Bramblings (Kent) Limited

Bramblings Residential Home

Inspection report

Bramblings Residential Home
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Date of inspection visit:
21 November 2017
22 November 2017

Date of publication:
15 January 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 21 and 22 November 2017. The inspection was unannounced on 21 November and announced on 22 November as we told the provider and registered manager when we would return.

Bramblings Residential Home is registered to provide accommodation and personal care without nursing for up to 42 people. There were 36 people living at the service at the time of our inspection.

People living in the service required care and support and had varying needs. Some people were living with dementia and some people had medical conditions such as diabetes or respiratory conditions and some people were recovering from suffering a stroke. Most people living in the service needed some support to move around. Some required the support of one staff member to move around whilst others required the support of two staff. Two people needed staff to support them to move by using a hoist. Some people were unwell and cared for in bed and others chose to remain in bed.

The service was set out over two floors with a passenger lift to take people between floors. The service was set in large grounds with pleasant gardens that people could sit out in when the weather was fine.

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.

The last inspection report for Bramblings Residential Home was published on 13 December 2016 following a comprehensive inspection on 24 October 2016 when the service was rated requires improvement. Four breaches of legal requirements were found in relation to Regulations 9, 11, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider and registered manager to take action to meet the regulations.

After the inspection, the provider sent us an action plan on 14 December 2016 which detailed how they planned to address the breaches of Regulations. They said they would be compliant by June 2017.

At this inspection, we found some improvements had been made to meet the regulations, however further improvement was required and the service continued to be in breach of regulations.

Some elements of how medicines administration was managed continued to need improvement. Prescribed thickeners to add to people's drinks to prevent choking were not stored or administered safely. Anomalies were found in the numbers of medicines in stock when checked. Medicines audits did not highlight the concerns found.

Individual risk assessments were not in place to give the guidance necessary to staff when providing care to

keep people safe and prevent harm. Infection control procedures were not robust as people shared the use of a hoist sling and personal toiletry products were left in communal bathrooms.

Fire prevention processes were not always evidenced to show robust systems were in place to keep people safe in the event of a fire on the premises. All servicing of systems and equipment had been carried out by the appropriate professionals.

Safe recruitment procedures were not followed to ensure only suitable staff were employed to provide care and support to people living in the service.

Staff did not always complete the training required to carry out their role. One to one staff supervision was not undertaken regularly or as described in the provider's supervision procedure.

The basic principles of the Mental Capacity Act 2005 had not always been followed to ensure people's rights were upheld. Deprivation of Liberty Safeguards applications had been made and the registered manager kept these under review.

People's needs were not regularly assessed to ensure the appropriate care and support was being delivered. People's needs had changed and care plan reviews did not capture this to make sure staff were given the most up to date information. People's interests and preferences were not always identified and recorded.

The provider had a system in place to monitor the quality and safety of the service. However, these were not effective enough to identify the failings or improvements required.

People were referred to appropriate health care professionals when required although changes to care and treatment were not always reflected in care plans. We have made a recommendation about this.

Mealtimes were not always equally spaced out so that people could manage their appetite and nutritional intake. We have made a recommendation about this.

There were suitable numbers of staff to provide the care and support needed by the people living in the service. Staff had a good understanding of their responsibilities in safeguarding people from abuse and where they could report any concerns they had.

People were able to access all areas of the service whatever their mobility needs were.

Staff knew people well and spent time with people to make sure they were not rushed. People were supported to maintain their independence and they told us they were treated with dignity and respect.

People and their relatives knew how to complain. Complaints had been fully investigated and responded to as set out in the provider's complaints procedure.

People were able to express their views of the service through regular meetings and annual surveys. The provider and registered manager made changes where necessary based on people's feedback.

Positive feedback was given about the management team and how the service was run. Staff felt supported and listened to.

During this inspection we found six 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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some elements of medicines administration were not managed well.

Safe recruitment procedures were not followed when employing new staff.

Individual risk assessments were not completed to prevent harm and keep people safe.

There were suitable numbers of staff to provide the care people required. Staff knew what they should do to identify and raise safeguarding concerns.

The premises were suitably maintained and equipment was appropriately checked.

Is the service effective?

Requires Improvement

The service was not always effective.

The basic principles of the Mental Capacity Act 2005 were not always followed to ensure people's basic rights were upheld.

Staff had not always received regular basic training or supervision to ensure they had the skills necessary to carry out their role.

A more robust system for recording health care visits was required.

People enjoyed the food provided and were supported to maintain their individual dietary needs.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect. People were supported to maintain their independence and were not rushed.

People and their relatives told us the staff had a kind and caring approach and it was clear staff knew people well.

People were given clear information about the service before they moved in.

