Bramblings (Kent) Limited

Bramblings Residential Home

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

About the service
Bramblings Residential Home is a residential care home accommodating up to 42 older people in one adapted building. There were 31 people living at the service at the time of our inspection. People had varying care needs, including, living with dementia, Parkinson's disease, epilepsy and diabetes. Some people could walk around independently, and other people needed the assistance of staff or staff and equipment to help them to move around.

People's experience of using this service and what we found
Although improvements had been made in most areas and this was continuing, some areas continued to need further work to ensure a good service was received.

Environmental risks were present as doors to areas that housed equipment or substances that could be harmful to people were left unlocked, posing a potential hazard to people's safety. Individual risks to people's health and safety had improved, however, some areas of risk had not been identified so measures were not in place to protect people.

The safe management of people's prescribed medicines had improved, people were given their medicines by staff who had received additional training to ensure their competence. There were still areas of concern that meant further safety measures needed to be applied around topical creams, patches and the safe disposal of medicines.

Some staff had not kept their essential training up to date and new staff had not completed training deemed mandatory by the provider in a timely manner to make sure they had the skills to provide the care people needed.

The premises needed updating and repairs were not always carried out quickly, creating potential health and safety risks. Areas of the service and the signs in place did not present a dementia friendly environment. The garden was not accessible for many people as it was overgrown at a time when the weather permitted opportunities for people to enjoy the outdoors.

People's care records were not always accurately recorded to make sure their needs were fully met, although improvements had been made in this area. Improvements had been made to the monitoring and auditing processes to check the quality and safety of the service, however, this area needed to improve further. The quality processes needed to be embedded and sustained to provide assurance.

Access and opportunities to meaningful activities that met people's social needs and preferences needed further improvement. We have made a recommendation about this.

Care plans to help staff support people with their wishes at the end of their life were still a work in progress

and needed further improvement.

Improvements had been made to staffing levels. People told us they did not have to wait for staff to assist them and staff said they could spend more time with people, meaning their own well-being had improved. Safe recruitment practices continued to be used. Staff had a good understanding of how to keep people safe and what their responsibilities were to raise concerns they had about people's treatment.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People were supported to access the advice of healthcare professionals and treatment plans were now followed. Only good feedback was given about the food and people were given assistance when they needed it.

A more person-centred care planning process had been introduced and this was reflected in the staff approach to care and support. People were supported with their individual communication needs and this was evident when observing in the communal areas. Supporting people to maintain their independence was clear from care planning documents and seeing the support provided.

How complaints and concerns were listened to and dealt with was more open and the opportunity was taken to learn lessons from issues raised.

The manager had been appointed since the last inspection, after the previous registered manager had left. The staff we spoke with had overwhelmingly positive comments to make about the manager's open approach and their willingness to listen to and support staff as well as people. We were told this had a positive impact on staff morale.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published on13 April 2019) and there were multiple breaches of regulation. We took enforcement action against the provider. We imposed conditions on their registration to make sure they sent us a report each month to update on progress made towards improvements. The provider submitted a plan of action to show what they would do and by when to improve. At this inspection we found improvements had been made in many areas and the provider was no longer in breach of some regulations. However, improvements were continuing and the provider was still in breach of three regulations. More time was needed to make sure improvements could continue and be sustained.

This service has been in Special Measures since 13 April 2019. During this inspection, the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

Enforcement
We have identified three breaches in relation to, safe care and treatment and medicines management; staff knowledge and skills; accurate record keeping and effective monitoring of the quality and safety of the

service.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Bramblings Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Bramblings Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager who was not yet registered with the Care Quality Commission, although their application was in progress. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information

helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and two relatives about their experience of the care provided. We spoke with eight members of staff including the manager, deputy manager, senior care workers, care workers and kitchen staff. We also spoke with the provider.

