Carebase (Histon) Limited

Bramley Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Bramley Court provides accommodation and personal and nursing care for up to 67 people, some of whom were living with dementia. There are three units, one on each floor, called Damson, Pear and Cherry. There are external and internal communal areas for people and their visitors to use.

This unannounced inspection took place on 5 and 6 April 2016. There were 65 people receiving care at that time.

The service had a registered manager in place. 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.

There were not always sufficient staff on duty to ensure people's needs were met safely. People's safety was not always managed effectively. Staff were aware of the procedures for reporting concerns. However, these systems were not always followed and concerns were not always investigated.

Staff were only employed after the provider had carried out comprehensive and satisfactory pre-employment checks. People received their prescribed medicines appropriately and medicines were stored safely.

Staff were well supported by their managers. People's health, care and nutritional needs were effectively met. People were provided with a balanced diet and staff were aware of people's dietary needs.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. We found that there were formal systems in place to assess people's capacity for decision making and applications had been made to the authorising agencies for people who needed these safeguards. Staff respected people choices and were aware of the key legal requirements of the MCA and DoLS. People were involved in decisions about their care.

People received care and support from staff who were kind, caring and respectful to them and their visitors. Staff treated people with dignity and respected their privacy.

Care records were detailed. However, these did not always provide staff with sufficient guidance to provide consistent care to meet each person's individual needs.

People had access to information on how to make a complaint and were confident their concerns would be acted on. However, we could not be confident that all complaints had been fully investigated.

There was a varied programme of events for people to join in with and opportunities for people to develop hobbies and interests. Staff supported people to spend their time in a meaningful way.

The registered manager was supported by a staff team that including registered nurses, care workers, and ancillary staff. The service had a quality assurance system in place. However, although areas for improvement were identified, actions were not always taken to bring about improvements to the service.

People and relatives were encouraged to provide feedback on the service in various ways and their views were listened to and acted on. People benefitted from good links with the local community.

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

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.

People's safety was not always managed effectively. Reporting systems were not always followed and concerns were not always investigated.

There were not always sufficient numbers of staff to ensure people's needs were met safely.

Staff were only employed after satisfactory pre-employment checks had been obtained.

People were supported to manage their prescribed medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff knew the people they cared for well and understood, and met, their needs.

People's rights to make decisions about their care were respected. Where people did not have the mental capacity to make decisions, they had been supported in the decision making process.

People's health and nutritional needs were effectively met and monitored. People were provided with a balanced diet and staff were aware of people's dietary needs.

Is the service caring?

Good

The service was caring.

People received care and support from staff who were kind, caring and respectful.

People were involved in every day decisions about their care.

Staff treated people with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records were detailed. However, they did not always provide staff with sufficient guidance to ensure people's needs were being met.

People had access to information on how to make a complaint and were confident their concerns would be acted on. However, we could not be confident that all complaints had been fully investigated.

There were opportunities for people to develop hobbies and interests and spend their time in a meaningful way.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service had a quality assurance system in place. However, although areas for improvement were identified, actions had not been made to improve the service for people.

People were encouraged to provide feedback on the service in various ways. People's comments were listened to and acted on.

People benefitted from good links with the local community.

Bramley Court

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 unannounced inspection took place on 5 and 6 April 2016. It was undertaken by two inspectors and an inspection manager.

Before our inspection we looked at all the information we held about the service including notifications. A notification is information about events that the registered persons are required, by law, to tell us about. We also asked for feedback from the commissioners of people's care and Healthwatch Cambridge.

During our inspection we spoke with nine people, seven relatives and one visiting healthcare professional. In addition to the business manager, the registered manager and the deputy manager, we spoke with one nurse, two team leaders, three senior care assistants, two permanent care workers and two agency care workers, a chef, a domestic and a hairdresser. Throughout the inspection we observed how the staff interacted with people who lived in the service.

We looked at five people's care records, three staff recruitment records, staff training and supervision records and other records relating to the management of the service. These included audits, rotas and meeting minutes, complaints investigations and policies and procedures.

