Bramblings (Kent) Limited

Bramblings Residential Home

Inspection report

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14 November 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 13 and 14 November 2018. The inspection was unannounced.

Bramblings Residential Home is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Bramblings Residential Home provides accommodation and support for up to 42 older people. There were 36 people living at the service at the time of our inspection. People had varying care needs. Some people were living with dementia, some people had diabetes or had Parkinson's disease, some people required support with their mobility around the home and others were able to walk around independently.

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

At our last inspection on 21 and 22 November 2017, the service was rated as 'Requires Improvement'. We found breaches of Regulations 9, 11, 12, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to, medicines administration processes were not managed safely; safe systems were not in place to identify and manage individual risks; robust recruitment processes were not used to make sure only suitable staff were employed; the basic principles of the Mental Capacity Act 2005 were not adhered to; effective system were not in operation to identify shortfalls in quality and safety; people's needs and preferences were not met through the care planning and review system; Staff did not receive the appropriate training and supervision to carry out their role.

We took enforcement action against the provider and registered manager and told them they must meet Regulations 12 and 17 by 22 February 2018. At this inspection, improvements had been made to the management of people's prescribed medicines, however the practices used when giving medicines to people were not safe. Risks to people's safety were still not appropriately managed to prevent harm. Although accidents and incidents were suitably recorded, the management of falls continued to be a safety concern. Although some improvements had been made to quality monitoring, these were not robust enough to identify and sustain improvements.

The provider and registered manager sent an action plan dated 4 February 2018 stating they would meet Regulation 18 by May 2018 and Regulations 9, 11 and 19 by August 2018. At this inspection, the provider and registered manager had made improvements in some areas. Recruitment processes were now more robust, records showed safe practices were in place so only suitable staff were employed. Staff were now receiving the training and supervision support to carry out their role in providing care and support to people. However, the protection of people's rights within the basic principles of the Mental Capacity Act 2005 continued to be an issue of concern. Time had been spent on a new care planning system, however, care

plans did not capture and accurately record people's specific and individual needs.

Although the provider and registered manager said they had enough staff to meet people's needs, staff thought there were not enough to meet people's social and emotional needs. Our observations showed this. We have made a recommendation about this.

Some people had their breakfast very late in the morning which meant they were not always able to eat their lunch, placing them at risk of not eating a healthy balanced diet. Their care plan did not record if it was their preference to get up late in the morning. This is an area we found needed improvement.
People's end of life wishes had been recorded, however, some people's care plans did not include the detail needed to make sure people's wishes were known. This is an area that needed further improvement.

No complaints had been logged since the last inspection. When people and their relatives were speaking with us it was clear some concerns had been raised, and although dealt with to people's satisfaction, there was no record of these to make sure lessons could be learnt. We have made a recommendation about this.

Improvements to fire safety measures had been made, including fire alarm testing and fire evacuation drills to keep people safe. All essential maintenance and servicing had been carried out at the appropriate times.

The service was clean and odour free and infection control practices were being used to better effect.

Staff knew their responsibilities in keeping people safe from abuse. Procedures were in place for staff to follow. The provider and registered manager had worked with the local safeguarding team when concerns had been raised.

The provider carried out an initial assessment with people before they moved in to the service and a care plan was developed. People were involved in the assessment, together with their relatives where appropriate.

People were happy with the food and confirmed they had a choice. People were supported to access some healthcare professionals such as GP's when needed. However, some people had not been appropriately referred for appropriate advice and guidance as records had not been maintained and monitored.

People described staff as kind and caring. However, people were left for long periods of time without staff chatting with them or helping them to get involved in their interests. People's dignity was not always respected.
Staff respected people's privacy by knocking before entering their personal bedroom space. People confirmed they were encouraged to maintain their independence.

Activities coordinators helped people to access things to do through the day. There was scope for further improvements and this had been recognised by the provider who was taking action.

People and their relatives found the registered manager and deputy manager to be approachable and available to listen. They felt their views were heard and acted on.

Staff felt supported and confirmed they could speak with the registered manager at any time if they needed to.

The provider had displayed the ratings from the last inspection, in November 2017, in a prominent place so

that people and their visitors were able to see them.
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During this inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. You can see what action we told the provider to take at the back of the full version of this 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?

Inadequate

The service was not safe.

The assessment of individual risk had not been sufficiently considered and recorded.

The practices used when administering medicines did not provide a safe service.

Accidents and incidents were recorded by staff and monitored by the registered manager. The management of falls was not robust enough to prevent repeat incidents.

Staffing numbers did not allow for a holistic approach to people's care and support.

Staff followed safe procedures to control the risk of infection. Robust recruitment practices were now followed.

The provider and staff had a good understanding of how to keep people safe from abuse and their responsibilities to report any concerns.

Fire safety measures were now in place to keep people safe. Servicing of equipment was carried out as appropriate.

Is the service effective?

Requires Improvement

The service was not always effective.

The basic principles in relation to the Mental Capacity Act 2005 were not always followed to make sure people's rights were upheld.

People were supported to eat a balanced diet and were happy with the meals prepared and choices available. More consideration needed to be given to mealtimes so people had suitable intervals between meals.

People's needs were assessed before moving in to the service and care plans developed accordingly.

People had access to advice and guidance from health care professionals although people were not always referred for appropriate support.

Staff received the training they required to make sure they had the knowledge to provide the care and support people were assessed as needing. Staff had the opportunity to have one to one supervision meetings with the management team.

