Care Quality Commission

Virgin Mary Ltd

Bramber Nursing Home Ltd

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires Improvement
Is the service effective?	Inadequate
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

Bramber Nursing Home provides nursing, personal care and accommodation for up to 21 older people living with dementia. There were 13 people living at the home during the inspection and all required assistance with looking after themselves, including personal care and moving around the home.

At the time of this inspection the local authority had an embargo on admissions to the home pending the outcome of on-going safeguarding investigations. At the last inspection 9 June 2014 we asked the provider to make improvements for respecting and involving people who use services; care and welfare of people who use the service and records. The provider sent us an action plan stating they would have addressed all of these concerns by December 2014.

This inspection took place on 27 January and 6 February 2015 and was unannounced

The home has been without a registered manager since August 2013. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal

Summary of findings

responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A registered nurse was managing the home during the inspection. They told us they were applying to register with CQC as the registered manager of the home. The appointee manager was present on the first day of the inspection. Staff had difficulty contacting management on the second day of the inspection, and the manager was unable to attend. Staff said they did not always feel supported by the management of the home and relatives told us there was no management oversight or leadership at the home.

A generic safeguarding policy was in place to protect people, but the provider had not followed this, referrals to the local authority had not been made and CQC had not been notified of allegations. People may not have been protected, as far as possible from abuse.

Care plans did not show person centred care was provided, and as part of the care planning process risk assessments had been completed, but they had not been regularly reviewed and updated when people's needs changed. This meant people may not have received the support and care they needed.

Food and fluid charts, used to record how much people had to eat and drink, were not completed appropriately. Therefore, staff were unable to evidence people received a nutritious diet, suitable to the needs.

People had access to healthcare professionals and staff said they visited the home when required. However, these visits were not always recorded, so there was no clear evidence to support staff comments.

There were systems in place for the management of medicines, but nurses did not follow always follow up to date guidance regarding record keeping. People may have been at risk of not receiving their prescribed medication.

There were not always enough staff to meet people's needs and there was no system in place to determine appropriate staffing levels. This meant people had to wait for staff to assist them.

Not all staff had received up to date training, such as safeguarding, supporting people with dementia, moving and handling and infection control. People may not have received care and support based on current guidance.

A complaints procedure was in place. However, some relatives felt the management did not listen to their concerns and felt appropriate action may not be taken.

Staff did not feel they had opportunities to meet regularly and discuss or improve the support provided, because if this they felt management may not address concerns they might have.

There was no clear system in place to monitor and assess the quality of the service provided. Areas for improvement were not identified and appropriate action was not taken to improve the service.

People said they were comfortable and relatives felt people were safe, and relatives and friends could visit at any time and were made to feel very welcome.

People thought the staff looked after them and relatives thought the care staff were very good. Staff understood people's specific needs and treated people with respect and protected their dignity when supporting them. We saw a range of activities were provided and people enjoyed spending time with staff.

Pre-employment checks for staff were completed, which meant that only suitable staff were working in the home.

Staff had knowledge of the Mental Capacity Act 2008. Not all staff had attended training and mental capacity assessments were not up to date, although staff had a good understanding of people's capacity to make decisions about their care.

Mobility aids were available for staff to assist people to move around the home safely, and we observed staff using these. The home was clean and some rooms had been redecorated, with the involvement of people and their relatives.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 consistently safe.

The provider had not taken appropriate action to address safeguarding concerns, but staff knew how to keep people safe and protect them from abuse.

Risk assessments were in place, but they had not been reviewed and updated to reflect people's needs.

The staffing levels had not been reviewed and there was no evidence that they were appropriate to meet people's needs. Recruitment checks were completed to help ensure that suitable staff were working in the home.

The system for the management of medicines was in place, but nurses were not following it consistently.

Is the service effective?

Inadequate

The service was not always effective.

Staff had not received up to date training to make sure that people were receiving the care and support they needed.

People were provided with food and drink which supported them to maintain a healthy diet. However, the records did not reflect this.

Staff ensured people had access to healthcare professionals when they needed it, but did not always record these in the care plans.

Staff were aware of the Mental Capacity Act 2005 and understood people's capacity to make some decisions.

Is the service caring?

Good

The service was caring.

People were treated with kindness, they were respected and their dignity was protected when staff provided personal support.