Following our inspection eight regular visitors to the home provided us with further feedback. The registered manager also sent us an initial action plan telling us how they had, or planned to, address some of the concerns we had raised.

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection concerns had been raised about staffing levels. During this inspection we found that people were not always kept safe because there were not sufficient staff to meet their assessed needs.

The registered manager told us she assessed people's dependency using a recognised tool that helped identify the numbers of staff required on each unit to meet people's needs. However, we found the identified numbers of staff were not always provided in two of the three units. For example, the registered manager had identified a significant increase in people falling on Cherry unit during January and February 2016. The dependency tool showed that six staff were required to safely meet people's care needs during the day on Cherry unit. However, we found these staffing levels were not always met.

One relative told us that the staff on Cherry unit "are very kind and work very hard" but that the unit was, "Understaffed occasionally." Another relative said, "There's sometimes not enough staff, especially at weekends." They went on to tell us that the people living in Cherry unit "get agitated and uptight" when there were less staff on duty. Staff also told us that six staff were needed to meet people's needs on Cherry unit, but that they often worked with less staff. They told us that on the first day of our inspection there had been three staff on duty who knew people well and two staff who normally worked in other areas of the home. They said, "That's why it's been so manic – they [the staff] don't know people so well. It's not often like it was today, but it's more often than it used to be."

During the first day of our inspection we saw staff were very busy in Cherry unit. People lacked any meaningful occupation and became anxious and upset. For example, one person called out a lot, which upset other people. On two occasions we saw a visitor when one person became anxious and upset when they were approached by another person living at the service. Neither of these people were the relative's family member. On another occasion the inspector had to intervene when one person started moving the chair another person was sitting in. This caused the person sitting in the chair to become distressed. On each occasion there were no staff available in the immediate vicinity.

The registered manager told us that when there were less staff on duty, another member of staff, for example, a member of the senior team, worked part of that shift in Cherry unit. However, there were no records to support this and records showed that in the 10 days before our inspection Cherry unit was not fully staffed for eight morning shifts and five evening shifts.

The registered manager told us there should be four staff working in Damson unit in the mornings and three in the afternoon and evenings. Staff told us these levels were not always maintained and three staff were not sufficient staff to meet the needs of people living in Damson unit. They said this affected the care that people received. For example, they told us about one person who leaned forward when sitting in a chair. One staff member said, "If we're short staffed [person] has to go back to bed as [they] are safer there." Staff told us there were 21 people living on Damson unit, eight of whom required two staff to assist them to move and 10 lived with varying levels of confusion. This meant that if one staff member was administering medicines, sometimes both other staff members were engaged in providing care to one person, leaving the

other people vulnerable. One staff member commented that when there were less staff on duty they were often called away whilst they were administering medicines and they were "worried about making a mistake". Staff told us that a lot of people preferred to have baths in the afternoon or evening, but they were unable to offer this because there were insufficient staff. One staff member told us that the service provided was often "task orientated" and they didn't want it to be like that.

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

On the second day of our inspection there were six staff on duty in Cherry unit. People were calm and staff encouraged them to be meaningfully occupied on their own or in small groups. Staff had the time to sit with people and provided the comfort and support they needed.

Following our inspection the registered manager told us that staffing levels were being maintained during the day with six staff on duty in Cherry unit and four staff in Damson unit at all times during the day.

People living in Pear unit told us there were enough staff to meet their needs. We saw that people who were in bed had an alarm so that they could call staff if needed. One person said, "Staff come straight away when I press my buzzer." Another person said, "There are a lot of staff in the day and they are good but at night it's a bit hit and miss."

People were not always kept safe from harm because staff did not follow the providers safeguarding protocols. Most staff told us they had received training in how to safeguard people from harm and were aware of the provider's reporting procedures in relation to accidents and incidents. However, we found two incidents that had affected the health and wellbeing of two people, which had not been reported or dealt with appropriately to keep those people safe. Following our inspection we referred both of these concerns to the local authority for investigation.