Is the service caring?

Requires Improvement

The service was not always caring.

People thought the staff were kind and caring in their approach. However, staff were not able to spend quality time with people.

Staff did not always treat people with dignity as they were left waiting for care and support.

People were supported to maintain their independence. Staff were aware of people's privacy and respected this.

People could receive visitors when they wanted. Visitors were made to feel welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were in place, however the information required for staff to provide individual care and support was not always accurately recorded.

The recording of verbal complaints in order to learn lessons was an area for improvement.

People were encouraged to make plans for the end of their life if they wished to although these were not sufficiently detailed. Their cultural and spiritual needs were addressed.

People were given the opportunity to take part in some activities. The provider had identified the activities programme needed further enhancement.

Is the service well-led?

Inadequate

The service was not well led.

Opportunities had been missed to make improvements through

the quality audit and monitoring process.

The recording of changes in peoples care and the outcome of reviews was not clearly recorded and acted upon to ensure safe care.

The registered manager did not always work with other agencies to provide people with joined up care.

People thought the management team were approachable and listened to their views. Staff felt they were supported and listened to.

Bramblings Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 13 and 14 November 2018. The inspection was unannounced. The inspection was carried out by two inspectors, an assistant inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we looked at notifications about important events that had taken place in the service which the provider is required to tell us about by law. We also looked at the provider and registered manager's action plans from the previous inspection. We used this information to help us plan our inspection. We did not receive an up to date Provider Information Return before the inspection took place as this inspection was carried out earlier than planned. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with eight people who lived at the service and three relatives, to gain their views and experience of the service provided. We also spoke to the provider, the registered manager and nine staff including the deputy manager and activities staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spent time observing the care provided and the interaction between staff and people in the communal

areas of the service such as the lounges and dining room. We looked at 10 people's care files, medicine administration records, four staff recruitment records as well as staff training and supervision records, the staff rota and staff team meeting minutes. We spent time looking at the provider's records such as; policies and procedures, auditing and monitoring systems, complaints and incident and accident recording systems. We also looked at residents and relatives meeting minutes and surveys.

We asked for some information to be sent to us following the inspection. The provider and registered manager sent this within the timescales requested.

Inadequate

Is the service safe?

Our findings

At our last inspection on the 21 and 22 November 2017 we found a continuing breach of Regulation 12 and a further breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The administration and storage of people's medicines were not safe and monitoring processes were not effective to ensure ongoing safe management. Measures were not in place to mitigate individual risks including falls and pressure area care. Fire safety measures were not robust to make sure staff were confident and competent to protect people in the event of an emergency. Infection control procedures were not robust.

We took enforcement action against the provider and registered manager by serving a warning notice to be compliant with Regulation 12 by 22 February 2018. At this inspection, although some improvement had been made to the processes to monitor the safe management of people's medicines, we found staff did not follow safe practice when they administered people's medicines. There continued to be concerns around the assessment of individual risk and risk management. Infection control procedures and fire safety had improved.

The registered manager sent us an action plan following the inspection detailing what they planned to do to meet Regulation 19 by August 2018. At this inspection, improvements had been made and safe recruitment practices were now followed. Therefore, the breach of Regulation 19 is now met.

People knew what tablets they were taking and told us they were given them when they were due. One person said, "I get my heart tablets every morning, if I have a headache I just ask for Paracetamol" and another person commented, "Without fail I get my medication at breakfast time".

However, people did not always receive their prescribed medicines safely. One person had their breakfast at 10.25am assisted by a member of staff. The member of staff brought the person's medicines in a pot with their breakfast and proceeded to give them their medicines. The morning medicines round had been completed some time earlier, at about 8am. When we checked the person's medicines administration record (MAR) the member of the management team who signed the MAR as having given the medicines and seen the person taking them was not the member of staff who actually gave the tablets to the person. Another person had been given their morning medicines by a member of the management team. The member of staff signed to say the person had taken their medicines. While taking part in the morning activity some time later, at approximately 11am, the person gave their partly chewed tablets to a member of staff, asking what they should do with them. The member of staff took them straight to the registered manager's office. While observing the medicines round at lunchtime, the member of staff responsible for administering medicines signed the MAR before giving people their medicines and on some occasions, they did not watch to make sure people actually took their tablets. Staff did not follow safe practice when administering people's prescribed medicines as set out in the provider's medicines procedure. This placed people at risk of not receiving the treatment they had been prescribed, affecting their health and well-being and of receiving an unsafe service.

One person had been assessed by a speech and language therapist (SaLT) as needing to use a thickener to prevent the risk of choking. 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. It is important only the prescribed amount of thickener is used for each individual to provide the correct consistency to maintain their safety. Thickener powders must be stored safely and appropriately, as with other prescribed medicines, as incidents have been reported where harm has been caused by the accidental swallowing of the powder when it had not been securely stored. Although staff knew the correct procedure for keeping the thickener safely locked away, we found the person's thickener in their unlocked wardrobe, not in a locked cabinet. The person was prescribed four scoops of thickener in 200mls of fluid. The staff we spoke to who added the thickener to the person's drinks were not clear how much the person should have. One staff member started by saying four scoops in 300mls of fluid then changed to 250mls. Although some staff knew the correct amount of four scoops in 200mls of fluid, staff were using different sizes of cups and beakers and adding fours scoops to all sizes. This meant the person's safety was compromised as the drinks could be too thin or too thick.