We reviewed a range of records. This included five people's care records and many medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service including monitoring and auditing records were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, management meeting records and maintenance and servicing records. We spoke with one professional who regularly visits the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection, this key question has now improved to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider and registered manager had failed to robustly assess the risks relating to the health, safety and welfare of people in a number of areas. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider had made many improvements to the assessment of risk and the response to accidents and incidents, meaning people were receiving safer care. However, there were areas that needed further improvement, so the provider was still in breach of regulation.

● Health and safety concerns were present around the premises. Some doors to hazardous areas were not locked when they should have been, as staff were not present in the area. This placed people at risk of being harmed. A large cupboard with medical equipment such as sterile dressings, ampoules of sterile water and sharps boxes with used needles in them, was unlocked. The cupboard was on a busy corridor used by people walking up and down. The inside of the cupboard was not clean, with cobwebs and an unclean floor.
● Other unlocked rooms had cleaning equipment inside and no sign on the door to show hazardous substances were stored in them. One room had hazardous substances stored alongside food products. People were placed at risk of harm from easy access to harmful equipment and substances.
● The manager responded to our concerns immediately and a maintenance operative attended to fix new locks to the doors. A domestic cleaner attended to clean the cupboard area. Cleaning products were moved to a safer, locked area. However, these areas of risk were not identified until we pointed them out.
● Environmental risk assessments were in place to identify risk to people, staff and visitors. However, noticeable hazards around the service had not been identified. Such as trip hazards caused by ramps, uneven surfaces in corridors and worn carpets.
● Individual risk assessments had improved. Risks that were specific to the individual and control measures for staff to follow keep people safe from harm were in place. However, some areas of risk had not been identified. One person had a diagnosis of epilepsy and was prescribed medicine to prevent a seizure. A risk assessment was in place to draw staff attention to the risks associated with the person having a bath or shower and the measures they should take to make sure the person was safe at that time. However, the risks associated with the person having a seizure outside of this scenario, what the triggers or signs were and what form the seizures took, was not in place.
● One person was assessed as high risk of acquiring pressure sores. They had an area of soreness and a healthcare professional was attending regularly to dress this. Although a risk assessment was in place, this did not include the guidance for staff to prevent further breakdown of the person's skin and to maintain

their skin integrity.
● Although risk assessments had been reviewed every month, they had not always been reviewed and updated following an accident or incident. For instance, one person fractured a bone and had severe bruising following a fall on 8 May 2019. Their falls/mobility risk assessment had not been updated following the fall to support their continued independence and check the control measures needed to prevent a reoccurrence of the incident. People were at risk of potential harm as records in place to keep them safe were not always kept up to date.

The failure to ensure risks were robustly identified and managed to prevent harm so people received care that was safe is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt safe and did not have anything to be concerned about. They knew who they would talk to if they were worried about their safety. One person said, "I feel safe. I like to use the hoist" and another person told us, "I feel safe here."
● Accidents and incidents were now managed in a safer way and monitoring systems were in place to learn lessons. Incidents had been recorded in detail by staff when an incident occurred. Any further action, such as attendance by the emergency services was included. The care and treatment needed following the incident was documented, including referral to health care professionals if required.
● The manager monitored incidents and kept a record to show the action taken and any themes, such as falls happening at the same time of day or in the same part of the service. This meant they could learn lessons from their analysis, put preventative measures in place and feed back to staff to improve outcomes for people.
● People had comprehensive personal emergency evacuation plans to make sure staff had the information they needed to support people to evacuate in the event of a fire or other emergency. All the necessary fire safety checks were carried out regularly to keep people safe.
● Servicing of equipment had been carried out regularly by appropriate professional operatives. Regular servicing included fire alarm and equipment, electrical safety, gas safety and electrical portable appliances.

Using medicines safely

At our last inspection the provider and registered manager had failed to make sure people received their prescribed medicines safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider had made many improvements and people were being given their medicines by staff who had received extra training and were following safer procedures. Thickener powders were now stored safely. Thickener powders are used to add to food and fluids as part of a treatment plan for people with dysphagia (swallowing problems) to prevent the risk of choking. Information about people's medicines was now available to staff. However, there were areas that needed further improvement, so the provider was still in breach of regulation.