The provider had procedures in place for staff to report concerns, but we found these were not always followed. During our inspection we found a letter of concern about a staff member's practice had been filed but no action had been taken. The registered manager told us she had not been aware of these concerns. Following our inspection we referred this concern to the local authority for investigation.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents were not always investigated. For example, although two people had been taken to hospital to have their injuries assessed following falls, the registered manager was unable to show us that satisfactory investigations into the circumstances leading up to these falls had been completed. This meant that the provider had not taken appropriate steps to ensure people were safe and risks were minimised.

Information relating to accidents or incidents was not always accurate or sufficiently detailed. For example, information of the time that one fall occurred was inaccurate and there was no information that showed what another person was doing at the time of, or leading up to, the fall. This meant it would be impossible to properly investigate the circumstances around these falls.

Following our inspection the registered manager told us they would review accident forms promptly. They said they would ensure that people's risk assessments and care plans were reviewed in a timely manner and appropriate referrals would be made to the local authority under safeguarding protocols. They also told us

that all staff member's personal files had been audited and no further concerns were found.

People's individual risks were assessed and measures were put place to minimise the risk of harm occurring. Risks identified included assisting people to move safely and the risk of developing pressure ulcers. For example, one person who was at risk of developing pressure ulcers told us that staff helped them to reposition every two hours so that they didn't become sore. Records confirmed that this was the case and that they had been referred to a tissue viability nurse for further support. However, we found risk assessments were not always updated to take account of changes in people's conditions. For example, we saw one person had an assessment about the risk of falling. This had not been updated when the number of falls the person experienced had increased. This meant it was not clear whether appropriate action was being taken to minimise risks and hazards. Following our inspection the registered manager told us they would check that risk assessments were reviewed as part of their auditing process.

At our last inspection on 23 November 2015 we found that improvements had been made to ensure corridors and areas under stairs were clear of combustible materials. However, during this inspection we found that combustible materials were stored in the area under the stairs and in corridors leading to fire exits. Staff told us that the items under the stairs had been there for "a couple of days". We raised this with the registered manager who arranged for these areas to be immediately cleared. Following our inspection the registered manager told us they, or the deputy manager, carried out daily checks to ensure these areas remained clear and safe.

People told us that they felt safe. One person said, "I feel very safe. If I didn't feel safe I would tell someone straight away." Another person told us, "I feel much safer than when I lived at home. The [staff] are very good. They make me feel very safe and nothing is too much trouble for them." A relative told us they felt their family member was safe. They said their family member was "settled, and comfortable with staff."

Staff told us that the required checks were carried out before they started working with people. These included written references, proof of recent photographic identity as well as their employment history and a criminal records check. One staff member told us they "couldn't start until [the checks] came back." This showed that there was a system in place to make sure that staff were only employed once the provider was satisfied they were safe and suitable to work with people who used the service.

Medicines were safely managed and people said that they received their medicines on time. One person told us, "Staff always bring [my medicines]." Another person told us that they were always offered pain relief. This was confirmed in their medicine administration records (MAR). A relative said, [Staff] are very careful to give [medicines] on a spoon. They take a lot of care [with them]." Staff told people what their medicines were for when they were offered to them. One relative said staff were proactive in that staff requested the GP reviewed their family member's medicines. This was because staff felt the prescribed medicines may have been having a negative impact on the person.

People were administered their prescribed medicines by staff who had received the necessary training and competency checks. There were safe systems in place for the administration, recording and storage of medicines. Protocols were in place for medicines that were to be given only when the person required them. This provided staff with guidance so they knew when to administer the medicines. Medicines were disposed of in a timely manner and MARs were audited each month. This helped to identify any discrepancies that may have occurred and ensure action was taken to address them. This showed that there were suitable systems in place to ensure medicines were managed safely.