Some people did not have PRN guidelines in place to advise staff the reasons the medicines could be given, when they should give the medicines, how many could be safely taken in a 24 hour period and what were the side effects to watch out for.

The failure to ensure the safe administration of prescribed medicines is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Individual risk assessments had not been completed in order to mitigate the risks associated with people's specific needs. Risk assessments were missing relating to, for instance, self harm and falls.

A section of one person's care plan detailed that they could become agitated and confused over things and staff needed to be aware of this and report any concerns to senior staff. It also said that the person could threaten self harm. The registered manager told us the person was at risk of self harm. However, neither a care plan or risk assessment was in place to make sure appropriate measures were in place to prevent the risk of the person self harming and provide guidance to staff in giving the right support to keep them safe.

Accidents and incidents were recorded by staff including what happened and if any further action was taken. All the accidents recorded, except one, were falls within the service. A significant number had been reported, 53 between June and November 2018. On 30 October 2018 there had been five falls in one day and on 24 October, three falls. Each person who had fallen had a falls monitoring record in their care plan file. A general falls risk assessment tool was used for each person. The risk assessment tool did not suit the needs of the people who were at risk of falls. Responses of yes or no were given to questions about people's falls history. There were 12 questions staff were expected to answer. The risk assessment tool stated, if more than eight answers of 'yes' had been given, the person should be referred to a specialist falls team. Some boxes stated a yes answer meant a referral to a GP or specialist falls team should be made. No referrals had been made. One person had fallen 15 times since 30 June 2018 yet a referral had not been made to a specialist health care professional, or a record made of why this was not appropriate. Another person had 27 falls in the period from June 2017 to January 2018 and 19 falls between January 2018 and July 2018 and an appropriate referral had not been made for advice and guidance. An individual risk assessment was not developed for people at high risk of falls and who had fallen more than once. This would have given specific advice and guidance to staff about the individual needs of people to keep them safe from harm.

The registered manager monitored the falls every month. They had moved one person to a downstairs room where they could be monitored more closely following a number of falls. Reviews and care documentation

since then stated the person had not fallen since the move. However, the falls monitoring form showed they had suffered three falls since the move to their new bedroom. A risk assessment had not been completed and the care plan had not been adjusted to take this into account. The person had not been referred to a specialist health care professional for advice and guidance to try to prevent falls and the risk of serious injury. Despite the regular monitoring by the registered manager, lessons had still not been learned to prevent falls.

The failure to ensure people were kept safe from harm is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people thought there were enough staff and some thought there wasn't, but all felt they got the care they needed even if they had to wait a short time. The relatives we spoke with thought there were not always enough staff at weekends although they said their loved ones always received the care they needed. Staff told us they did not think there were enough staff at times. They said that sometimes they were short staffed in the afternoon or the night time shift. This meant that sometimes there was only one staff member upstairs while the senior member of staff was giving people their medicines or dealing with other priorities. Staff then had to use the call bell if they needed assistance to provide people's care. We looked at the staff rota and this showed there had been occasional shifts where the full compliment of staff were not on the rota but these were not usual. However, all the staff we spoke with thought they needed one extra staff member on each shift to enable them to provide the person centred care staff thought people needed. Staff told us they prioritised people's personal care needs, but they were not able to spend time with people, chatting or encouraging involvement in hobbies and interests. The provider did not use a dependency tool to calculate and evidence the staffing requirements in the service.

We recommend the provider and registered manager take guidance from a reputable source to find the most appropriate way to determine staffing levels and the deployment of staff within the service.

People and their relatives were very clear they felt safe at Bramblings Residential Home and they knew who they would speak to if they had any concerns. The comments we received from people included, "I feel safe, the staff always pass the door, lovely people, always stop and check to see how we are"; "Staff tend to look after me extremely well. No issue with staff, if I had I would speak with (Deputy manager)." A relative told us, "Yes, (family member) is safe, she is always well looked after. Staff are always checking with her to make sure she is safe."

Staff had a good understanding of their responsibility to protect people from abuse. Guidance and advice for staff about how to report a concern was available through a safeguarding procedure. Staff described how they would raise any worries they had with the registered manager and they were aware of who to contact outside of the organisation if they needed to.

At the last inspection, on 21 and 22 November 2018, robust recruitment processes were not in place. At this inspection, safe recruitment practices were now followed to ensure that staff were suitable to support people living in the service. The provider checked written references and their employment history, employment gaps had been discussed. Disclosure and Barring Service (DBS) criminal records checks had been completed before staff began work at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services.

At the last inspection, improvements were needed to fire safety measures. These areas had now been addressed and improvements made. Each person had a personal emergency evacuation plan (PEEP) to support their safe evacuation in the event of an emergency. Fire alarm tests were now carried out regularly

and fire evacuation drills had been practiced and recorded. All essential works and servicing were carried out at suitable intervals by the appropriate professional services including, fire alarms and equipment; gas safety; electrical safety; lifting equipment; legionella testing.

Staff were employed to manage the laundry. A small building to the side of the service housed the laundry equipment. Laundry staff described how they made sure the correct bags were used to prevent the risk of cross infection. They also took responsibility for making sure people's clothes were properly tagged and delivered clean laundry back to people's rooms. A member of staff had been given the responsibility of infection control champion and they had completed additional training to increase their knowledge. The infection control champion had influenced changes following their training such as how they used the laundry bags for clean and unclean linen and where they were situated.

