Runwood Homes Limited

Braywood Gardens

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We conducted an unannounced inspection at Braywood Gardens on 16, 19 and 26 October 2018. Braywood Gardens is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Braywood Gardens is situated in Carlton, Nottinghamshire and is operated by Runwood Homes Limited. The service accommodates 99 people across eight units which are split across two floors. At the time of our inspection there were 95 people living at the home.

At our last inspection in December 2015 the service was rated good. At this inspection we found the quality of some aspects of the service had deteriorated. Consequently, we found concerns across a range of areas including safety, staffing, hydration and nutrition, consent and choice and leadership and governance. This resulted in several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. This was the first time the service had been rated as requires improvement.

There was a registered manager in place at the time of our inspection. 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.

During our inspection we found there were not always enough staff to meet people's needs or ensure their safety. We saw staff were not always present to reduce risks such as falls. Risks in areas such as choking, skin integrity were not always identified or addressed and this placed people at risk of harm. Equipment used in people's care and support was not always used safely. People were not always protected from the risk of abuse and improper treatment as staff were not always present, or did not always intervene in verbal and physical altercations between people. Improvements were required to ensure the home was clean in all areas. Overall, medicines were managed and administered safely, some improvements were needed to ensure staff had clear guidance about medicines. There were systems in place to learn from accident and incidents. Safe recruitment practices were followed.

There was a risk people may not be provided with enough to eat and drink. Mealtimes were not well organised; people were not always served with an appropriate diet and were not always offered timely or appropriate assistance at mealtimes. People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not support this practice. Staff required more training to enable them to provide effective support to people with dementia. In other areas staff had training and support to enable them to do their job and told us they felt supported. People had access to a range of specialist health care professionals and feedback form these professionals was positive. The home was adapted to meet people's

needs.

Staff were not consistently kind and caring and did not always communicate clearly with people. People and their relatives told us that changes in the staff team meant they were not able to develop meaningful relationships. People's rights to privacy and dignity were not always respected. People were not supported to be as independent as possible. People had access to advocacy services if they required this to enable them to express their views.

People did not consistently receive personalised care that met their needs and staff were not always responsive to people's needs. People and their relatives were not always involved in planning their care and support. Further work was needed to ensure people had the opportunity to discuss their wishes for the end of their lives. People were not always provided with opportunity for meaningful activity. There were systems in place to respond to complaints. However, concerns were not always resolved. People's diverse needs were accommodated. People's diverse needs were identified and accommodated.

Systems to ensure the safety and quality of the service were not fully effective. Where issues had been identified, improvements had not always been made or sustained. This failure to identify and address issues had a negative impact on the quality of the service provided at Braywood Gardens. People and staff had opportunities to make suggestions about the home and this was used to make improvements. The management team were responsive to feedback and took swift action to address issues identified in this inspection. There was positive partnership working with health professionals.

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.

There were not always enough staff to meet people's needs. Risks associated with people's care and support were not always managed safely. People were not always protected from the risk of abuse and improper treatment. Improvements were required to ensure the home was clean in all areas. Overall, medicines were managed and administered safely. There were systems in place to learn from accident and incidents. Safe recruitment practices were followed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There was a risk people may not be provided with enough to eat and drink. Mealtimes were not always positive experiences for people. Further work was needed to ensure people's rights under the Mental Capacity Act 2015 were protected. Staff required more training to enable them to provide effective support to people with dementia. In other areas staff had training and support to enable them to do their job and told us they felt supported. People had access to a range of specialist health care professionals. The home was adapted to meet people's needs.

Is the service caring?

Inadequate

The service was not caring.

People did not receive person centred support and staff were not always kind and caring. Staff did not always treat people in a respectful and dignified manner. People were not always supported to be as independent as possible. People had access to advocacy services if they required this.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not consistently receive personalised care that met

their needs. Staff were not always responsive to people's needs. People and their relatives were not always involved in planning their care and support. People were not always provided with opportunity for meaningful activity. There were systems in place to respond to complaints. However, concerns were not always resolved. People's diverse needs were accommodated.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems to ensure the safety and quality of the service were not fully effective. Action taken to address issues was not always effective. People and staff had opportunities to make suggestions about the home and this was used to make improvements. The management team were responsive to feedback and took swift action to address issues identified in this inspection. There was positive partnership working with health professionals.

Braywood Gardens

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 16,19 and 26 October 2018. The inspection team consisted of three inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection visit, we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events, which the provider is required to send us by law, such as allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

During our inspection visit, we spoke with 12 people who used the service and the relatives or friends of 10 people. We spoke with 11 members of care staff, the activities coordinator and maintenance manager. In addition, we spoke with the following members of the management team; two deputy managers, the dementia services manager, the registered manger and the regional manager. During our inspection we also spoke with two visiting health and social care professionals.