There were systems in place to control and prevent the spread of infections. Staff were aware of the

importance good hand washing and the use of protective clothing when providing personal care. Systems were in place to ensure the service was cleaned regularly and thoroughly.

Requires Improvement

Is the service effective?

Our findings

Staff had mixed views about the training they and other staff received, particularly about induction. For example, one staff member told us, "New staff don't get the in-house training on induction." Another staff member told us they had spent a week working with a more experienced member of staff and had completed safeguarding training. A third member of staff said, they had been "taken round and introduced" to people as part of their induction. They had been "shown their job role" and had also worked with an experienced member of staff. They said they had completed various topics in training, including how to assist people to move safely, administration of medicines, cardio-vascular resuscitation, safeguarding and food and hygiene.

We requested to see the induction records for three staff members who had started work at the home within the last year. The registered manager was unable to find any of these staff member's induction records. Records showed, and the registered manager confirmed, that two of these staff had worked at the home for two weeks but there were no records to show they had completed any of the provider's core training. The registered manager told us that the provider's policy stated that staff should complete core training, such as safeguarding people from harm and infection control, within three months of starting work. We could not therefore be confident that staff received sufficient induction into their roles before providing care to people.

People told us they liked the staff who worked at the service and that their care needs were met. One person said, "There's no separation between us and the staff." Another person told us, [The] staff are very nice." A relative told us, "The place [Bramley Court] is brilliant. [My family member has lived] here eight years. [It's a] fabulous place."

Relatives told us that staff seemed well trained and competent. One relative told us, "Yes, they understand [my family member's] needs. The care's good." Another relative agreed. They said it was the "way [staff] respond to [my family member] and the way staff cater for people's different needs" that made them think this.

Following our inspection the registered manager told us they planned to reintroduce an induction checklist for staff to work through based on topics covered by the Care Certificate. The Care Certificate is a nationally recognised qualification in care. The registered manager also said they had reviewed their practice and now expected staff to complete all of their basic training within one week of starting work at the home.

Staff told us, and records showed, that they received regular refresher training in the topics the provider deemed to be key. These included safeguarding people from harm, infection control and assisting people to move.

Staff had also had the opportunity to receive training in other areas relevant to the needs of the people they were supporting. This included end of life care. Several staff members said how much they had enjoyed and benefitted from recent dementia training. One staff member told us, "It was helpful … [it gave us] ideas of how to communicate and understand people with dementia." Another staff member said, "It can be quite

intimidating [working with people who are living with dementia], but knowing why changes everything. [I] want to make their life meaningful." A therapist who visited regularly said, "[Staff] training in the needs and therapeutic support for folks with Alzheimer's in particular is really good and makes a difference to the level of care [people] receive." A health care professional told us they felt staff had a good awareness of how to meet the needs of people living with dementia.

Staff members told us they felt well supported by the senior staff team. Staff described members of this team as "amazing" and "fantastic". Staff received formal supervision and said that this was a useful experience and provided an opportunity to discuss their support, development and training needs. One member of staff said, "I spoke about things I don't agree with. [My supervisor] took note and spoke with the [staff member]. I've seen a positive change in the [staff member's] practice."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found the service was working within the principles of the MCA. We saw that assessments and decisions to restrict people's liberty had been properly taken and the appropriate applications made to the relevant authority for authorisation. This showed that consideration had been taken to ensure the service provided was in people's best interest and was provided in the least restrictive manner.

Where people had been assessed as not having the mental capacity to make specific decisions, we saw that decisions were made in their best interest. Records showed that the views of appropriate people, such as relatives, had been taken into consideration. This included people who knew the person well or the person's legal representative.

Members of care and nursing staff were trained and knowledgeable in relation to the application of the MCA on two of the three units. However, staff working in Damson unit had not received training regarding MCA and were less clear about their responsibilities. One member of staff told us that if a person lacked the mental capacity to make a decision they would "involve [the person's] family". However, the staff member was not aware of whether the relative could make decisions on behalf of the person or not. Following our inspection the registered manager told us there would be further training for staff in this area.