The atmosphere in the home was calm and staff knew people very well.

The support staff provided ensured that people's equality and diversity needs were respected.

Relatives were able to visit at any time, and were made to feel very welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were not always assessed, reviewed and updated as their needs changed.

Summary of findings

People were given information how to raise concern or make a complaint, but some relatives felt the provider did not take their concerns seriously

A number of different activities were provided, depending on people's choices.

Staff said they addressed people's concerns at the time they were raised, and referred relatives to the nurse or manager if they had issues.

Is the service well-led?

Inadequate 

The service was not well led. The home was without a registered manager and there was a lack of clear leadership and direction.

Staff did not have the opportunity to meet regularly and did not feel supported by the management.

Relatives said the home had no management oversight or leadership.

There was not a robust system in place to assess the quality of service provision.

Notifications had not always been reported appropriately or in a timely manner.

Bramber Nursing Home Ltd

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 checked 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.

On 1 April 2015 the Care Act 2014 came into force. To accommodate the introduction of this new Legislation there is a short transition period. Therefore within this inspection report two sets of Regulations are referred to. These are, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. All new inspections will only be completed against the new Regulations - The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The inspection took place on the 27 January and 6 February 2015 and was unannounced. The inspection team consisted of one inspector and an inspection manager.

Before the inspection we looked at information provided by the local authority, contracts and purchasing (quality monitoring team) and safeguarding investigations. We also looked at information we hold about the home including previous reports, notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with all of the people living at the home, five staff, four relatives, the appointee manager and the provider. We observed staff providing support and care, such as assisting people around the home and helping people with their food and drink.

Some of the people who lived in the home were unable to verbally share with us their experience of life at the home because of their dementia needs. Therefore we sent a large amount of time during our inspection observing the interaction between staff and people, and we watched how people were being cared for in communal areas.

We viewed a range of documents including three care plans, food and fluid charts, four staff files, training information, medicine records, minutes of meetings with staff, menu's and some policies and procedures in relation to the running of the home.

On this occasion the provider had not been asked to complete a Provider Information Return (PIR) by CQC. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because the inspection was bought forward due to the need to follow up on previous concerns.

Requires Improvement

Is the service safe?

Our findings

People told us they were comfortable and relatives of people we spoke with said they felt people were safe at the home. One person said they liked sitting in the lounge, "To see what is going on." One relative said, "The staff are very good. They know how to look after people and keep them comfortable."

Staff demonstrated a good understanding of different types of abuse and the action they would take if they had any concerns. Three of the four staff said they had attended training in safeguarding people, although they did not recall when this was. We looked at the records for safeguarding training; they showed that 12 of the 24 staff listed had not attended this training. On staff member said, "I know what to look out for and if I saw anything I would deal with it at the time and also report it." However, staff were unsure if action would be taken if they raised concerns with the management. Three staff said they did not know what to do if action was not taken by management; that is they did not know about referring concerns to external agencies, which meant they may not be addressed.

People may not have been protected, as far as possible, from abuse. The provider had failed to make safeguarding referrals to the local authority and had not notified CQC of any concerns. The home's safeguarding policy and Sussex Multi- Agency Policy and Procedures for Safeguarding Adults at Risk stated concerns should be referred to external agencies. The provider had not followed their own or Sussex Multi-Agency Policy. If concerns are not reported they could not be investigated, and actions identified to further safeguard people would not be put in place.

The provider had not ensured that people were safeguarded against the risks of abuse. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulate Activities) Regulations 2014).

There was not always enough staff at peak times to ensure people's needs could be met. Staff told us there were enough staff working in the home. They said they were able to look after people and provide the care and support they needed. One staff member said, "There are 13 people living here at the moment and there are enough of us. If more people move in I think we will need more staff." However, during lunch time there were only three staff in the lounge area, and we observed one staff member supporting three people to eat their meal at the same time. This did not enable the level of support needed and resulted in one person leaving their meal. We saw three people's meals were interrupted while staff needed to support other people with either their personal care or to prevent them becoming anxious. One person was supported by three different staff members during the course of their meal, which did not promote orientation and confidence for this person.