The service was clean and odour free. Domestic staff were employed to take responsibility for the cleaning tasks around the service. They followed a cleaning schedule which was kept up to date. Personal protective equipment such as disposable gloves and aprons were available and being used by staff when providing personal care. This helped to prevent the spread of infection within the service.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on the 21 and 22 November 2017 we found breaches of Regulations 9, 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's needs had not been fully assessed, creating inconsistency in what was recorded and the care delivered by staff. People's assessments had not been reviewed to take account of their changing needs. There was a lack of understanding of people's rights within the basic principles of the Mental Capacity Act 2005 (MCA 2005), consent was not always appropriately considered and best interest's decisions for those who lacked capacity were not evidenced. Staff had not received suitable training and supervision to enable them to carry out their role.

The registered manager sent us an action plan following the inspection detailing what they planned to do to meet Regulations 9 and 11 by August 2018 and Regulation 18 by May 2018. At this inspection we found that improvements had been made to the assessment and care planning process and the breach of Regulation 9 was now met. Staff had a better understanding of the MCA 2005, however, care plans did not evidence that people's rights were upheld in relation to consent and best interest's decision making. Staff now received suitable training and supervision to carry out their role, therefore the breach of Regulation 18 was now met.

The Mental Capacity Act 2005 (MCA 2005) 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.

Most people had signed their own consent forms agreeing to their care and treatment in the service, or had given verbal consent if unable to sign their name. We were told by the registered manager that many people were living with dementia. Some people's care plans stated they had memory loss or had been diagnosed as living with dementia. A capacity assessment had not been completed for any person living in the service to check if they understood what they were giving their consent to and could retain that information. No best interest's decision making process had been followed or recorded. The registered manager told us about a person who was being asked to make a decision by health and social care professionals. They told us they did not think the person had the capacity to make the decisions asked of them and had spoken to the health and social care professionals about this. A capacity assessment had not been completed with the person to evidence the registered manager's conclusion and to check their capacity to make decisions within the service regarding their care.

One person had a learning disability and did not use speech to communicate, instead they used body language and facial expressions. A capacity assessment carried out by a specialist learning disability nurse in 2013 stated the person did not have the capacity to make decisions around their care and to keep this under review. No further capacity assessments had been completed. The registered manager and deputy manager had completed and signed the person's consent to care and treatment, stating 'in their best interests'. However a capacity assessment had not been completed prior to the decision to sign consent on their behalf and a best interests decision making process had not been recorded to show how the decision

was reached. A record was made in the person's daily records that, 'all entries must state all tasks carried out in (person's name) best interests'. A capacity assessment had not been completed to show that the person did not have the capacity to make their own choices and decisions on a day to day basis. A note was made in the health care professionals visit record on 6 June 2018 that a care manager and a Court of Protection officer visited. No record was made of why they had visited and what the outcome was to keep staff up to date with relevant information.

One person's records had shown they had fallen from a wheelchair. The registered manager told us the person should have been strapped in, as they usually would have been. The person had not signed consent to being strapped into a wheelchair or a capacity assessment and best interests decision had not been taken about this. If the person had not consented, or lacked the capacity to give their consent, this could be seen as a form of restraint if the correct processes had not been considered.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. 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 2005, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. The registered manager had previously made applications for DoLS authorisations although no person was subject to a DoLS at the time of the inspection visit. The registered manager had not kept under review those people for whom an application had been made and turned down in previous years. This meant people's rights may not be taken into account if their circumstances had changed. Staff did not know if people were subject to a DoLS authorisations. When we asked staff they named people who they thought did have a DoLS authorisation when in fact, they did not. This meant that people may not always receive the appropriate care and treatment to maintain their basic rights.

The failure to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005 is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were often referred to healthcare professionals such as GP's or district nurses and a record was kept of their visit or appointment. One person commented, "I have been having pains in my toe and the doctor has been in to check it out for me. Recently I had my flu jab." However, there were times when people had not been appropriately referred for advice and guidance as records had not been maintained and monitored. People's care plans were not updated with the advice and guidance given when they had been seen by a healthcare professional.

One person was admitted to hospital in September 2018 with a serious health condition. No record was made of this episode within their care plan file and had not been included in review meetings as relevant information. The person's monthly weight record showed they had lost a significant amount of weight, 5kgs in one month between August and September 2018. This was not highlighted as a matter of concern and the person was not weighed again for another month, until October 2018, when it remained the same. Staff had not monitored the person's weight more closely to check if the loss of weight was a sign of deteriorating health. Another person's weight record was not added up correctly on more than one occasion and this had not been noticed. For example, one record was made on their weight chart that they had lost 4kgs, when in fact, they had lost 4grms. On 30 July 2018 their weight was recorded as 38.8kgs and on 5 September 2018 as 35kgs. This meant they had lost 3.8kgs; a significant amount when their weight was already low. They were not weighed again for one month, no checks were made in between. On 7 October 2018 their weight was

recorded as 38kgs. This meant a mistake may have been made, or the person may have put the weight back on again within the month. No record had been made that a check had been carried out to make sure the weight was accurate and the person was not at risk of serious health issues. The monthly review of their care plan at the time did not highlight weight concerns, the same record was made as other reviews, saying, 'weight monitored'. Referrals to a healthcare professional such as a GP had not been made in either of these examples.