People told us of different experiences in relation to the choice of food they had depending on which unit they lived on. People living on Damson unit made favourable comments about the food. These included, "The food is good. [There is a] good choice." Another person said, "The food is very good." A third person said, "[The] food is what you expect of group feeding. It is good enough." Relatives of people living on Cherry unit also made positive comments about the food. One relative told us, "The food looks good."

On Pear unit one person made favourable comments about the food saying, "It's superb, it's always lovely." However, everyone else raised concerns about the food saying that the meals were repetitive and that the quality varied. Two people said that their relatives brought additional food in for them such as fruit and sauces to put on their food. People said that there was a choice of food at breakfast and that a cooked

breakfast was available but that on some occasions there were no bread so they were unable to have toast. On person said, "The food is terrible but it was a little better today. The pudding today is exceptional, it's usually crumble or ice cream".

On the first day of our inspection the food was presented poorly. The food on some people's plates wasn't served in a way that made it look appealing. One relative commented that although the food was hot, the plates the meals were served on were cold.

Most people told us they were offered a choice of food at mealtimes. Where appropriate, we saw that staff showed people the choice of food available so they could choose the meal they preferred. However, we noted that staff did not always also explain to people what the food was. In addition, some people needed their food to be processed to a soft consistency because of their swallowing difficulties. The chef told us that they took account of people's preferences when preparing these foods, but that people did not have a choice of meal if they required this diet.

People could choose where they took their meals and we saw some people chose to eat in their bedroom. Other people chose to take their meals in communal dining rooms or lounges. Staff offered people help with their meals and drinks, if they needed assistance. Staff made an effort to make mealtimes a social occasion for people. For example, introducing people to each other and initiating conversations. There were good interactions between staff and people using the service at lunchtime. We saw staff sitting with people assisting them to eat and people were encouraged to eat at their own pace. However, due to lack of staff on Cherry unit on the first day of our inspection, we saw staff often had to leave the person they were assisting to eat to help other people.

People were supported to have enough to eat and drink. Appropriate diets were provided to people who required them and people were referred to a dietician when needed. This showed that people at an increased risk of malnutrition or dehydration were provided with meal options which supported their health and well-being. Where required, people's food and / or fluid intake was being monitored and the records were completed accurately. This was to help identify any change in people's food and fluid intake. Where people's intake had been low, this was communicated to staff who then provided additional support. Drinks were available and people had water and fruit drinks in their bedrooms. One relative commented, "I do see staff prompt fluids."

People's healthcare needs were met. People told us that staff arranged for them to see a doctor when they were unwell. One person said, "You can't fault the nurses here. As soon as my dressings become loose the nurses will change them without me even asking." Records showed that people's health conditions were monitored regularly. Staff made appropriate referrals to healthcare professionals when the need arose. This included opticians, chiropodist, dieticians, and therapists.

Good

Is the service caring?

Our findings

People and their relatives were complimentary about the staff. Several people referred to individual staff members as "caring" "very caring" and "kind". One person said, "Staff are nice and helpful." Another person told us, Staff are very nice. There's the odd [staff member] you like more than the other. Staff are always polite." A relative told us, "Staff on the floor are very kind and work very hard." They commented on one senior staff member, "[Staff member] is outstanding as a leader. She knows why she's doing things. She cares a lot about people."

Visitors to the service also complimented and praised the staff. A religious leader who visited the service regularly told us, "Staff at Bramley Court are most diligent in their work and attend to the needs of the residents with great patience and care." Another religious leader said, "[The staff] treat the residents as individuals according to their needs and nothing is too much trouble." A therapist who visited the home told us, they found the staff, "Very welcoming, open, warm, attentive." Another visitor said, "The respect with which the staff show to the residents is excellent."

All the staff we asked, said they would be happy with a family member being cared for by the service. One staff member told us, "I've seen the way the staff are with the residents. I have no problem at all." An agency staff member said of the permanent staff, "They are good staff. They genuinely want to give good care."

