engaged and involved in the running of the service. We found the registered provider had established systems for seeking feedback from people, their relatives and staff. There were people and relative's meetings, relatives and people's surveys and professional visitor surveys. In addition, there were staff meetings and staff surveys. This meant that the provider had demonstrated how they had actively encouraged feedback about the quality of care and overall involvement with people.

We noted that the provider had considered best practice guidance. They had been part of a pilot scheme with the local clinical commissioning group on the use of 'secure red bags' for sharing hospital transfer records also known as hospital passports. This was an initiative to improve the way services shared people's records and to reduce the risk of records going missing during a transfer between care homes and hospitals. Hospital transfer records are documents which promote communication between health professionals and people who cannot always communicate for themselves.

We looked at how staff worked as a team and how effective communication between staff members was

maintained. Communication about people's needs and about the service was robust. We found handovers, were used to keep staff informed of people's daily needs and any changes to people's care. Information was in people's care plans records showing what care was provided and anything that needed to be done.

We checked to see if the provider was informing the Care Quality Commission (CQC) of key events in the service and related to people who used the service. Notifications had been submitted and the registered manager knew their regulatory responsibilities for submitting statutory notifications to the CQC. A notification is information about important events that the service is required to send us by law. We found the provider had complied with the regulatory requirement to display their previous inspection ratings in the home and their website.

We found the organisation had maintained links with other organisations to enhance the services they delivered and to support care provision, service development and joined-up care. They worked with organisations such as local health care agencies and local commissioning group, local pharmacies, and local GPs. The registered manager had a system to ensure the service shared appropriate information and assessments with other relevant agencies for the benefit of people who lived at The Brambles Rest Home.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had failed to ensure the proper and safe management of medicines and ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;. Regulation 12 (2) (c) (g)</p> <p>The provider had failed to establish systems and processes that assure compliance with statutory requirements, national guidance on the safety of their premises and/or equipment within it. This was because emergency lighting inspections had been carried out in line with regulations. Regulation 12 (2) (d)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had failed to operate an effective quality assurance system in order to monitor and improve the quality and safety of the service. Regulation 17 (1) (2))</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The provider had failed to ensure that staff received such appropriate support, training, professional development, as is necessary to enable them to carry out the duties they are employed to</p>

perform. Regulation 18 (2) (a)