● We found a large cupboard unlocked with medical equipment inside as described above, a flip top bin was inside the doorway, full of rubbish and four tablets on the top of the rubbish. This meant unused medicines were not always disposed of safely within best practice guidance. This posed a risk to people living in the service who could access the cupboard at any time.
● Some people were prescribed transdermal skin patches as a form of pain relief. Pharmacy guidelines recommend patches are sited on a different part of the body each time they are changed to avoid the risk of

skin irritation. Body maps were not in place for staff responsible for changing the patch at the appropriate time to check where it had been sited previously to make sure the risk of skin irritation was minimised.
● Some people were prescribed topical creams, to be administered regularly by staff when providing personal care. Topical cream charts in place to ensure they were applied regularly, as prescribed, showed sporadic recording by staff. One person was prescribed a topical cream, to apply thinly to an area of their body. The recording chart did not document how often the cream should be applied. The last three records on the chart showed the cream had only been applied once each day, on 16 May, 21 May and 3 June 2019. This meant people may not have had their creams as prescribed by a healthcare professional to maintain their health and well-being.
● Some people had been prescribed creams containing liquid paraffin in the ingredients. These creams have a heightened risk of fire ignition due to the ingredients contained in them. Staff were not aware of this and a risk assessment had not been undertaken to make sure control measures to reduce the risk of fire and burns was in place.

The failure to ensure peoples prescribed medicines were managed in a safe way is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff received further training in March 2019 to make sure they were aware of safe practice when giving out people's prescribed medicines. Staff now followed good practice when giving people their medicines, providing a safe and competent service. The manager had provided training for staff who had not previously administered medicines, to increase the numbers of competent staff and offer development opportunities. Staff were pleased with this improvement and one member of staff said, "The more staff that are trained means they know if it is being done correctly when seeing it."

Staffing and recruitment

At our last inspection, people, relatives and staff told us there were not enough staff deployed around the service to make sure people received the care they needed. We made a recommendation about this. The provider had made improvements.

● The provider had responded since the last inspection by increasing the numbers of staff on duty on each shift. Staff rotas confirmed this. Staff told us about the increase in staffing numbers and how this had made a big difference to the time they were able to spend with people and to make sure their needs were quickly met. They also said their own well-being had improved as they were less stressed at work.
● Staff were more visible around the service, in the communal lounge spending time chatting with people and answering the call bells when people rang for assistance. People told us they did not have to wait for staff to come to their assistance when they needed it. The comments we received from people included, "I use my (call) button – they come when I do"; "Staff come within 10 minutes when I press bell" and "If I ask for help – they are there and help."
● Staff continued to be recruited safely. Application forms were completed, interviews were held, and references and proof of id were checked. Disclosure and Barring service (DBS) checks had been completed which helped prevent unsuitable staff from working with people who could be vulnerable.

Systems and processes to safeguard people from the risk of abuse
● All the people we spoke with told us they felt safe and would feel comfortable speaking to staff if they did not.
● People were protected from the risk of abuse. Staff knew how to identify and raise concerns.
● Staff told us the manager was approachable, listened and took action where necessary, so they felt

confident any concerns would be dealt with. A member of staff told us, "When the new manager first came they said they had an open door policy and will always listen – and they have done that. The manager has dealt with things straight away. It's really reassuring." Staff felt sure action would be taken, however, they knew where they could go outside of the organisation to raise concerns if necessary.

● When concerns had been raised these had been dealt with appropriately and reported to the local safeguarding team and the Care Quality Commission (CQC).

Preventing and controlling infection

● Domestic staff were on duty each day to make sure the service was clean and free from odour. People confirmed they were happy with the cleanliness of the service. One person said, "My room is always clean – they do it every day."