Our observations showed the staff were kind, caring and respectful to the people they were caring for. Staff called people by their preferred name and spoke in a calm and reassuring way. Throughout our inspection staff maintained a caring attitude towards people. This included responding to people's requests. For example, we heard one person calling out saying they were cold. Shortly after a staff member brought their cardigan and asked if they would like help to put it on. We saw staff members were discreet in relation to personal care needs. For example, a staff member identified that one person needed some personal care. They offered the person their arm and asked them to "go for a walk" with them and then spoke very quietly about when explaining the reason.

Staff knew people well and told us about people's history, health, personal care needs, religious and cultural values and preferences. This information had been incorporated into people's care plans. One relative commented on how their family member lived with dementia and often resisted personal care. They told us, "[Staff] are good at changing people and keeping them clean." They went on to tell us that staff tried to reassure the person. They said, "[Staff] keep up a conversation while they're doing it [personal care], so it's less humiliating."

Relatives told us that they could visit whenever they wanted. Two relatives told us they like to visit at mealtimes to support their relative with their meals. Other visitors said they were made welcome and were treated well and provided with tea and coffee whenever they visited. One relative said, "I feel comfortable and welcome [when I visit]."

Relatives said staff kept them informed of any changes in their family member's health and well-being. One

relative said, "[Staff] do let us know if any issues, such as [if our family member] falls." Another told us that a senior staff member had telephoned them the day before to update them on their family member's well-being.

People told us that they either made their own decisions or received support to make decisions if this was needed. For example, one person told us that they preferred to have their bedroom door open so that they could see people walking past and that staff respected their decision. People who required advocacy were supported in a way which best met their needs. For example, relatives and people who knew the person well were consulted about people's care and involved in best interest decisions. The registered manager told us an advocacy service was available if people required it. Advocates are people who are independent of the service and who support people to decide what they want and communicate their wishes.

Each person had a keyworker from the staff team. A staff member told us, "Keyworkers are someone [for the person] to have a connection with. Someone [a person] feels safe to tell anything. [The keyworkers],go that extra mile. [People] can choose who they want [to be their keyworker]." They went on to tell us that staff involved people in decisions about their care as much as they could. "We tell [people] they can see [their] care plans." However, people told us they were not aware of their care plans and one person said they thought it "would be very interesting."

People and relatives told us that staff respected people's privacy and dignity when supporting them. One person told us, "Staff knock on my bedroom door." Our observations throughout our inspection showed us that staff knocked on people's doors and waited for a response before entering. They also let people know who they were as they entered. Staff were polite when they addressed people. For example, a staff member said to a person who was talking to us, "Sorry for interrupting, here is your desert [person's name]." This meant that staff respected and promoted people's privacy.

People had their own bedrooms and staff had supported people to personalise their bedrooms with photographs and small items of furniture. We saw that people had brought in their own furniture and that rooms were personalised with pictures, photos and paintings. This was to help people orientate themselves as well as being able to personalise their own room.

A religious leader told us that care provided for people who were dying was, "Excellent." They said staff made "every effort… to make this as painless, dignified and comfortable as possible." They said "Sensitivity to needs is always the first thought." They told us that a staff member had organised an annual "remembrance service" for the past four years. They said, "It is a real positive time to recall that the person who has died is remembered as that – a person – not just a number in a home."

Requires Improvement

Is the service responsive?

Our findings

People and their relatives felt that staff understood and responded to people's needs. One person told us they were, "Quite happy. I'm looked after very well." One relative told us that staff knew their family member could no longer verbally communicate their needs or wishes. They told us staff knew their family member well. They said "Staff have picked up non-verbal clues" and "could tell" what their family member was trying to communicate. Another relative said the staff understood their family member's needs and preferences. They told us, "[Staff] come over straight aware and make sure [my family member's] OK."