Is the service responsive?

Requires Improvement

The service was not always responsive.

A person centred approach was not always taken when developing and reviewing individual care plans.

People were not always supported to follow their interests and clear plans and records were not kept to support activities.

Complaints were investigated and recorded well to respond to people and learn from mistakes.

People were asked their views through regular meeting and annual surveys.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had monitoring systems in place. These had not been effective in identifying areas that required improvement.

People and their relatives thought the service was well run and knew who the management team were.

Staff felt they were given good support by an approachable registered manager.

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 21 and 22 November 2017 and was unannounced on the first day. We told the registered manager when we would return for the second day. The inspection was carried out by two inspectors and one expert by experience who has experience of family members living in a care home. 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 asked the provider to complete a Provider Information Return (PIR). 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. We looked at notifications about important events that had taken place in the service which the provider is required to tell us by law. We looked at previous inspection reports and at the provider's action plans following the last inspection. We used this information to help us plan our inspection.

We spoke with 16 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, the deputy manager and four staff. We received feedback from two healthcare professionals and one local authority commissioner.

We spent time observing the care provided and the interaction between staff and people in the communal areas of the service. We looked at four people's care files, medicine administration records, eight staff files which included recruitment records, supervision documents and staff training 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 the provider and registered manager to send us further information following the inspection and they sent this within the time requested.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 24 October 2016, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured there were sufficient medicines available for people or that people received their medicines as prescribed. Risks to people's health and welfare were not sufficiently mitigated to keep people safe.

At this inspection, we found that sufficient improvement had not been made to the management of medicines or to the assessment and mitigation of individual risks.

Improvements were required in the management and administration of people's prescribed medicines. Some people had thickeners prescribed to add to their drinks to prevent the risk of choking. Due to the risks associated with thickeners by accidental swallowing or incorrect measurements, thickeners must be stored in a locked cupboard as other medicines are. Thickeners must only be given to those for whom they are prescribed. The thickener used by some people in the home was kept in the kitchen and on the tea trolley used to serve drinks. Staff spoken with knew that they must measure the powder using a scoop supplied. However, they were not aware that the thickener must be treated as a medicine and be kept in a locked cabinet. This meant that people were not protected from the potential risk of the accidental swallowing of prescribed products that were not stored and administered securely.

There were gaps on the medicines administration record (MAR) which meant some people may not have received their medicines as prescribed. We checked the amount of medicines left in stock against the medicines recorded as given on the MAR and found that tablets remaining did not tally with the records. One person's records showed they were prescribed Fexofenadene 120mgs, one tablet to be given once a day. Fexofenadine is an antihistamine used to relieve allergy symptoms. The MAR showed 16 tablets had been carried forward and two had been signed as given on the MAR. However there were 15 tablets left instead of 14 tablets which meant one tablet had been signed for but not administered. Another person was prescribed one tablet of Nicorandil 10mg to be administered twice a day. Nicorandil is used to treat angina. The MAR showed 60 tablets were signed in and three tablets were signed as administered. However, 58 tablets were left remaining. This meant one tablet had been signed for but not administered. Some people who had been prescribed 'As and when necessary' (PRN) medicines did not have PRN protocols in place. Guidance should be available so staff administering medicines knew what the medicine was used for, why people were prescribed the medicine, the side effects to watch out for and the safe levels to take in a 24 hour period. This meant people may not receive their medicine for the purpose it was prescribed. People were at risk of being given too much of the medicine or not enough, as well as suffering side effects that may go unnoticed by staff.

A medicines audit was undertaken each month. However, we saw that checks were not made that medicines had been given as prescribed. Most medicines were delivered from the pharmacy in blister packs, although some were delivered in individual boxes. Medicines not provided in the blister packs and delivered in boxes were not counted during the audits to ensure that people were receiving all their medicines as prescribed. The audits had not picked up the issues we found with medicines administration as they were

not comprehensive enough to cover all areas that required checking.

The failure to ensure the safe management of medicines administration is a continuing breach of Regulation 12(1)(2)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Some individual risk assessments were in place, however other important risk assessments were missing. People at risk of falls and who had recorded incidents of falling did not have a risk assessment in place to ensure control measures were in place to mitigate the risks and prevent further falls. There were many documented incident reports of one person having falls on a regular basis, yet there was no falls risk assessment in place. One person's daily records had shown that they had a red and sore pressure area where staff had started to apply a cream. However, there was no risk assessment in place to mitigate the risks of skin breakdown and to give guidance to staff in maintaining skin integrity, such as how often the cream should be applied. Staff had completed a scoring tool designed to assess the risks of acquiring pressure sores for another person. The result showed the person was at high risk, yet a risk assessment had not been developed and the care plan gave conflicting information stating the person was at low risk. This meant people may not be protected from harm as the processes necessary to prevent harm by guiding staff how to provide safe care were not in place