● People were protected from the risk of infection. Staff had access to appropriate equipment such as disposable gloves and aprons.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection, although improvements had been made, this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- The manager told us staff training continued to be an area they were working to improve to make sure staff had updated their training.
- Although some staff had kept their training updated, other staff had not. The training matrix showed new staff had not undertaken essential mandatory training. One member of staff had started in post on 12 March 2019 and had only completed two training courses, basic first aid and fire safety awareness. Both courses were undertaken on 21 May 2019, over two months after starting in post. Another new staff member commenced in their position on 12 April 2019 and undertook five training courses in one day, on 22 May 2019. Neither staff member had completed moving and handling training, safeguarding adults training, Mental Capacity Act training or infection control. This meant the provider could not be assured of their ability to make sure people were provided with safe care that supported their basic rights and met their needs.
- Domestic staff had completed very few training courses. The manager told us this group of staff had asked for face to face training as they found online training difficult. However, none of the ten domestic staff on the training matrix had completed manual handling and infection control training. Only one staff had completed first aid training and two of the ten staff had completed health and safety training and Mental Capacity Act training. This meant the provider could not be assured that the staff responsible for the cleanliness of the service had the skills and knowledge to carry out their important role.

The failure to ensure staff received the training and support to continue to provide effective care is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us improvements were being made to training as more staff had been trained to administer people's medicines and new courses were now being planned. Such as a practical moving and handling course. Although staff had not yet completed this, they were aware of the planned date. Most staff welcomed the opportunity to access face to face group training rather than only online training as they felt they could learn more and ask questions.
- The manager had made sure staff had regular one to one meetings and observational checks of their competence. This provided personal support to staff as well as checking their ability and skills, providing constructive feedback where needed.

Adapting service, design, decoration to meet people's needs

- The manager told us bedrooms were freshened up with new paint before new people moved in. However,

many areas of the service needed updating. Some carpets were worn and in need of repair and some furniture was worn and in need of replacement.
● Floor coverings in communal areas did not support some people living with dementia to walk unaided. Carpets were patterned and changed from one carpet design to another, making it difficult for people whose perception was altered. One person was walking back to the lounge from the dining area with a member of staff. They were having difficulty walking, worrying, and asking the member of staff what was on the floor. The member of staff needed to reassure them and show them it was the pattern of the carpet.
● People did not have the choice of a shower, only a bath. The provider told us they were planning a new shower wet room to benefit people living in the service who preferred to have a shower. We spoke to the provider after the inspection, who confirmed work had started on the new shower room and sent photographs as evidence.
● Although some signage to help people to find their way around the service was in place, this was limited. Many rooms did not have a sign or name on, so it was impossible to know if the room was a bedroom, a store room or a bathroom. We asked one person whose room did not have their name displayed if they had chosen not to have this. They said they did not know why they did not have their name on their door.
● People told us they enjoyed going out into the garden when the weather was warm. However, although the warmer months had arrived, the garden was overgrown and not suitable for people to sit out in. The provider explained they had prioritised the work they needed to complete and the garden had therefore taken a back seat. This meant people were missing the opportunity to enjoy the fresh air and sunshine while the weather made this possible.
● Updates and improvements to the premises were an area that needed further improvement at the last inspection, however, improvements had not been made.

The failure to ensure the premises is suitable for the purpose it is being used is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● At the last inspection we found the provider needed to make improvements to the timings of breakfast and lunch. Some people were being offered their breakfast late in the morning and they then found it difficult to eat their lunch, often going without.
● The provider had made improvements by listening to staff suggestions and changing the rota so staff started earlier for the morning shift. This meant they were able to support people to get up earlier and therefore have their breakfast earlier. Those who continued to want to stay in bed later still had this choice. One person told us, "There's no set time to get up. I do need help in the morning."
● People were happy with the food provided. One person said, "The food is very good." We asked people if they enjoyed their food at lunchtime, one person said their choice was, "Lovely."
● People's dietary and nutritional needs were planned for and guidance was clear in individual care plans. One person had a poor and diminishing appetite and ate very little. Their care plan recorded that breakfast was very important to the person as this was the time they ate the most, so staff needed to prioritise this time. The plan advised staff should offer only small meals and encourage desserts if they did not eat their meal, as well as making sure they had access to snacks throughout the day. The person's lunchtime meal was small, and offered on a small plate, they had snacks and drinks around them through the day.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

At our last inspection the provider had failed to keep accurate records of people's health care needs and treatment advice. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

At this inspection we found enough improvement had been made and the provider was no longer in breach of regulation 17 in the key question effective.