There was no evidence that people's needs were taken into account when determining staffing levels. The staffing levels were not flexible and had not been reviewed to ensure that staff could meet people's needs. There were times when there were no staff in the lounge, where the majority of people were seated during the day. One staff member was responsible for re-heating food or providing sandwiches and cold snacks for the evening meal, and other staff were assisting people who were in their rooms. There were no staff in the lounge for long periods, which meant people were at risk of falling if they stood up to leave the lounge. One relative said, "We know the staff are very busy at times. They do their best, but sometimes we have to stop people getting up so they don't fall." Another relative told us, "The staff are very good, I think there are enough, people always look very clean and comfortable."

The provider had not safeguarded the health, safety and welfare of people living in the home by ensuring there were sufficient numbers of suitably qualified staff. This was breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, (which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014).

Systems for recording, responding to and preventing people falling need to be improved. All care plans included risk assessments, which were specific to each person. These included the risk of people falling and there were some preventive measures in the care plans. However, these had not been reviewed and updated as people's needs had changed. One person had had four falls at different times of the day in their room. These had not been recorded in the relevant part of the care plan; action had not been taken to prevent re-occurrence and there was no evidence that a referral had been made to the falls team.

Requires Improvement

Is the service safe?

Systems for auditing Medicine Administration Records (MAR) need to be improved. The nurse told us that the nurse responsible for each shift checked the MAR when they administered medicines. The nurse said, "If there are any gaps we leave a note for the previous nurse and when they are back on duty they sign the chart." A gap means that the nurse responsible for the medicines had not signed the MAR to show if the medicine had been administered or not. The nurse said, "It could be couple of days or more", before the nurse who had not completed the MAR was informed. We looked at the staff meeting minutes of 21 January 2015 it stated, 'MAR charts to be checked after each drug round and any omissions to be amended'. Nurses were not following the Nursing and Midwifery (NMC) Code of Conduct, which requires nurses to, 'complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event'. This meant that people may not have been given their prescribed medicines, which left them at risk of harm from inappropriate treatment.

We observed medicines being administered. The nurse wore a red tabard, which stated do not disturb, so that staff and visitors knew they were administrating medicines and was not to be disturbed. The medicine trolley was kept in the locked clinical room and was wheeled around the home as medicines were administered. People were asked if they needed anything for pain, which was an 'as required' (PRN) medicine. Polices were in place for the administration of PRN medicines and staff recorded those given, and the reason why, in the correct part of the MAR chart. All MAR charts were up to date, completed fully and signed by trained staff. Medicines were stored and ordered correctly. Medicines were kept in a fridge when appropriate and the temperature of the fridge was checked each day. One member of staff was responsible for ordering stocks of medicines.

Recruitment procedures were in place and there was evidence in the staff files these had been followed, to ensure the provider employed people who were suitable to work at the home. The documentation included completed application forms, employment history, interview records and Disclosure and Barring System (police) checks. Two references had been obtained for all staff. However, two character references had been obtained for one staff member, which meant that there was no professional employment reference for this person. The manager said this would be addressed immediately.

We observed equipment, such as hoists, walking frames and pressure relieving devices were used to protect people, and risk assessments in care plans identified the aid staff used for each person. Relatives said hoists were used by two members of staff, but one relative said, "Staff don't always use the hoist and aids like they should. It is quicker for them if they don't and it depends on which staff are working." We saw staff used appropriate equipment and spoke with people explaining what they were doing, so they were aware what was happening, when they transferred them to and from the lounge. One person used a specific aid to walk with assistance to the bathroom. Relatives told us they had never seen it before. Staff said it was used by one person only when they walked to the bathroom from the lounge, because it was a short distance. When they assisted the person to their bedroom they used a wheelchair because it was too far for them to walk, and they would have been at risk of falling.

The provider had plans in place to deal with an emergency. There was guidance for staff on what action to take and an evacuation plan to move people to ensure their safety, if they had to leave the home at short notice.

The home was clean and some of the rooms had been recently decorated in consultation with people and their relatives. The manager said checks were carried out for electricity and gas, call bells and electrical appliances, and there was ongoing maintenance of the home. However, the paperwork to support this was not available at the time of the inspection.

The manager told us improvements planned for the home included a new carpets and redecoration of the corridors. We found that the carpet in the downstairs corridor was frayed. Tape had been applied across the carpet, but we noted the tape did not keep the frayed edges of the carpet secure. This meant people walking along the corridor may be at risk of falling.