People's care needs were assessed prior to them moving to the service. This helped to ensure staff could meet people's needs. This included people's life history, individual preferences, care and support needs and their hobbies and interests. The assessment formed the basis of people's care plans and provided guidance to staff to help them provide effective and consistent care that met people's needs. For example, there were clear instructions as to how to care for a person who needed regular repositioning to keep their skin intact. However, we found that care plans did not always cover all areas of a person's need. For example, during the two days of our inspection we noticed that two people's finger nails were very long and dirty. A senior staff member explained that they expected staff members who were assisting people with their personal care to attend to any nail care requirements. However, this was not included one people's care plans. This meant that people may not receive all the care they required in a timely way.

People's care plans were reviewed regularly. However, they did not always reflect people's changing needs. For example, we saw one person had a care plan in place to reduce the likelihood of them falling. However, this had not been reviewed despite an increase in falls in the two weeks prior to our inspection. This meant it was not clear whether appropriate action was being taken to meet this person's needs. Following our inspection the registered manager told us they would check that care plans were reviewed following changes in the person's care and support needs as part of their auditing process.

Care plans included information on how staff could support people with their religious and spiritual needs. Two religious leaders made positive comments about how staff supported people with this. One told us, "These days it is easy to ignore the resident's spiritual needs but this is certainly not the case at [Bramley Court] where people are invited to take part in the religious services if they would like to." The other leader told us, "…spiritual need is recognised by the staff where appropriate and I think this is where [staff] do their utmost to meet individual needs."

Daily care notes provided information about how people had spent their day and whether there had been any changes in the person's health or well-being. Additional records were completed where people's health required additional monitoring. For example, records showed how frequently people were repositioned to maintain their skin condition and how frequently people were offered, and accepted fluids to monitor their intake and ensure they did not become dehydrated.

Information on people's hobbies and interests were included in their care plans. The provider employed an activities co-ordinator who had put together an extensive and varied programme of events and activities for

people to join in with. People told us that there were also opportunities to go out when the staff escorted them. One person said, "We go out in the van," and, "We go out sometimes to the church with staff."

The activities on offer included a mixture of individual and group sessions and were run by the activities co-ordinator and external individuals and groups, with additional staff support. For example, group and individual sessions were run by an aromatherapist and music therapist. We saw that a visitor to the service brought in from a miniature horse. We were told that other pets and 'Pat Dogs' were frequently brought into the service and were very well received by people. The activities co-ordinator had arranged for various community groups to visit and spend time with people. These included the local youth football team schools. People were encouraged to be involved with these sessions as much or as little as they wanted.

On the first day of our inspection we saw few meaningful activities in Cherry unit and there had been many missed opportunities for socialising because staff had been too busy to engage with people. On the second day of our inspection we saw staff responding to people and engaging them in numerous small group and individual activities which people were interested in. For example a group of people were cleaning brass items, one person was listening to music and another person was looking at a magazine. We saw staff engage periodically with another person who was enjoying stroking and dressing a doll. The staff member helped the person to redress the doll and spoke with them about it and reminisced about when her children were young. This showed staff knew people's interests and spent time with them.

People and their relatives said that staff listened to them and that they knew who to speak to if they had any concerns. One person told us, "Quite happy. I'm looked after very well. [I've] no complaints." Another person said, "[I] would complain to staff but [I've] not needed to." Two people's relatives said they had seen improvements after they had raised concerns with members of staff, including the registered manager. For example, one relative told us they had noticed a malodour when they visited. After they mentioned this they told us the issue had been attended to and effectively remedied. Another relative said, the response from the registered manager was, "Very apologetic." They were satisfied the compliant had been investigated and action taken to prevent a re-occurrence.

Information about how people could complain, make suggestions or raise concerns was available throughout the service. Staff had a good working understanding of how to refer complaints to senior staff or the registered manager for them to address.