● People were supported to access the health care they needed. Records to evidence when people had a health care appointment or had been visited by a healthcare professional had improved. Staff now recorded the advice and treatment given and any further treatment staff needed to support people with. One healthcare professional told us, "This is one of the best homes and they are very efficient."
● When people had a health concern, staff made sure they were referred to the appropriate healthcare professional to get the advice and treatment they needed. One person's records showed they had been visited by a GP, opticians and chiropodists on a regular basis. Where people had a low appetite, referrals had been made to a dietician to gain advice and guidance.
● The medical conditions and concerns people had were recorded in their care plan, with information about each condition to support staff understanding. For example, where people were living with dementia, a description of how this affected people individually was recorded so staff had an understanding and could use the information to provide the appropriate care.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

At our last inspection the provider and registered manager had failed to make sure people's basic rights were upheld within the principles of the MCA. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found improvements had been made and the provider was no longer in breach of regulation 11.

● Appropriate applications had been made when people had been assessed as requiring a DoLS authorisation in their best interests.
● Where people's capacity to make specific decisions was in doubt, a mental capacity assessment had been undertaken to determine if they did have the capacity to make that particular decision. One person's capacity had been assessed to check if they could understand and retain the information to be able to consent to their care. They were assessed as not having the capacity and their care plan was written taking account of their best interests. The manager had involved others who knew the person, such as their relatives, to plan their care.

● Staff had a good understanding of how to support people to make their own choices and decisions, even when this was difficult. One member of staff gave an example of how they supported one person living in the service, "I know (Name) can't make a choice about the tea time meal in the morning, but (they) will in the afternoon, so I go back and ask then."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's care and support needs had been assessed before they moved into Bramblings Residential Home. People confirmed this, one person told us, "We talked about my needs when I moved in and my (Relative) helped."

● Assessments were used to develop each person's care plan and meant the manager could make decisions about the staffing hours and skills needed to support people. This included making sure that support was planned for people's diverse needs, such as their religion, culture, relationships and expressing sexuality.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now improved to good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

At our last inspection, staff did not have time to spend with people, chatting and helping them with their interests. People sitting in the communal lounge were not asked if they needed to use the bathroom throughout the day.

At this inspection, we found this area of concern had improved.

● Staff asked people regularly if they wished to use the bathroom and supported them when needed. Staff were patient and helped people to walk when they were able. One person sitting in the lounge said to staff they wanted to get something from their room. The staff member immediately said, "We can go now if you want." The person was pleased and keen to set off.
● People told us they were happy living at Bramblings Residential Home and thought the staff were good. The comments we received from people about the staff included, "The girls are wonderful, and they do everything as we want it"; The girls are a good crowd, they have a laugh and joke" and "I find them very friendly, happy to have a joke, I find them very nice."
● There were many caring interactions between staff and the people living at Bramblings throughout the day. One person was feeling cold. Staff found a blanket to wrap around them while sitting in the communal lounge. Staff returned regularly to check and ask if they were warming up. Another person became upset about their circumstances. Staff were caring and patient, kneeling down, encouraging them and giving reassurance. Staff kept returning to check the person was feeling better.
● Staff clearly knew people well and enjoyed chatting with them. One person was so pleased to see a staff member, who bent down to speak to them, that their face lit up and they held the staff member's face between their two hands.
● Staff were able to describe people's likes and dislikes and how they liked things done. Discussions with staff corresponded to the guidance given in people's care plans. One person had a favourite drink, and this was recorded in their care plan. Staff told us about their preference and when we visited the person in their room, their favourite drink was next to them on their table and plenty more in stock by the side of their chair.

Supporting people to express their views and be involved in making decisions about their care
● Care plans now gave individual and personal information about people and what was important to them, to help staff to provide their care in the way they wanted. One person loved football and had followed their

favourite team since they were a child. The person was wearing a top displaying their team, showing that staff knew what was important to them by helping them to choose the top.