People sat in the lounge for most of the day and staff told us the lounge was full when the 12 people who used the lounge were there. The seating was arranged along the walls of the lounge area and when tables where placed near people so they could have a drink, meal or take part in an activity there was very little room to walk around or for additional seating. We observed when visitors arrived their additional seating was arranged so they could sit with their relative, but this blocked access to the fire exit. One relative said, "It is usually blocked when there are visitors, but we

Requires Improvement

Is the service safe?

know it is there." A person was being supported with a hoist to transfer from a wheelchair to a lounge chair. There was no room within the lounge areas to use a privacy screen in order to promote the person's privacy.

At lunchtime the majority of people ate their meal whilst seated in the lounge chairs they had been seated during morning. This may not always promote orientation or good posture to aid digestion. We did not see or hear people being asked if they wanted to sit at a table to eat their meal. We were told by a staff member that there was not enough space for everyone to sit up at dining tables to eat meals. We also saw space was limited in the dining area. The positioning of the dining tables meant that those sitting at tables were largely facing the wall, which may not promote a positive eating environment for people living with dementia.

The flooring from the dining area to the lounge was not fixed to the floor. We noted as staff, visitors and people walked on it there was movement of the flooring and this may put people who have poor balance at risk of falling.

There was no specialist equipment or adaptations to the building to support people living with dementia, to orientate themselves or promote their independence. For example, signage to enable people to navigate their way around the home.

We recommend the provider seek advice with regard to providing a suitable environment for people living with dementia.

Inadequate

Is the service effective?

Our findings

People told us the staff were lovely and the food was nice. A relative said the food was good, "They give them the food they want. I know my relative has a pureed diet and they need assistance, which the staff always provide." Another relative told us there are always choices and staff meet different people's needs, such as vegetarian and diabetic.

Staff said they had access to training and had attended several training sessions in the previous six months. We looked at the training plan and found only three of the 24 staff listed had attended training in supporting people with dementia; 10 had not attended moving and handling training, 20 had not attended infection control training and seven had not attended fire training. According to the training plan none of the staff had attended all the training listed. Records showed staff were not up to date with the provider's essential training. Feedback from two of the training providers was that the response they received was not as good as expected. This included that a separate training room or space with seating for staff had not been arranged; staff had not been given time off work to attend; and they did not have confidence in the management to ensure that the staff followed the training to improve their practice. They had chosen not to offer additional training.

The induction programme for new staff did not follow the Skills for Care common induction standards. These are the standards people working in adult social care need to meet before they can safely work unsupervised. We asked to see the induction training programme and found the manager worked through a list, which included information about the home, confidentiality and fire safety with new staff. Staff told us they worked with more experienced staff for a number of shifts. One staff member worked three four and half hour shifts and another staff member worked three twelve hour shifts. They said, "We worked with experienced staff who were able to tell us what support people need and they showed us the records we have to complete to show what we have done." One staff member said they had attended moving and handling and fire training and another staff member was unable to use hoists and aids to assist people until they had completed this training. This meant that staff may not have the knowledge and skill to provide appropriate care when working unsupervised.

The provider did not ensure that staff received appropriate training. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, (which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

We looked at the food and fluid charts that staff said they completed for some people. One person had lost weight; their GP had been consulted and staff had been instructed to fortify the person's meals using cream, full fat milk and cheese. Staff said they had done this but the food charts did not support their comments. There were gaps in all of the charts and we found they did not reflect the food and drink that we observed people were offered during the inspection. Staff told us they filled the charts in when they had time, which may be some time after lunch and supper. One staff member said, "We fill them in as soon as we can and some people are better than others at doing them. Sometimes we just forget, but we know that people are eating and drinking enough."

The manager told us healthcare professionals were consulted when people's health needs changed. This included their doctor, psychiatrist, community mental health nurse and the speech and language team (SALT). We found in one persons' care plan they had completed a course of antibiotics. In the daily notes it stated the person's doctor (GP) had been contacted. However, it was not clear if the GP had visited the home or if the decision to administer antibiotics had been made in a telephone conversation, which meant the person may have been at risk of receiving the wrong medication. The care plan had not been reviewed and updated to reflect the changes in the person's healthcare needs and it was not clear if staff had provided the appropriate support and care.