Records showed that two complaints had been received since 1 January 2016. The registered manager had responded to these within the agreed timescales. However, we noted that a full record of the investigations were not available. For example, the letter of response said that the registered manager had spoken with staff, but there was no record of these conversations. We therefore could not be confident that a full investigation into the complaint had taken place. Following our inspection the registered manager told us they had implemented a 'File note' system. They said this would enable them to show the full investigation of any future complaints.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in place. The registered manager was supported by a staff team that included registered nurses, care workers and ancillary staff.

Relatives we met said they did know who the manager was. However, most of the people using the service that we spoke with were not aware of who the registered manager was. One person told us, "I don't know who's in charge." Staff were clear about the reporting structure in the service. They said they felt well supported by the senior team, describing the deputy manager as "amazing" and praising the support they received from a team leader. One staff member commented that the registered manager was approachable and listened to them. However, other staff members told us they did not often see the registered manager around the home. One staff member told us that the registered manager walks around the home "a couple of times a week, checking round". However, one staff member said they didn't always know if the registered manager was in the building and another said, "The [registered] manager does not come onto the floor." Following our inspection the registered manager told us they carried out "daily walk rounds" to go through all home and talk to people.

All the staff we spoke with were familiar with the procedures available to report any concerns within the organisation. They all told us that they felt confident about reporting any concerns or poor practice to more senior staff including the registered manager. However, we found that a concern raised by staff about a staff member's practice had not been addressed and the registered manager was unaware of these concerns. In addition we found that unexplained injuries and falls had not been investigated or reported to the local authority under safeguarding procedures. This showed that concerns were not always addressed or investigated. Following our inspection the registered manager told us that new systems had been implemented to ensure concerns were addressed and investigated promptly.

Various audits were carried out to monitor the quality of people's care and the service provided. These included audits of medicines, care plans and accidents. However, we found that actions were not always taken from these findings. For example, the provider had employed an external consultant who carried out a comprehensive audit of the service on 21 January 2016. They identified some areas for improvement. This included that rotas sampled did not demonstrate that the identified staffing levels were consistently maintained. This reflected our findings during this inspection over two months later. In addition audits of accident forms had highlighted the need to increase the number of staff working on Cherry unit. However, although this had been identified in the first week of March, the increased staffing levels were not being consistently maintained.

The registered manager sought feedback from people formally and informally. This included surveys and relatives meetings. One relative told us they always attended meetings and had seen improvements in the service as a result. For example, the activities co-ordinator updated them on the activities their family member participated in and they had seen that fresh fruit was made available every day. They said, "There is a point. They do listen." Staff told us, and records showed, that staff meetings were held where various topics were discussed. These helped the registered manager to communicate with staff and provided an

opportunity for staff to present their views.

The registered manager and staff members told us about their links with external organisations, including with local community groups. Examples of this were visits from local schools, religious leaders and groups, and a local youth football team. Strong links had also been formed with a local charity and events took place to raise money for this. Representatives from these groups told us that they valued the links they had formed with the service and praised the service provided to people. One representative told us, "It has been a great social experience … and we have always been welcomed and received very well by residents and staff alike." Another representative said, "I was so utterly impressed with Bramley Court and [a staff member's] dedication to the residents in [their] care. [The staff member] clearly gave them all such individual respect and you could tell in [their] rapport with them all that they respected [the staff member] too. A senior member of staff like this modelling to the other staff is just so exciting to see, because enthusiasm like that is infectious and has such an all-round positive effect on staff and residents alike."

The registered manager told us that staff were members of the National Activity Provider's Association (NAPA). This is a registered charity for staff interested in increasing activity opportunities for older people in care settings. Posters in the service requested nominations for an awards ceremony to be held at the service. This showed that good practice was recognised and celebrated.

Records we held about the service, and looked at during our inspection confirmed that notifications had been sent to the Care Quality Commission (CQC) as required. A notification is information about important events that the provider is required by law to notify us about.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Concerns were not always investigated or reported to the local authority under safeguarding protocols Regulation 13(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient staff to meet people's needs Regulation 18(1)