● People, and their relatives where relevant, had been involved in decisions about how they wanted their care and support provided. The manager had reviewed all care plans since starting in their role. They had discussed the plans with people and asked them to sign to confirm their involvement.

Respecting and promoting people's privacy, dignity and independence

● People told us their privacy and dignity were respected. Staff spoke quietly to people when asking if they wished to use the bathroom, so they could not be overheard. One person said, "They (staff) knock on the door and ask if they can come in, they are all nice. It's fine having my door open."

● A theme of respecting people's independence was clear through people's care plans and our observations during the inspection, where people were encouraged to walk around the service, assisted by staff. One person told us how staff helped them to keep their independence and commented, "I like to do things myself for as long as I possibly can." Another person said, "I walk around the home. I can still walk. I feel safe, I have had a couple of little falls and staff have helped me." A member of staff said, "If people's mobility is declining, we need to help them to do as much as they can for as long as they can, because once they stop, they will never do it again."

● Confidentiality was maintained. Information was locked away as necessary in a secure cupboard or filing cabinets. Computers and electronic devices used by the provider and staff were password protected to keep information secure.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection, although improvements had been made, this key question has remained the same. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Some improvements were needed at the last inspection to increase the range and choice of meaningful activities for people to regularly take part in. No further improvements had been made and this continued to be an area for investment and planning. Activity opportunities to join in were limited and new ideas had not been tried. Choices included bingo, knitting, sewing and quizzes. Not everyone wished to take part and were not offered other choices.

● Although many people we spoke with did not complain about the activities available to them, it was clear by looking at activities schedules and speaking to staff that this had not changed. One person said, "Activities staff offer me things, but they don't excite me." Other people told us they joined in armchair exercises, bingo and quizzes. The manager agreed this was an area that now needed to be prioritised and they said they had spoken with the provider and the activities coordinator to create a plan to ask people for their views and ideas to make improvements.

● There was a consensus amongst the staff that most people did not have enough variety and stimulation to occupy them each day.

We recommend the provider gains appropriate guidance from a reputable source to improve the opportunities of meaningful engagement to meet people's needs and preferences.

● Most people living in the service described themselves as a Christian. Other people did not practice any religion. Lay preachers visited the service regularly to hold a service of Christian prayers, so people could attend if they wished. If people were not able or did not wish to take part in the communal lounge, the lay preachers visited people in their rooms if they requested.

End of life care and support

● At our last inspection, we found end of life care plans needed to be improved as they were basic and included limited information of people's individual wishes for the end of their life. At this inspection, this continued to be a work in progress. Although more information had been sought from some people and their loved ones, the care plans continued to need adding to.

● One person's end of life care plan recorded they were non-religious, in contradiction to other parts of their care plan that said they described themselves as Christian and enjoyed joining in religious ceremonies when they could. The section, 'How I would like to be cared for' was left blank and the name of who had completed the plan or the date of completion had not been documented. This is an area identified as needing further and continued improvement

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the provider had failed to keep accurate records of people's care needs. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found enough improvement had been made and the provider was no longer in breach of regulation 17 in the key question responsive.

● People's care plans had improved and provided more information for staff to follow to make sure people's needs and preferences were met. Personal information, including what and who was important to them and how they liked things done, was clear and detailed. One person had many grandchildren and great grandchildren who were important to them. The names of all their loved ones were recorded. This meant staff had the information they needed to regularly chat to the person about their important relationships, even when they did not always remember.
● Where people had preferences, for instance, where they liked to sit through the day or what time they liked to get up or go to bed, this was recorded in their care plan. Some people became anxious at times through the day, their care plans gave staff individual guidance how to reduce their anxieties. For example, one person sometimes shouted when they were upset and they felt better when offered a cup of tea or supported to go to their room to look at their personal belongings.
● What had been important in a person's life was now included in their care plan, for instance, where they grew up, how many siblings they had and if they married and had children, or had a partner. This meant staff knew individual details about people to strike up a conversation or to understand their needs and preferences better.
● Staff were pleased with the changes and improvements made to care plans since the last inspection. One staff member said, "I did not feel confident before, for example if paramedics came and wanted information and we couldn't find it, which was often the case. That doesn't happen now, so it is a more professional approach. The care plans are more personal with people's history and more about them."