The risk assessments that were in place were not responsive to people's changing needs so did not always identify the current risks as clearly observed during the inspection. One person had a moving and handling risk assessment dated 13 November 2015 which had been reviewed each month since then with no changes made to the original assessment. The risk assessment stated the person was independently mobile with a rolator frame and the occasional assistance of one staff member required to rise out of a chair or bed. We observed the care and support given to the person in the communal lounge area. It was very clear their needs had changed significantly and they required the full support of two staff members with all movement and were transferred from one area of the home to another in a wheelchair. This change was not evident in any section of the person's care plan.

Falls management was not robust. Some people had clearly had falls as these were recorded within their care file with a clear description and detail. However, the falls were not monitored appropriately. Accidents and incidents had been analysed by the registered manager every month when they checked how many falls had happened. For example, the numbers of people involved and how many falls each of them had. In October 2017, 13 people had 29 falls between them. The registered manager had checked if any themes were evident, for instance the time of the day and which staff were on duty. No common themes had been found. However, no further action plan was developed in order to document the action required to prevent further falls for those people who were identified as being most at risk. The audit did not show that people's records had been reviewed which would have identified the lack of specific individual risk assessments to improve the outcomes for people.

Two people were assessed as needing a hoist to help them to move around. Although both people did not require the assistance of the hoist at all times they both regularly used a hoist. Individual slings to attach to the hoist were not available for each person, so both people used the same sling. This meant there was a risk of cross infection. We spoke to the registered manager and the deputy manager about this who both said they did not know each person should have a separate sling. The registered manager said they would purchase another sling to ensure the sharing ceased. Personal toiletry products were left in a communal bathroom. This meant people were at risk of ingesting harmful products or using products that may be harmful to them and could increase the risk of infection.

Fire safety procedures required improvement. Although fire drills were carried out every six months, these

were not fully recorded to ensure learning points could be addressed and action for improvement could be taken. Proper evacuation was not attempted or simulated so the registered manager and provider could be assured people could be safely evacuated if a fire broke out. It was unclear how often fire alarm tests should have been carried out as some records stated monthly and the provider's fire risk assessment stated weekly. However, it varied how often the tests were carried out between weekly, monthly and sometimes longer. For example, a fire alarm test had not been undertaken since 17 October 2017 until the second day of inspection, 22 November 2017. The provider's fire risk assessment required an annual review and had not been reviewed since 15 June 2016. A detailed and easy to understand personal emergency evacuation plan (PEEP) was recorded within people's care plans. A PEEP sets out the specific physical, communication and equipment requirements that each person had to ensure that they could be safely evacuated from the service in the event of a fire. The PEEP's were also kept in a 'grab bag', along with other important information needed in an emergency situation. The registered manager kept a summary of the PEEP's in place showing who was living in the service at any given time, for use in case of a fire on the premises. The summary was not kept up to date as some people included in the summary were no longer living in the service at the time of the inspection. The document was not dated to enable the registered manager to check the information was current.

The failure to ensure that appropriate measures were in place to prevent and keep people safe from harm is a continued breach of Regulation 12(1)(2)(a)(b)(d)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The registered manager did not ensure safe recruitment practices were followed to check that new staff employed were of suitable character to provide care to the people living in the service. Application forms were not complete as there were a number of gaps in employment that were not accounted for. References had not been received for some staff who had completed their induction and were working and providing care to people. Although references had been requested, they had not been received and this had not been identified. Suitable identification was not available for some staff. Interview notes were not available to evidence that the registered manger had met with applicants prior to offering employment to check their experience and suitability to provide care to the people living in the service.

The failure to ensure that recruitment practices are safe and robust to protect people from being cared for by unsuitable staff is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People told us they felt safe living at Bramblings. The comments we received from the people we spoke with included, "The staff are very kind and look after me well, I do feel safe here. Everyone would like to be cared for in their own homes but this has become my home"; "The staff are very good. They are just caring and they look after what you want. If I felt unsafe I would ring the bell or press the buzzer and they would come. They would come within five or 10 minutes but it could be longer depending on how busy they are"; "I feel quite safe the staff are so good here they help you with anything. If you press the buzzer they will come. The time they take varies, sometimes it takes minutes other times it is ten. It depends on the time of day. If I felt unsafe or worried I would talk to [Staff member] she brings the tablets in the morning" and "I have lived here for two years and I find it quite safe. I have had one fall and staff came very quickly within a few seconds. I feel much safer here than in my own home. If I felt unsafe or worried I would speak to [the deputy manager]. I should hope she would help me".