Turning charts were used for one person to record when they had been repositioned in bed to help prevent skin breaking down. Staff told us how one person needed to be repositioned every couple of hours, records of the day before our inspection confirmed this. However, there was a period of 17 hours since the previous day that no record had been made to confirm if the person had been regularly repositioned, which placed them at potential risk of pressure sores.

The provider did not ensure that people were protected against receiving care or treatment that is inappropriate or unsafe. This was a breach Regulation 9 of the Health and

Inadequate

Is the service effective?

Social Care Act 2008 (Regulated Activities) Regulations 2010, (which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Staff told us they were able to progress professionally. One staff member had their level 2 qualification in Health and Social Care; one of the new staff had signed up to start this and three staff had completed Level 3.

The manager said regular supervision was provided for all staff and these were recorded. A supervision programme was displayed on the manager's office notice board and three of the four staff spoken with said they had had one to one supervision in the previous two months. Annual appraisals had not been completed, as the manager had only been managing the service for six months.

Staff had knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. No applications had been made for a DoLS. Staff said they understood that people can have capacity to make some decisions, but not others. 16 staff had attended training on MCA, but according to the training plan no staff had attended training on DoLS. Mental capacity assessments had been completed in two of the care plans viewed. In two of the care plans we found relatives and doctors had discussed how people should be supported when their health needs changed and end of life care may be required. The relatives and doctors had signed do not resuscitate forms. We found that one had been updated in October 2014, with the comment 'no change' in some areas.

One staff member said, "We always ask people if they want us to assist them before we do anything. This includes if they want to get up, what they want to eat and when they want to go back to bed. We also involve their relatives when people cannot make decisions, like if they are not well, and some of them are very involved." We observed staff asking talking to people and gaining their consent to put on an apron ready for eating their meal.

People were provided with a range of food, with choices for each meal and alternative meals if they did not want what was available. Staff knew each person's dietary requirements and the chef knew what people liked and disliked. We noted that soft and pureed diets were provided as required and staff spent time assisting people to eat. One person was offered a number of different food choices at supper time and decided on a mixture of fruit and cakes. Staff said, "People change their minds just like us and they should have what they want at the time." One person enjoyed walking around the home and we saw how staff enabled this person to eat their meal wherever they decided to sit down momentarily.

Good

Is the service caring?

Our findings

People told us the staff looked after them, helped them to sit where they wanted to and were very friendly. Relatives said the care staff were very good, they were very patient and involved them in decisions about the care provided. A relative told us they felt involved, they visited the home regularly and the staff phoned them if there were any changes. Another relative said, "The staff make sure people are comfortable. My relative is always clean and well dressed with a special chair to prevent pressure sores. I don't think the staff could do any better."

At the last inspection 10 June 2014 we asked the provider to make improvements for respecting and involving people who use the service and the care and welfare of people who use the service. The provider sent us an action plan stating they would have addressed all of these concerns by October 2014. At this inspection we found that people had been involved in decisions about the support they received.

The home had a calm atmosphere and it was clear from observing staff that they knew people well. Each person was treated with kindness and as an individual. Staff spoke quietly with people making eye to eye contact, using their preferred name and taking time to listen to them. People were treated with respect and staff protected people's privacy and dignity when they assisted them with personal care. A staff member told us, "Although I am new to care you don't have to have years of experience to be able to show care and compassion towards people and to treat residents how you would want a relative to be cared for."

We observed a lovely interaction between a staff member and a person which demonstrated how well the staff member knew the person and the person triggers for becoming anxious. The staff member used affectionate terms of address and gentle physical contact which the person clearly responded to. This persons care plan noted their need for affection and made it clear to staff what to do in order to promote continuity in this person's care.

Staff promoted people's independence and ensured they were able to make choices about all aspects of their daily living. 11 people living in the home were unable to mobilise independently and required assistance from staff in all aspects of their daily living. Staff talked to and asked people if they needed assistance and they waited until people were ready to move before they provided support. If people did not want to return to their room, or have their meal when it was offered, staff accepted this and asked them again later. Relatives were involved in decisions about the support provided. One staff member said, "We are here to support people, it is their home and we respect that." Two people were able to walk around the home; staff said they observed or supported them to ensure their safety and we noted staff doing this when they were in the lounge.