Improving care quality in response to complaints or concerns

At our last inspection, the provider and registered manager had not kept a record of verbal and informal complaints made. We made a recommendation about this. The provider had made improvements.

● Complaints and informal concerns had been recorded with the action taken and the outcome. People and relatives who had made a complaint had received a letter acknowledging their complaint. Following investigation, the findings and action taken was sent to them in a letter.
● One person had complained about their food being cold. The manager had met with kitchen staff to reiterate food must not leave the kitchen until it was ready to be served. The manager had sent a letter to the person who complained to apologise and inform them of the action taken. This meant people were listened to and their complaints taken seriously, with action taken by the manager.
● People told us they would feel comfortable making a complaint if they needed to and said they would speak to staff or the manager. One person said, "They are friendly I wouldn't be frightened to ask. No problems at all."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to

follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's care plans were detailed but written in a way that people could understand, avoiding jargon and written in the first person so people could relate the information to themselves.

● People's communication needs were clearly recorded and guidance for staff so they knew what areas people needed support with. Some people needed hearing aids as they were hard of hearing. Care plans advised staff to speak slowly and clearly, checking people's understanding. Staff checked the batteries regularly to make sure hearing aids continued to work well and appropriate healthcare appointments were made to make sure people's needs continued to be effectively met.

● One person had a sight impairment and staff clearly knew their needs. One member of staff assisted the person to go to the bathroom, using a walking aid to help their independence. The staff member was patient, giving the person clear directions, such as, "Walk a little to the left" and "We are going through the door now."

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection, this key question has now improved to requires improvement. This means the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to keep accurate records of people's care. This was a continuing breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made, including the response to accidents and incidents. However, there continued to be inconsistencies in record keeping and records were not always accurately kept. Further improvement was required, so the provider was still in breach of regulation 17.

● Daily records and checks on peoples' safety had not been consistently kept up to date by staff. Two people used pressure relieving mattresses as they were each assessed as being at high risk of acquiring pressure sores. Their care plans each said the pressure in the mattresses must be checked daily to ensure their continued effectiveness. The daily record stated the mattresses must be checked and recorded daily. The mattress check recording sheets for both people had not been completed daily. One record had not been completed on any day between 22 May and 29 May 2019 and not since 1 June up to the day of inspection, 6 June 2019.
● Some people had a poor appetite and had been visited by a dietician. The manager told us they had introduced new daily recording sheets which include the food people ate, but that people with specific nutritional needs had a separate nutritional chart in their room. One person's care plan said they had a nutritional chart to record the amounts of food eaten and the snacks they had through the day. A nutritional chart was not in place. Staff were recording the person's main meals on the daily record. However, this did not provide the detail needed to keep track of their food and fluid intake, as the daily recording sheet was limited, not intended for people who had specific nutritional needs. For example, snacks were not included. The amount of fluids taken were not recorded. People were at risk of not maintaining their health and well-being through their nutritional intake as records were not accurately kept.

We found no evidence that people had been receiving poor care or had been harmed, however, records had not been accurately kept to evidence people had received the care they needed to maintain their health and well-being. This placed people at risk of harm and poor care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to ensure a robust approach to measuring the quality and safety of the service through successful auditing processes. This was a continuing breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found improvements had been made. However, these were recent improvements and the new monitoring and auditing process had not been tested and embedded to evidence improvements could continue and be sustained.