The relatives we spoke to also felt their loved ones were safe living in the service. One relative told us, "We feel that she is very safe they help her with her mobility because her mobility is not very good. The security is good. So far the carers have been kind and not disrespectful. If we felt unsafe we would approach [The

registered manager or deputy manager], they are approachable and responsive".

People were protected from abuse and mistreatment. Staff had a good understanding of their role in safeguarding people in their care from abuse. They described how abuse may occur and how they would recognise concerns. Staff were clear about their responsibilities in reporting any suspicions of abuse and knew who they would report these to. Although staff had confidence that the registered manager would act immediately on concerns raised, they also knew who they could report to outside of the organisation should they need to. One member of staff said, "I know who I can report to – it's called whistleblowing (telling someone). It has to be nipped in the bud. I would have confidence though that [Managers] would deal with it as they are approachable".

Suitable numbers of staff were available to meet the assessed care needs of people living in the service. Three domestic cleaners and one laundry assistant were employed and a chef and kitchen assistant to cover the week. This meant that staff did not have to carry out cleaning and cooking duties, leaving them with more availability to undertake their caring role. Staff told us they thought there were enough staff to be able to provide the care people required at the time. However, they felt that if the service was full with no vacancies, this would be far more difficult. Staff said they would prefer to have more time to spend with people as the main time they managed to chat with people was while they were assisting people with their personal care needs.

Essential servicing of equipment had been undertaken at the appropriate intervals by the relevant professionals to make sure the premises were well maintained and safe. This included; all fire alarm and equipment servicing, equipment such as hoists and bath chairs, electrical installation certificate, gas safety certificate and electrical portable appliance tests.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 24 October 2016, we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Appropriate arrangements were not in place to seek people's consent and where people lacked capacity to ensure the care they received was in their best interests.

At this inspection, we found that sufficient improvement had not been made to ensure people's basic rights were upheld within the principles of the Mental Capacity Act 2005. We also found concerns around the lack of person centred care and the training and supervision of staff.

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.

A mental capacity assessment had been completed with each person who it was considered may lack the capacity to make decisions. However, the assessments did not relate to a specific decision. Evidence was not shown why the assessment had led to the determination that the person did not have capacity to make their own decisions. A 'consent to care and treatment' form was completed in one person's care file and stated, 'Verbally discussed with resident (sic) and LPA'(Lasting Power of Attorney). The consent form was signed by the person's son. However, there was no evidence in the person's care plan that an LPA was in place and whether the LPA was to support the person with their finances or their health and welfare. An appointed LPA can only sign consent to care and treatment if they have been appointed as LPA for health and welfare. There was no evidence of best interests decisions having been made with the relevant people where people did lack the capacity to make decisions. This demonstrated a lack of understanding of people's rights within the basic principles of the MCA 2005. Less than half the staff team, 18 out of 40, had received training in the MCA 2005.

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

People can only be deprived of their liberty in order to receive care and treatment when this is in their best interests and legally authorised under the MCA 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made appropriate DoLS applications to the supervising authority and kept these under review.

The registered manager carried out an initial assessment before people moved into the service to make sure

the service was able to meet their needs and to inform the care plan. No further assessments were undertaken following the initial assessment in order to capture people's changing needs and identify changes to the care plan. Care plans were therefore not always up to date. Many care plans had initially been completed in 2015 with monthly reviews since. However, reviews often stated 'no change' each month when clearly there had been changes, evidenced by what we observed and what we found in other parts of the care plan or management files. One person's medical profile stated they were paraplegic, suggesting they had loss of feeling or paralysis of the lower limbs. However, their moving and handling risk assessment stated they were independently mobile in all areas. When we asked staff about this they said that they initially thought the person was paraplegic but they had found that they were more able, although sometimes unsteady and needed more help some times than others. For example, they occasionally required a hoist to help them to move. This change in need was not reflected in the care plan or within monthly care plan reviews. Another person had a leg ulcer requiring regular treatment from the district nurse. This was recorded in the registered manager's record of healthcare professionals visits, kept separate from people's care plan files. Some care plan reviews referred to the leg ulcer and on 17 May 2017 the review stated this was 'resolved'. When we asked the registered manager about this they were unsure why this was recorded as it was not the case, although the leg ulcer was responding well to treatment. They confirmed the district nurse continued to visit twice a week, however, there was no specific care plan or risk assessment regarding this or the treatment given.