The failure to ensure people's records were accurately kept and monitored to maintain their health and keep them safe is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we made a recommendation to the provider and registered manager as healthcare notes for individuals were kept in a filing cabinet accessed only by the registered manager and not with people's own care plan files. At this inspection people's healthcare notes were now kept within their care plan file so they could be recorded and updated by staff.

At the last inspection we made a recommendation to the provider and registered manager regarding the length of time between mealtimes as some people had a very late breakfast and were then presented with lunch a short period of time later. At this inspection, this continued. Some people got up quite late in the morning. This meant they were given their breakfast late as breakfast was not served until people got up. One person was served their breakfast at 10.35am. Lunch was served at 12.30pm. Staff placed the person's lunch on a table in front of them in the lounge area. They were falling asleep and did not eat any of their meal. At 1pm staff asked if they were going to eat their lunch but the person didn't respond. No further encouragement was given and their meal was taken away untouched at 1.05pm. The person was offered a dessert and they ate this. Another person's nutrition care plan said they needed a high calorie, high protein diet as they had low weight and needed encouragement to eat their meals. Their care plan said the person sat in the lounge for their meals to enable staff to give plenty of encouragement. However, we did not see any encouragement by staff until their meal had been taken away and their dessert was served. This was not as described in their care plan. Other people did not eat their lunch, a staff member said most would eat their dessert though so they were not worried. However, this meant people may not get a healthy balanced diet. At the last inspection, on 21 and 22 November 2017 we made a recommendation to the provider and registered manager regarding some people having breakfast and lunch close together. At this inspection we found similar practice with a similar outcome of people not always eating their lunch. This is an area that continues to need improvement.

Kitchen staff spoke to each person every morning to ask what they would like for lunch and tea that day, giving them two choices. People were happy with the food and told us they could make choices. They could choose whether to eat in the dining room, the lounge or their bedroom. One person said, "Staff know me well, I have just started having my lunch in my bedroom, staff check with me if I want to go down to the dining room." A relative commented, "He loves eating, eats very well. He is very satisfied with what he gets." Some people needed special diets such as low sugar, high protein or softened. Kitchen staff were aware of people's dietary needs and were kept updated if their circumstances changed.

The premises was not suitable for people living with dementia or who had memory loss to easily get around and find their bearings. Some bedroom doors did not have people's names on, or a photograph to identify whose room it was and many bedroom doors also did not have numbers on them. There were few signs to direct people which direction they needed to go to find the lounge area, the dining room, the bathroom or their bedroom. We spoke with the provider and registered manager about this. The provider contacted us after the inspection visit to tell us of their plans to increase the use of suitable signs and had already started

to order these.

People told us they felt staff were able to meet their needs and they were able to direct their care and support. The comments we received included, "Before I go to bed I get my clothes out ready for the next day, when I wake up I buzz for the staff, they come and help me with my shower, and help me put on my clothes"; "I prefer being washed rather than having a shower. I find the girls are gentle when they wash me." A relative told us, "He always looks well cared for, people who visit him always comment that he looks good."

People's needs were now assessed to plan their care. People told us they were involved in their initial assessment before moving in to the service. People's relatives were also involved where appropriate. One person told us, "The manager came and did an assessment with me. I was asked about what I liked to do and about my family and what help I wanted from the staff." The assessment covered the person's needs in relation to their, personal care; nutrition; mobility; elimination and social and religious. The assessment identified what support was needed and this was used to develop the care plan. This enabled the registered manager to make an informed decision that the staff team had the skills and experience necessary to support people with their assessed needs.

Staff told us they shadowed more experienced members of staff for four shifts when they first started in their role, although this could be more if needed by an individual staff member. This helped them to get to know people and how they liked things done. Staff told us this helped them to feel supported and confident in their new role.

Staff told us they had sufficient training to carry out their role and to give them the knowledge they needed to feel confident. Staff who had worked at the service since before the last inspection told us the training had improved and they had access to more than they previously had. Staff gave examples of training they had recently completed, such as MCA 2005 and infection control, and confirmed they now have a better understanding.

Senior care staff had been given lead roles in various subjects so they could support good practice and be a role model for the staff team. Each had received extra training in their field to increase their knowledge and confidence. Lead roles included, infection control, moving and handling and end of life care. The staff we spoke with who had been given these roles spoke with pride and confidence about their new responsibility.

Staff had received one to one supervision with one of the management team to support them in their role and to plan their personal development. Staff were also observed carrying out their everyday practice such as carrying out personal care and administering medicines; these checks had been incorporated in the personal one to one meetings held.

Requires Improvement

Is the service caring?

Our findings

People and their relatives were complimentary and positive about the staff who provided their care. The comments people made included, "Staff have to be caring to do this job. I have plenty of banter with the staff. If I feel a bit low they pop in more often to check how I am"; "Always happy, in the morning always check if we are alright. Very good at noticing if you are off colour. We are well looked after"; "They (staff) are so easy to talk to, they have remarked on all my pictures on my wall and asked which ones are family." A relative told us, "The girls are nice. When he gets frustrated trying to communicate the girls give him the time and don't rush him"; "They (staff) talk to him as an individual, always with a smile on their face"; "I am always made welcome. Most of them know me by my first name. They always ask me what I plan to do with mum today and it's genuine interest."