● The new manager had started a system of reviewing people's care plans to make sure they were current and up to date, with the information needed to provide person centred care and to keep people safe. They had taken on this role themselves until they felt sure staff had the confidence and ability to continue.
● However, only two care plan audits had been completed so far and these had not picked up the areas in people's care plans we found needed to improve, such as individual risk assessments.
● An audit to check infection control procedures were being followed had not been undertaken since August 2018. This meant the provider could not be assured of the safety of the service.
● Health and safety checks had not identified risks found in the environment, for instance, hazardous substances stored with food and doors to unsafe areas left unlocked. Some doors housing unsafe products and equipment did not have a lock and this had gone unnoticed.
● Where safety issues were found during the audit, the action needed to make sure these were addressed had not been recorded. For example, a torn carpet on a flight of stairs was found in March 2019 and recorded as an issue again in April and May 2019. Action taken or planned had not been documented. This meant unsafe areas in the service may remain unsafe as they were not observed and when they were, the necessary action was not followed up.

Although improvements had been made and we found no evidence that people had been receiving poor care or had been harmed, systems had not been sufficiently established to demonstrate quality and safety was effectively managed. This placed people at risk of harm and poor care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the last inspection, the registered manager had left, and the provider had appointed a new manager who had the experience and qualifications to manage the service. Although the new manager was not yet registered with CQC, they had made an application, and this was in progress.
● Senior care staff had taken on a more supervisory role. The increase in staffing levels had meant they could spend time observing the care given and help to eliminate poor practice. The manager had increased the responsibilities of all staff. For instance, care staff had received training to administer medicines and were having their competency checked. This meant they were able to take on this task if senior staff were busy with other priorities, as well as increasing their skills and supporting their personal development. The manager told us this had the added benefit of improving quality and safety, as an increased knowledge base made sure all staff spotted poor practice if they saw it.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Improvements were evident in the developing person centred approach in the service. The new manager had set out to promote an open and transparent culture. Staff confirmed this. The staff we spoke with were well informed about the vision for the service which was now focusing on person centred care, dignity and respect. One member of staff said, "There has been a massive improvement in the last six months. The manager is caring and speaks to people and asks after them." Another staff member commented, "We now

work in prevention rather than cure now. In the time (The manager) has been here, (they) done such a lot, things are much better."

● When things went wrong or there were incidents, the manager had been open and transparent about these and informed relatives, commissioners and CQC as appropriate.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider had not yet undertaken surveys or held meetings with people and relatives to gain their feedback since the last inspection. However, the last inspection had been less than 12 months previously. The manager told us they had prioritised issues around people's safety since coming into post. They planned to hold a meeting with people and their relatives to feed back on the progress of improvements in the near future. Surveys were also planned over the coming months. However, people felt they could raise concerns if they needed to. The comments we received included, "One of the staff comes round and they do a check to see if I am happy – or I can go to the office and talk to (Manager)." A relative said, "The new manager rings up and lets us know any problems."

● The manager had held regular staff meetings since they started in post. They had used these opportunities to start to embed the values of the service and create a culture where staff could raise ideas for improvement and be listened to. Standards of good practice were discussed and the expectations of staff and their responsibilities in providing a safe service.

● Staff were overwhelmingly positive about the new manager and all said they had made many improvements in the short time they had been in post, increasing staff morale. The comments we received from staff included, "All the staff were involved in making improvements after the last inspection"; "(The manager) listens and puts into action. (They) will try to have a solution if staff haven't got one and always tries to resolve an issue"; "(The manager) listens to staff – for example, problems and things, and has time for everyone."

Working in partnership with others

● The manager had engaged with others since commencing in post to make sure they were aware of best practice and to provide a better service to people. These included commissioners of people's care, local authority safeguarding teams, GP's and other health care professionals.

● As the manager was new in post they had not yet attended local provider forums or made contact with local networks to share good practice. However, they had started to make contacts and was planning on attending future meetings.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks were robustly identified and managed to prevent harm. The provider failed to ensure peoples prescribed medicines were managed in a safe way. 12 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure the premises was suitable for the purpose it was being used. 15 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure accurate records were kept. The provider failed to ensure systems were sufficiently established to demonstrate quality and safety was effectively managed. 17 (1)(2)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider failed to ensure staff received the training and support required to provide effective care.

18 (1)(2)