Although staff monitored people's weight by measuring and recording this at regular intervals, the weight recording forms were not fully completed to ensure close monitoring was maintained. One person was being weighed every week by staff and had lost weight consistently since April 2017. They had lost 12 kgs which equates to 26.4 pounds or 1 stone 12lbs, from 1 April 2017 to 20 November 2017. Staff had not fully completed the weight chart as directed. Columns to record the amount of weight lost or gained each time the person was weighed were left blank. Although staff were meant to complete a malnutrition scoring tool each time the person was weighed, this was not recorded on the weight chart as directed. The care plan did not specify how often the person should be weighed and although they were prescribed nutritional supplements this was not recorded in the care plan. This meant that the person's loss of weight was not monitored as it should have been when there was a clear and significant risk of malnutrition.

Daily records were documented well by staff who described the care they had given, although the records were in contradiction to the care plans. It was clear through daily recordings that staff knew people well and had adjusted their care even though this was often not what was recorded in the care plan. For example, one person's care plan stated they had their own teeth and may need assistance with teeth care. Staff had recorded in the person's daily records dated 17 November 2017, 'Needs teeth cleaned as black through medication. Cleaned best I could'. There was no reference in the care plan that the person required full assistance with cleaning their teeth or that they required special care due to the medication they were taking.

The failure to provide care and treatment that meets people's specific needs is a breach of Regulation 9(1)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People told us they thought the staff were skilled in their role and they were able to make everyday choices. One person said, "The staff are good at their jobs and I can decide what I want and when" and another told us, "The staff do help me the way I want as I can't do this myself". People and their relatives also knew they had a key worker and most knew who this was. People told us, "[Staff name] she is my keyworker, she comes up and asks questions and puts them on paper" and, "The name of my keyworker is on the door". One relative said, "[Staff name] is her keyworker, he is monitoring and he tells us how she is and what her food and fluid intake is, and another told us, "Yes she has a keyworker who is responsible for mum's welfare. We

have also attended a care plan review".

Staff told us they had a good induction which consisted of some mandatory training and a period of shadowing more experienced staff until they got to know people and were confident. Although a training plan was in place and most staff did undertake the mandatory training, we found that not all staff had completed the training required for their role. Out of 40 staff, only five staff had completed infection control training, 16 staff had undertaken health and safety training, only 18 staff had undertaken Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training, 27 staff completed first aid training and 30 staff had completed safeguarding vulnerable adults training. This meant the provider could not be assured the staff had the skills and knowledge to proficiently undertake the role they were employed for. However, some staff told us they had been given the opportunity to undertake distance learning courses to enhance their interest and knowledge. These included care planning, dementia and food hygiene.

Although most staff had received at least one, one to one supervision meeting with their line manager, some had not. Supervision meetings are a way to provide staff with the necessary support, constructive criticism and personal development to be able to carry out their role successfully. The provider's supervision policy stated that staff would have one to one supervision a minimum of six times a year. This was not the case for any staff. Some staff supervisions that had taken place had shown through meeting documents that staff had not been given the opportunity of a two way individual discussion, as the records were identical for many members of staff.

The failure to ensure staff receive the appropriate training and support is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People could choose to get up when they wanted in the morning. Some people who got up from bed late had their breakfast late, once they were up and sitting in communal areas. One person was being assisted to eat their breakfast at 10.40. Lunch was served between 12.00 and 12.30. This meant that those mealtimes were very close together for some people, which could disrupt their appetite and nutritional intake. One person did not eat any of their lunch and at 12.40 a staff member cleared the plates away and noticed the person had not eaten their food. The staff member said to the person, "You haven't eaten your scampi and chips, did you have a late breakfast?" However, the staff member did not wait for an answer and took the plate away. This showed there was an awareness amongst staff that people having a late breakfast may impact on their ability to eat their main meal at lunchtime. The person was given dessert and was encouraged to eat some of this by the registered manager.

We recommend the registered manager seeks advice from a qualified health professional in relation to person centred nutrition.

People told us the food was good and confirmed they had a menu to choose from, "The food is good quality, there is always enough I have never had to ask for more"; "The food is edible. Everybody has their own personal needs not everyone likes the same thing but we get two choices a day of both main courses and puddings" and "I find the food good, there are two courses and we have different choices every day of both main and desserts. I can make my own drinks and I have my own fridge in my room".

A relative told us, "We tell them that there is certain food mum does not like and they do their best. The food is very good, they do smaller portions for her so the food is not too much".

A light and airy dining room was available where people could choose to sit at a table to eat their meals. The dining room overlooked the gardens and tables were set with tablecloths and menus also available on each

table. Some people ate their meals in their room which was their preference and choice. People who required a special diet such as diabetic, soft or pureed were catered for. Good communication was maintained between the kitchen staff and care staff to ensure the correct diets were prepared.