Although this was the feedback we got from people and their relatives, we saw that staff did not have time to spend sitting and chatting with people or helping them to follow their interests when they were sitting in the communal lounge or in their bedrooms. Although staff were friendly and chatted to people as they walked through, interactions were mainly task orientated. Four people were sitting in the lounge all day and staff did not come in to sit and have a chat with them through the day. The activities coordinators did not engage any of the four people in activities. A DVD of musicals was set up on the television in the afternoon. People were asked if they liked musicals, one person responded by pulling a face. The staff member said, "Oh, you don't like musicals?" The person pulled a face again and the other three people did not/were not able to respond. The staff member continued to set up the musical DVD saying, "You can't please everyone." The music DVD was left on very loud and staff left the lounge area.

People's dignity was not always respected. One person tried to get out of their chair at 2.10pm, pushing their lap table out of the way and spilling their cup of drink on the floor. Staff were not available to provide assistance, so we went to get a member of staff. The staff member who responded realised the music was on too loud and turned it down, 35 minutes after it was put on. The person wanted to go the bathroom, they were unable to do this independently. Staff assisted them to mobilise out of the chair using the hoist. Three of the four people, including this person, in the lounge area, had not been asked all morning to this point if they wanted to go to the bathroom. Staff still did not ask the other two people if they wished to use the bathroom at this time. At 2.47pm another person in the lounge called for help to go to the toilet and said it was too late when staff came to help. Staff took the person to the bathroom.

The TV was on in the lounge earlier in the day when Christmas films were played all morning. The people sitting in the lounge did not show any interest in the films and no staff chatted about the films or encouraged discussion.

Staff knew people and were able to describe how they preferred to be supported and their likes and dislikes. We saw some caring exchanges from staff to people, although brief and irregular. Staff had a quick chat with people in the lounge area when they could, asking if they were OK. A kitchen assistant brought a magazine for one person, placing it in front of them, letting the person know it was there and that it was a favourite, however, staff did not encourage the person to read it.

Staff encouraged people to be independent and people valued this. Some people were walking around the service independently. One person told us they liked to be busy as they got bored. They helped the staff with the clean laundry by folding all the laundry items once they were washed and dried. The person said, "I am quite independent and can manage most things for myself. I know if I need help I can ask one of the staff, actually I prefer helping them, I am the expert folder in the laundry." Another person told us how they were helped to remain as independent as possible, "Staff know I like to be independent, they make sure my frame is by my bed so I can reach it if I want to get up during the night." A staff member said, "The staff here work hard to make sure the residents are comfortable and well cared for."

People told us that staff respected their privacy. For instance, staff knocked on people's bedroom doors and waited for a reply before entering and addressed them with respect. The comments we received included, "Staff are all friendly and polite, they treat us as if we are family" and "Staff talk to me as an adult, we talk about things in general and what is happening in the world." A relative said, "Mum is always treated with dignity and respect, never seen any soiled bedding and always looks fresh."

People were supported to maintain as much contact with their friends and family as they wanted. Relatives and visitors told us they felt welcomed when visiting and there were no restrictions on what times visitors could call. Relatives told us, "Staff always appear pleased to see me, today when I arrived I was told he was joining in the exercise class and asked if I would like to join in the class with him" and "We took (my relative) out for lunch today and when it's his birthday the whole family are coming in and having a Chinese with him in his room."

Information about people was treated confidentially. The provider, registered manager and deputy manager were aware of the new General Data Protection Regulation (GDPR); this is the new law regulating how companies protect people's personal information. People's care records and files containing information about staff were held securely in locked cabinets or offices. Computers were password protected.

The provider had a comprehensive service guide which set out all the information people and their relatives would need before moving into the service. Information such as how to make a complaint and what services people could expect to find which helped to answer any questions they may have.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on the 21 and 22 November 2017 we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A person centred approach was not taken to providing care that took account of people's changing needs and preferences, including their interests and cultural and spiritual needs. The activities that took place and details of who had the opportunity to join in with activities was not clear as records were not accurately kept.

The registered manager sent us an action plan following the inspection detailing what they planned to do to meet Regulation 9 by August 2018. At this inspection, the provider and registered manager had made changes to try to improve the care planning system and activities were improving. Regulation 9 was now met, however the new care plans did not accurately record people's individual care needs and wishes.

People's care plans were basic with limited information about people's needs, or their individual preferences, and how they wanted staff to support them. Care plans covered the same areas of care and support for each person, personal care; nutrition; mobility; elimination; risk assessments; social and religious and special considerations – to capture the individual areas of need. One person's mobility care plan simply stated, 'Varying levels. Walks with rollator'. The person was known to be at high risk of falls. The special considerations care plan recorded, 'Sometimes tries to walk without rollator – staff to be aware'. However, no further guidance or instruction was given to staff how to respond when the person did walk without their rollator and if a risk assessment had been completed to help keep the person safe. Another person's medical record showed they suffered from depression. Advice and guidance was not available for staff to describe how this affected the person and what was the best approach to take if they were having difficulties. One member of staff told us about the person's depression and how this affected them. They said this was becoming more of an issue and they tried to provide support but were unsure what else they could do. How people's health conditions affected them personally and how this changed over time were not addressed within their records. An individual care plan was not in place to take this into account.

One person had hearing aids in both ears. They were concerned about them during our visit and said their ears did not feel comfortable. A record was made in their communication care plan that they had two hearing aids. However, no further information was given regarding the cleaning and maintenance of them, if the person managed this themselves, if they needed the assistance of staff, or who was responsible for changing batteries to make sure they continued to work well. The person's daily records also made no reference to the hearing aids and how the person was managing with them or if assistance had been given. People's care plan records did not document the person centred detail to make sure the care and support people needed to maintain their health and well-being was understood and provided by staff.