People's equality and diversity needs were respected. People took pride in their appearance and staff supported them to dress in their preferred way. We saw that it was important to one person that they feel feminine and they wanted to wear make-up and particular style of clothing to reflect their lifestyle. They were assisted to apply make-up; they were clearly happy with the result and they showed us how staff had previously applied the nail varnish of their choice. The provider told us how a Christian service was regularly held at the home to enable some people to practice their faiths.

Staff told us relatives and friends could visit people at any time. Relatives supported this and said they were always made to feel very welcome. One relative said, "We have to ring the bell for staff to let us in, which is good as it keeps people safe. Staffs are always happy to see us and they offer us a drink as soon as we get here. I think the care staffs are very good."

Requires Improvement

Is the service responsive?

Our findings

People said they could decide what they wanted to do. One relative said, "There are care plans, but I haven't seen one for months and I don't know if the changes I have asked for have been made. I don't think so as I can see that some of the things I asked for have not been done." Another relative told us, "The care staffs always ask us if everything is ok and we are very happy with the way they look after our relative."

People's needs had been assessed and care plans had been developed from this information. We found the care plans we looked at did not show that people received personalised. They had not been regularly reviewed or updated as people's needs had changed. One care plan had very little information about the person's needs, and there was no evidence that people and their relatives had been involved in developing or reviewing the care plans. One person's care plan showed a pressure relieving mattress was in place to reduce the risk of pressure damage; we found this was not in place and staff said it was not needed. A bed barrier assessment had been completed in another care plan. This stated the person had been consulted, although the care plan also stated the person could not communicate verbally. We noted that one of the care plans had been reviewed in September 2014; a relative had signed to show they had been involved, but this person's needs had changed since this date and the care plan had not been updated. This meant the person may not have received the care and support they needed.

A malnutrition universal screening tool (MUST) had been used to assess people's nutritional needs, but the records had not been reviewed and updated as people's needs had changed. One person's diet identification form stated their preferences to include toast, Weetabix, sandwiches and salads. A referral had been made to SALT and the assessment had identified the person as requiring pre-mashed food and normal fluids. The information in the care plans had not been reviewed and updated in line with the person's needs, which meant the person was at risk of receiving inappropriate food. The manager and nurses said they were working through the care plans, asking relatives if they wanted to be involved in the reviews, and updating them when people's needs changed. However, there was no evidence to support this.

People had daily care plans, which the manager described to us as a quick guide to people's needs. We looked at the daily care plan for one person who had complex needs. Their daily care plan was placed in their bedroom for ease of access for staff. The care plan did not provide staff with an accurate overview of their physical and emotional needs and was misleading to staff which placed the person at potential risk of their needs not being addressed.

In response to a specific health need some generic guidance had been provided for staff on the condition and exercises that needed to be done to help alleviate some symptoms for the person. There was no information for staff on how such guidance should be followed in order to support this person's health condition. A staff member said they were aware of the condition, but were not aware of what they needed to do to support this person.

The provider did not ensure that people were protected from the risk of unsafe or inappropriate care due to the lack of accurate records being maintained. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, (which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

A complaints procedure was in place, but there was no evidence it was effective and resolved concerns or issues raised. The procedure was displayed at the entrance to the home and was also available in the Statement of Purpose, although some of the information included was not correct, such as referring complaints to the CQC, and should be reviewed. We asked to see the complaints log; we received it after the inspection and found it was blank. We asked staff what they would do if someone wished to complain. One staff member said they would deal with it at the time if they could, "If people don't like the food or are not happy where they are sitting we can offer a different meal or assist them to move. Usually if there are any concerns it is the relatives or staff who raise them." Another staff member said, "If a relative made a complaint that we could not sort out we would ask them to talk to the nurse or the manager." Relatives felt the manager and provider did not always take their complaints seriously. One relative said, "I have raised concerns in the past and it has taken some time to sort them out, but they have been resolved." Another relative said, "We shouldn't really have to continually ask for things to be improved."