People had access to health care when they required and records showed when GP's, district nurses or other healthcare professionals had visited. Records within the care plan were limited however, with brief details in very small boxes on the document available. Sometimes the date and name of the professional who visited was all that was recorded. A more comprehensive record of visits was kept by the registered manager in a separate file in their office rather than within the person's own care plan file. This meant that the detail may be missed to inform accurate changes to the care plan.

We recommend the registered manager researches or seeks guidance into best practice in relation to providing suitable management records.

A healthcare professional told us they found the management team and care staff to be responsive to people's health needs, making appropriate and timely requests for home visits. They said they had managed to prevent people being admitted to hospital as a result of their responsiveness. They said, "I have no particular concerns, if I ask for something to be done I know it will be, if I prescribe antibiotics I know they will let me know if they are not working within a few days".

A lift was available between the two floors so that people could access any part of the building when they wished, whether they were independently mobile or required the use of mobility aids such as a wheelchair or walking frame. More than one communal area was accessible to people. A quieter lounge with a small kitchen on the first floor with views over the gardens and grounds was accessible to all via the lift. People were able to sit in there when they wished and the quiet lounge was another place they could take their visitors if they wished.

Good

Is the service caring?

Our findings

The people we spoke with told us the staff were caring and respected their privacy, treating them with respect. The comments we received included, "They definitely respect me. They knock on my bedroom door but it is not necessary as my door is always open except at night time. I feel I can trust the people here"; "The staff are kind and caring, very much so. I was downstairs and went to sit down on what I thought was a chair but there was no chair there and I fell flat on the floor. Within seconds there were staff there to help me. The staff are very good" and, "Yes the staff are kind and caring, for example they bring tea and breakfast to my room in the morning. Oh golly yes we have a laugh in this place. They treat me with respect and they knock on my bedroom door. They pretty much know about what I like and dislike, for example they don't have to ask what I want for breakfast, they know".

Relatives were also complimentary about the staff and their caring approach. One relative said, "Yes, very caring. I could pick out any one of the carers, they sit down and feed her and talk to her. They come in and have a laugh and a joke too". Another relative told us, "The staff are very kind and caring when we come in they ask us if we want coffee".

One person who had a poor appetite and was finding it difficult to eat due to their frailty was being assisted with their breakfast by a member of staff. The staff member was very attentive and alerted quickly to the fact that the porridge they had brought for breakfast needed to be of a different consistency. The member of staff went away and came back with a freshly prepared porridge of a different consistency to try. The chef knew the person was having difficulty eating and drinking and joined the staff in the lounge with a cup of hot chocolate to try. They said they knew the person liked hot chocolate and had drank a whole cupful the day before. The staff member spent time with the person encouraging and supporting to eat and drink with no rushing.

We listened to and observed staff interacting with people around the communal areas of the service. It was obvious that staff knew people well and knew what they liked and what their care needs were. One staff member told us about when they supported people with bathing or showering. They said, "[Person's name] is frightened of water going over their head, so that is why they would normally not have a shower. However, if I offered a shower and give reassurance and stay with [the person] they are okay to have a shower. This is because I have gained their trust". Staff chatted to people as they worked with good natured banter where appropriate. One staff member told us, "I know we have a laugh with some of the residents here but we know who is happy for us to do that and those who would feel uncomfortable by it. We do need to be careful how we approach people. People have told us what name they like to be called by and again we respect that". The hairdresser was visiting and people booked in for an appointment were involved in conversations with them and each other. It was clearly a social occasion that people enjoyed.

When staff were assisting people they explained what they were doing and made sure the person had understood. For example, one person was walking along the corridor without their walking aid. They were seen by a member of staff who went straight over to them. The staff member asked where they had left their aid and the person said, "You know I always forget where it is". The staff member reminded them why they

needed to use it and to try and remember it before walking. The person grinned at the staff member and they had a laugh together and talked about a loved one's visit. The member of staff gently guided the person to a chair and went to get the walking aid from where they had left it. The person then carried on their journey happily using the aid.

Staff told us they always gave people the choice of when they went to bed and when they got up in the morning. One member of staff said they asked people if they wanted to go to bed if they see them falling asleep in their chair. They told us several people ask to get ready for bed but then choose to sit in a chair in their room, usually watching the TV. We were told about one person who liked to get ready for bed and then come back into the lounge for the evening. They said, "We generally know which people like to go to their room early, but they are always asked, and if they change their mind that is respected".

Staff described how they maintained people's privacy and dignity. They told us how they would make sure the doors were shut and curtains were closed when assisting people with their personal care. One staff member said, "When I assist with washing a person I keep them covered up as much as possible and I get them to do the areas they can for themselves. It's good to encourage them to do what they can, it makes them feel better, and it helps them remain independent". The staff member gave an example, "One person we need to offer assistance to knows when we ask if they need to go [to the bathroom] but if we did not prompt [they] would not take [themself]. This way [they] do not have an accident which would be embarrassing for [them]".