The failure to ensure accurate and contemporaneous records about people's assessed needs and the care they needed from staff was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A 'life profile' provided some personal information about people, such as who is important to them;

children and grandchildren for example. What is important was also recorded, covering the areas of their care plan, for example to be pain free and to maintain personal hygiene. Very little information about some people's life history was recorded, for example, if they had worked, where they were born and where they had lived and what their hobbies and interests were.

Three activities coordinators were employed on a part time basis to cover the week. One of the activities coordinator's, who worked three days a week had been working in the service for four months and told us they were still getting to know people and what they enjoyed. People enjoyed the armchair exercises in the morning although not everyone wanted to join in. Bingo in the afternoon was better attended and people enjoyed playing bingo twice a week. The coordinator did arts and crafts with some people and had helped people to create poppies in remembrance of world war one which were displayed on the wall near the front entrance. An activities plan for the week or coming month was not displayed or given to people so they could choose and plan their days in advance or give their own ideas. The coordinator told us they planned to do this and was going to request the purchase of a notice board to advertise plans and events. They said the provider was supportive of ideas and had provided the materials for raised garden beds when this was suggested.

Another activities coordinator who worked in the role one day a week, spent time with people on that day knitting. Three people regularly attended with others joining if they wished. The group had made blankets that were sent to dog kennels as comfort blankets for the animals. Some people enjoyed making pom-poms which were put to various uses – including blankets. The activities coordinator told us about people who had very stiff fingers and once they had been knitting more often, they found they could use their hands far better. People played cards together; a group of up to eight some afternoons. Similar activities took place most days. Some people did occasionally have the opportunity to go out shopping or for lunch. For example, on 30 October 2018 two people went shopping to a local shopping centre supported by the activities coordinator.

Staff thought people did not have enough meaningful activities, particularly one to one sessions with people who stayed in their rooms or who were less able to join in a group. The provider told us they had identified through their audits that the activity programme needed improvement. They had recently held a meeting to discuss the way forward and to encourage ideas and plans.

People had an end of life care plan. One person told us, "When I first came I was asked what I wanted and my wishes are held in my file." One staff member told us how important their role was, "I believe it is important to give the residents the best possible care at the end of their life and it gives me a lot of job satisfaction to know that I have been able to make their last days comfortable." However, the end of life care plans gave basic information with limited detail of people's wishes. The care plan was not dated so it was not clear how current the information was or if it had been updated. This is an area identified as needing improvement.

People were able to walk around the home and garden without restrictions and use the lift to go from one floor to another. A lounge was available for use on the ground floor and the first floor. One person told us, "I like walking around and say hello to everyone, making myself a nuisance." Another person said, "I like reading, sometimes when it's warm I will sit outside all day reading and watching the birds and rabbits. One of the staff helped me plant some bulbs in the planter. I'll walk up and down to the end of the drive which is far enough for me."

Staff told us the people living in the service either described themselves as Christian or did not follow a religion. A Christian service was held in the lounge for those people who wanted to join in. Staff told us this

service was held once a month. One person commented, "I am able to join in the communion service held in the lounge downstairs" and another person said, "I go to the church with my family." One person's relative told us, "Our own vicar came and held mass for (relative)."

The registered manager told us they had not received any complaints since the last inspection, either formal written complaints or verbal and informal concerns. People and their relatives told us they had no reason to complain as they were happy with the service they received and if they had raised a concern it had been listened to. People felt confident if they made a complaint they would be listened to. The comments we received included, "No complaints, just grumbles. I complained about the food at the residents meeting saying we didn't get much of a selection, we now get a better variety. The manager does listen to our views"; "No complaints for us, the staff keep an eye on us. I won't hear a word against anyone here" and "I did complain that my mattress felt a bit lumpy and it was changed straight away." A relative shared that they had spoken to the registered manager, "If I have a complaint I speak to the manager. I did say that there wasn't enough stimulation for (family member). Now they have a new activity person in place, more things are happening. (Family member) is enjoying the exercise classes." Some informal complaints had been made. The registered manager and staff had not recorded them and the action taken to improve.

We recommend the provider and registered manager captures informal and verbal concerns in order to monitor action taken and lessons learnt.

Inadequate

Is the service well-led?

Our findings

At our last inspection on the 21 and 22 November 2017 we found a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Monitoring processes were not effective in identifying the areas of concern within the service.

We took enforcement action against the provider and registered manager by serving a warning notice to be compliant with Regulation 17 by 22 February 2018. At this inspection we found the provider and registered manager had made changes and some improvements to the monitoring and auditing of quality and safety in the service. However, the many areas of concern we found during inspection had not been identified and acted upon. Further improvement was needed to make sure compliance with regulations was effective and sustainable.

The provider and registered manager had introduced a system to monitor the quality and safety of the service. The provider was now more involved in the monitoring process, giving them greater oversight. A range of audits were completed including, health and safety; falls; accidents and incidents; care plans; staff files and medicines. Although audits were completed regularly and action plans developed to make improvements, the areas of concern we found during this inspection were not identified and dealt with in a robust manner to ensure the continued safety and quality of the service.