A programme of activities was displayed on the notice board near the entrance and staff said the activities listed were only suggestions and they supported people with

Requires Improvement

Is the service responsive?

different activities, depending on what they wanted to do at the time. One the first day of the inspection some people took part in a quiz and others read the newspaper with the activity person." One staff member said, "We like to help people do activities that they like, which are very personal to them and change depending on how people feel." On the second day of the inspection a staff member spent time singing with one person and looked through a book with another person who liked looking at pictures. We saw that people were comfortable and relaxed sitting in the lounge; people watched a film on both days of the inspection and one person remained in their room to watch vintage films, which they enjoyed.

We observed examples of how staff supported some people to do the individual things they enjoyed. This included spending time with a person looking and talking about a book of animals, which prompted discussions and interactions with other people living in the home. This was clearly enjoyed by the person. We saw another person deriving comfort from holding soft toys which a staff member supported them to obtain and was used to help orientate the person and to ease their anxieties.

In response to one persons need to walk around staff were seen enabling this person to walk as independently as possible, but whilst trying to balance their safety.

We noted from the photographs on the wall of the dining area people, relatives and staff attended a number of festivities in the six months before this inspection. These included BBQ's and Christmas parties and we saw from the photographs that all the participants clearly enjoyed themselves. One person said, "I like the parties."

Inadequate

Is the service well-led?

Our findings

At the last inspection 9 June 2014 we asked the provider to make improvements around record keeping. At this inspection we found that this had not been addressed. We found care plans had not been reviewed and updated in a timely manner, food and fluid charts had not been completed appropriately and the management of medicines needed some improvements. Staffing levels had not been linked to the needs of people living in the home, and the environment had not been maintained and may not meet the needs of people living with dementia.

The provider did not have an effective monitoring and assessment system in place to ensure that people were protected against inappropriate and unsafe care and support. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, (which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Relatives said there had been one meeting with the provider and manager, "Sometime in the summer last year." We asked to see the minutes of the meeting, but they were not provided. Relatives said there had been no clear leadership at the home for some months, and they were not confident any concerns they may have would be addressed.

Staff felt they did not have an opportunity to contribute to the running of the home. They told us regular staff meetings had not been arranged and there was very little opportunity to discuss issues or to make suggestions. We asked to see the minutes of the last four meetings. The minutes of the meeting in January 2015 were available and we found a list of instructions for staff to follow. Staff said they felt unsupported by the management. They said the manager was not available on the floor if they wanted to ask a question or clarify something, and if they raised any concerns they did not feel action would be taken to address them.

The provider did not have effective systems in place to listen to, investigate and take appropriate action when concerns or complaints were raised. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, (which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. This evidences the management are aware of any changes to the support provided at the home, the potential for impact on people who live in the home and the action they take to address any concerns. The provider had not informed CQC of the safeguarding concerns raised by the local authority, or that the staffing levels were insufficient to meet people's needs.

The provider did not inform CQC of any issues that might affect the safety of service users. This was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

A registered manager has not been in place at Bramber Nursing Home since August 2013. The current manager is a registered nurse and was employed to manage the home on a day to day basis in July 2014. They have put forward an application to register with the commission as the registered manager. The provider and manager said they had been working with management consultants to ensure people received appropriate support and care.

People said the manager and provider were nice and they talked to them when they came in. We saw the provider laughing and joking with relatives and talking quietly with people in the lounge. The manager spoke with people and they asked if people were comfortable and if they wanted anything else.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding people from abuse and improper treatment. The provider had not ensured that people were safeguarded against the risks of abuse. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. The provider had not safeguarded the health, safety and welfare of people living in the home by ensuring there were sufficient numbers of suitably qualified staff. Regulation 18 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care. The provider did not ensure that people were protected against receiving care or treatment that is inappropriate or unsafe. Regulation 9 (1)(3).

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. The provider did not have an effective monitoring and assessment system in place to ensure that people were protected against inappropriate and unsafe care and support. Regulation 17.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting upon complaints. The provider did not ensure appropriate systems were in place to listen to, take action and respond to concerns and complaints. Regulation 16.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Regulation 18(e)(g)(i) of The Care Quality Commission (Registration) Regulations 2009 Notifications. The provider did not inform CQC of issues that might affect the safety of people. Regulation 18(e)(g)(I)

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
	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Records The provider did not ensure that service users were protected from the risk of unsafe or inappropriate care due to the lack of accurate records being maintained. Regulation 20.

The enforcement action we took:
Warning notices were issued on 20 March 2015