The provider had a comprehensive welcome pack that people received when they first moved into the service. The welcome pack provided all the information they would need to know while living at Bramblings. Such as personal belongings, meals, activities, laundry arrangements, how to make a complaint and the contact details of useful organisations. People and their relatives were equipped with the details they would require which was beneficial at an unsettling time when they first moved in.

A health care professional said, "Staff here have a good attitude they are very caring, they enjoy what they are doing. I do go to other homes and therefore can see the contrast".

The registered manager said, "It's their [people's] home and they see it as that". The provider told us, "The core of it is the home is caring. It is a lot better than it used to be, there has been a clear culture change". One member of staff told us, "The care industry is poorly paid, but I love it. It is my calling".

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 24 October 2016, we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that the care and support people received was personalised and took account of their likes, dislikes and preferences.

At this inspection, we found that sufficient improvement had not been made to ensure a person centred approach was taken to provide care that took account of people's changing needs and preferences.

A key-working system was in place. A key-worker is the focal point in the care team for an individual living in the service. The key-workers were responsible for reviewing and keeping the care plan up to date and keeping in touch with family members. Although care plan reviews were recorded each month, often 'no change' had been recorded when there was evidence to suggest there had been changes in people's needs. Some people had signed that they had been involved in the review but other people had not. Where people had signed to say they had been involved, the review notes did not evidence how they had been involved or what they had said during the review. For example, one person had signed in the review box, however, the review only stated 'no changes' with no record of the discussion. More comprehensive reviews, including the involvement of others involved in people's lives, had not been undertaken to develop a revised care plan taking into account people's changing needs and preferences.

People's preferences in relation to their interests and hobbies were not always recorded within the care plan to make sure they were given the opportunities to maintain their interests. Although the care plan recorded if people had religious beliefs, it was not always clear what support they may require and how the service would meet those needs. For example, one person's care plan stated they were 'Christian' and 'to encourage with church service'. No further detail was given, such as whether the church service provided within the home was the same denomination or if the church service was frequent enough to meet the person's needs. We asked the deputy manager about the church service and they told us a Church of England vicar visited to provide communion to those who wished to join in. We asked if there were people who were Roman Catholic and the deputy manager was unsure but did say one person's daughter took their parent to mass some weeks. Another person's care plan did not state whether they had any religious beliefs.

The provider employed an activities co-ordinator to plan and undertake activities with people. Records did not always give a clear picture of the quality and amount of time given to people on an individual basis, for example people who stayed in their rooms by choice or need. Records to document the group activities to show who had taken part and if people enjoyed the sessions were sporadic and lacking in substance. For example, external entertainers were also used regularly, however the success of these had not been recorded to monitor people's on-going interest and enjoyment. A member of staff said, "If I had the time I would like to play cards and dominoes with people. There is less for men to do". The registered manager acknowledged activities needed to be improved and had taken steps towards this.

The failure to provide care and treatment that meets people's specific needs and preferences is a breach of Regulation 9(1)(b)(3)(c)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

A personal and family history was included within people's care plans to make sure that the information needed to describe what was important to people was available. For example, the names of people's children, siblings, parents or pets they had and where they had lived at different times in their lives.

Most people had been asked what plans they would like to have in place for when the end of their life was nearer. Funeral arrangements were discussed and who would lead on this. The plans did not always address further detail such as people's wishes in how they would like to be cared for at the end of their life and where they would prefer to be and with who. A health care professional told us, "The staff here are good at knowing and caring for end of life".

People told us they knew how to make a complaint and they knew who they would talk to if they did need to complain. People told us, "Yes I have got a letter that explains how to complain. I would speak to the manager if I was unhappy"; "Oh yes but I don't think I have anything to complain about. If I wasn't happy I would tell the manager"; "I never had to complain. I think I would talk to [the registered manager] and then I believe somebody in Bexley, the owner" and, "If I have a complaint I can get a written request form". Relatives were also informed about how to make a complaint if they needed to do so and told us, "Yes we know how to complain, we have no complaints. If we were unhappy we would go straight to the manager then social services" and, "Yes I know how to complain. I have raised a couple of things and they have been resolved. Mum made a fuss about a member of staff about a year ago. She didn't take kindly to them. We all sat down and talked about it and the problem is resolved. All is okay now".

The registered manager and provider followed their procedures when dealing with complaints. Although no formal written complaints had been received, two verbal complaints had been made in the previous 12 months. The registered manager had investigated these and recorded the outcome and the response made to the complainant. The staff we spoke with had a good understanding of the complaints procedure and their responsibilities in dealing with complaints. This showed the provider took all complaints seriously and investigated concerns in order to learn lessons and make improvements.