The provider and registered manager had developed the care plan audits since the last inspection to incorporate a wider check of people's documentation. Care plan audits were completed monthly by a member of the management team. Many audits stated, 'Audit criteria met'. Other months the audit recorded, 'care plan due'. The registered manager and deputy manager told us they gave the staff member responsible for the care plan three shifts to complete any action needed. However, it was clear the audits were a document checking exercise so they did not pick up the areas of concern regarding the quality of the care plans found during our visit. For example, the audit checked to see if standard risk assessments were in place and did not highlight where individual risk assessments were needed. Checks to make sure care plans were accurate and addressed people's specific and individual needs were not carried out.

Medicines audits had improved considerably. The registered manager carried out an audit once a week and then at random through the week. The deputy manager told us they also audited the medicines whenever they were on duty to administer medicines, following up on any issues found as they did this. When we checked a random selection of medicines we found no discrepancies and actions from audits had been followed up. However, we found serious concerns with the practice of medicines administration as previously described which meant safe procedures were not followed.

The failure to ensure a robust approach to measuring the quality and safety of the service through a successful auditing process is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager monitored accidents and incidents every month. They checked for themes such as

the time of day falls occurred or the area of the service where people fell. The registered manager had made some changes as a result of monitoring. For instance, they moved one person to a downstairs room where staff were more likely to see them by walking past their room more often. The person had three more falls since moving into their new room in early October 2018 and no further action had been taken, such as updating the care plan and risk assessment to try to prevent further falls. Some people were independently mobile and there continued to be a high number of falls in the service. An emphasis on prevention had not been established to try to improve safety.

People's records were not always accurately documented to make sure people received a safe and good quality service by clear communication and guidance. One person had two accidents in the space of two days. The person had fallen in their bedroom unwitnessed on 24 September 2018 and the accident record showed they had a bruise and skin tear on their arm following this with a swollen right finger and bleeding under their finger nail. The next day the person had an accident where they fell out of a wheelchair when being pushed down a small ramp by a member of staff. The accident record said their hand was red but no visible injuries. The next day, on 26 September 2018 the person's hand was swollen and bruised. A record by staff in the professionals visit record said the person had been to hospital and was found to have a fracture to their hand. It was not clear which accident the injury was a result of as no further record was made. We asked the registered manager about this who told us the injury had happened as a result of the accident in the wheelchair. They said they had contacted the GP for advice on 26 September when the person's hand was swollen. The GP had sent the person to hospital for an x-ray. The registered manager told us the person had a dislocation, not a fracture, stating the record in the care file was incorrect. No record was made of this sequence of events in the daily records, care plans and risk assessments had not been updated as a result of the fall from the wheelchair.

The failure to ensure people's records are accurately maintained and monitored is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager worked in partnership with some agencies to provide people with a joined-up delivery of care. For example, they had a good relationship with the local GP who visited the service and contact was maintained with commissioners who funded some peoples' care. However, as described earlier in this report, referrals had not been made to some specialist services to gain advice to keep people safe. The registered manager did not attend any local forums to gather information and meet staff from other agencies and services.

People and their relatives thought the service was well run and the management team were approachable. People commented, "I have been given the October newsletter with what is going on and what is happening at Christmas. We are kept well informed"; "The manager always listens to what I have to say and will help me if they can. I am quite happy here" and "The manager keeps an eye on everything. We have a lovely decorated room and everywhere is kept well maintained." People's relatives were equally happy with the management of the service, "(Registered manager) is friendly and easy to talk to. She takes time to chat"; "I like the manager, she is particularly good at listening and is sympathetic. I respect her honesty, she doesn't try to hide anything. I have read the last CQC report and I am sure that the manager has changed some of the processes for staff when they are recording the care they give" and "Overall it is well managed. Mum's room and bathroom are spotless and the garden is beautiful."

The provider asked for people and their relatives views of the service through an annual survey. The registered manager fed back the results and any themes through a newsletter. The most recent survey showed that some people thought not all staff were trained sufficiently. The registered manager responded to this concern through the newsletter, advising what was in place for staff training. People also had the

opportunity to give their views through occasional meetings. The last meeting was held in April 2018 and another was planned. The meetings were themed, the last meeting was held to discuss food and menu choices. Changes were made to menus as a result.

Staff said the management team were supportive and listened to their ideas and concerns. The comments staff made included, "I would be happy to speak to the registered manager or the deputy manager if I needed to and I think they would deal with any concerns I had"; "Managers are approachable, I could speak to them about anything and they would listen and deal with it"; "I have found the staff very helpful and I feel comfortable talking to the other care staff, senior staff and the deputy manager. Everyone here has been very supportive" and "If we do have any concerns we can go to the office if we need to talk."

The registered manager had been in post since before the last inspection so knew the service well. The provider and the registered manager understood that they were required to submit information to the Care Quality Commission (CQC) when reportable incidents had occurred. For example, when a person had died or had an accident. All incidents had been reported correctly and without delay.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating in the reception area of the service.

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 11 HSCA RA Regulations 2014 Need for consent The provider and registered manager failed to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005. Regulation (11) (1)(2)(3)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager failed to ensure the safe administration of medicines and that individual risks were mitigated to prevent harm. Regulation 12(1)(2)

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager failed to ensure records were accurately maintained and quality and monitoring processes were effective in identifying areas to improve. Regulation 17(1)(2)

The enforcement action we took:

We imposed conditions on the provider's registration.