The registered manager made sure people had the opportunity to meet regularly to share their concerns and suggestions. Discussions often focussed around food, snacks and activities. The registered manager also reminded people of services available such as the role of the keyworker and when the GP visited. The provider carried out an annual satisfaction survey with people and their relatives. Responses were generally positive in a survey undertaken in August 2017, most saying they were satisfied with all areas covered. The few comments that were made were responded to and measures put in place to improve the areas identified.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 24 October 2016, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's quality assurance systems were not effective in identifying the areas that required improvement. People's care records were not always accurate or contemporaneous in reflecting the care and treatment they received.

At this inspection, we found that although improvements had been made to the quality assurance systems they had not identified a number of areas that still required improvement.

The provider told us they had developed a service improvement plan with the registered manager and deputy manager after the last inspection to make sure they made all the improvements required. The provider was fully involved in the service and spent time researching and ensuring they were up to date with CQC regulations and any changes. We looked at the service improvement plan and it was very detailed with clear dedication and willingness to make improvements. However, a robust auditing system was not in place to ensure the areas identified within the improvement plan to improve the quality and safety of the service was achieved. The areas of concern found during the inspection had not been identified through the provider's monitoring processes. Where issues had been found, action plans had not been developed to rectify the shortfalls to ensure compliance.

Care plans were audited each month by the deputy manager. Although improvements had sometimes been identified, the action needed to address the shortfalls had not been recorded, this section was left blank. For example, the audits of one person's care plan showed that no action had been recorded for the months of March, May, June and September 2017. In the months where action was required and had been recorded, there was no date when the action should be completed by or who was responsible for completing the action. Some people's needs had clearly changed and no new assessment had been completed in order to make changes to the care plans. Care plan reviews had not identified changes. These areas had not been recognised as areas that required action and improvement in the care plan audits. This meant that areas of the care plans that required improvement had not been addressed as audits were not robust and complete.

Health and safety checks were undertaken each month which included checking for hazards, odours and cleanliness, electrical safety and equipment used in the service. Action required had not been recorded even though some issues found had been on-going from month to month. For example, obstructions were found in corridors each month and first aid boxes were documented as needing replenishing more than once. The auditor recorded that staff were made aware. However, no record was made if action was taken to remove the obstructions or to replenish the first aid boxes or which staff were made aware. This meant it was unclear who was responsible for taking action and if any action had been taken to address the on-going issues. On the day of inspection trip hazards were observed in corridors, particularly wheelchairs. An infection control audit undertaken monthly had not identified any of the concerns found on the day of inspection regarding the use of communal hoist slings and personal toiletries found in communal bathrooms.

The failure to have an effective system to identify and make improvements to the quality and safety of the service provided is a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with said that they were happy with the way the home was run. The comments we received included, "I am happy, there are staff around if I need help with anything, I get my pills on time and I can stay in my room when I feel like it"; "It seems to be run ok, the staff are not far away if you want something and the managers come around to make sure everything is just right"; "As far as I know the place is well managed but I do not know what it was like before. The only improvement I can think of is that I would like to go out more often that we do"; "Yes I am listened too, anything I have asked for they have always managed to get. For example they brought me this new table within two days. The staff are excellent. The manager she is strict but she is good. I admire her honesty, if she feels something she will say it" and "Yes, I feel listened too. We get a residents letter once a month. The sing-alongs are popular so is the bingo but I think we need to get more activities. They are trying to get something every day but the take up has not been good. I join in sometimes. I think the home is run fairly well".

Staff meetings were held regularly, including night staff and ancillary staff, and were well attended. Staff were able to raise issues and suggest improvements and changes. The registered manager took the opportunity to share good practice during staff meetings, for example, sickness reporting procedures, mobile phone use while on duty and choices given to people at mealtimes. One staff member told us, "I do feel supported by the managers, if I am not sure about anything I can always ask. They follow up on issues and let you know if they have already spotted it, and done something about it. They always come back to you if you do ask something". Another said, "The managers are very supportive. Their door is always open and they are always calm and approachable".

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 prominently displayed their ratings in the service.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries, Deprivation of Liberty Safeguards (DoLS) authorisations and deaths. The registered manager had notified CQC about important events such as safeguarding incidents, deaths and serious injuries that had occurred since the last inspection.

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 9 HSCA RA Regulations 2014 Person-centred care The registered manager and provider had failed to plan and review care and treatment to meet people's needs and preferences

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered manager and provider had failed to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered manager and provider failed to ensure safe recruitment procedures were used to employ only staff of good character

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager and provider had failed to ensure staff received the training and supervision necessary to carry out their role.