To help us assess how people's care needs were being met we reviewed all or part of 12 people's care records and other information, for example their risk assessments. We looked at people's medicines records, five staff recruitment files, training records and a range of records relating to the running of the service, for example, audits and complaints.

We carried out general observations of care and support and looked at the interactions between staff and people who used the service. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The provider completed a 'Provider Information Return' prior to our inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We used this to plan our visit and write our report.

Requires Improvement

Is the service safe?

Our findings

There were not enough staff to meet people's needs and ensure their safety. This was reflected in our observations and comments from people and their families. A relative told us, "I think there's a lack of staff. Before [relation] came here, I was told the unit would have two or three dedicated carers but now there is only one. This does affect how [relation] is cared for. Staff have to leave the unit unattended while they support others. This can take quite a long time." Another relative told us, "Sometimes staff ask me to keep an eye on people when they have to leave the unit. That's fine, but I don't know what I would do if someone fell."

Throughout our inspection we observed several instances when people were left unattended in communal areas. Some of these people were at high risk of falls, or sometimes behaved in a way that placed others at risk of harm. For example, on one occasion we had to intervene to prevent an altercation between two people as there were no staff present. On other occasions people were shouting and calling out but there were no staff present to respond. We also identified concerns about staffing levels at night. Staffing rotas showed there were usually seven staff on shift at night and there had been recent occasions where only six staff were deployed at night. The home was split into eight units, which meant there was not always a staff member present in each area. In addition, if two staff were required to support a person this left several units with no staff cover.

We discussed staffing with the management team who informed us that staff levels were based upon an assessment of each person's support needs. However, this did not take the layout of the home into account.

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

In response to our concerns the management team took immediate action to increase staffing levels whilst they reviewed staffing levels. We will assess the impact of this at our next inspection.

People were not always protected from risks associated with their care and support. Risks were not always identified or addressed. For example, we saw one person propel their wheelchair into others. This risk was not identified in their care plan and consequently there were no measures in place to reduce risks to the person or others. Another person had an area of skin damage but there was no information about this in their care plan or risk assessment. This meant staff did not have access to adequate guidance and placed the person at risk of inconsistent and potentially unsafe support. A third person had been assessed as being at risk of choking and a specialist health professional had recommended the person was supervised and given a specialist diet. This advice had not been incorporated into their care plan and we observed this person was served an incorrect texture diet and was not supervised when eating. This placed them at risk of choking. This failure to identify and assess risk placed people at risk of harm.

Risks posed by people's behaviour were not always managed safely. Care plans did not consistently contain enough information to enable staff to provide safe and effective support. We observed one person making

verbal threats to others on several occasions. Their care plan did not contain any information about this behaviour or how to reduce the impact upon others. Consequently, we observed staff did not intervene to reduce the risk of people experiencing distress.

Equipment used in people's care and support was not always used safely. Several people required specialist mattresses to reduce the risk of pressure ulcers. We found two pressure mattresses which were not set correctly. This could have had a negative impact upon the effectiveness of the mattress and placed people at risk of skin damage.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

People were not always protected from the risk of abuse and improper treatment as staff were not always present, or did not always act to diffuse altercations between people. Consequently, people were subject to verbal abuse and physical altercations. We observed an altercation between two people in a communal area, one person made threats towards the other and used offensive language. There were no staff available and this continued for approximately ten minutes until a staff member was located. On another occasion a person intentionally propelled their wheelchair into another person during a physical altercation, staff were present but did not intervene.

Referrals had not always been made to the local authority safeguarding adults team. Records showed some referrals had been made to the local authority safeguarding adults team; however, we identified other incidents, such as altercations between people, which had not been reported. This meant there was a risk safeguarding incidents may not be appropriately investigated resulting in people being left at risk of abuse. We discussed this with the management team who told us they had been advised by the local authority not to refer every incident. They advised us they would seek further advice on this and said they would ensure referrals were made in the interim.

The management team reviewed all incidents regularly to ensure appropriate action was taken in response, they also worked with the local 'falls team' to review factors such as timing and location of falls to enable them to make changes to the environment and reduce risk. However, during our inspection, we received concerns about systems to investigate and share information about unexplained injuries. This was under investigation by the local authority safeguarding adults team at the time of our inspection.

Although people told us they thought the home was clean we found further improvements were required to ensure the home was sufficiently clean in all areas. Some areas of the home, such as kitchenettes, lounges and dining areas, had not been cleaned to a sufficient standard. We discussed this with the management team who took swift action to begin to address this during our inspection, such as replacement of floors in the kitchenette areas. The Food Standards Agency had inspected the home in June 2018 and given it a food hygiene rating of five, which means very good. We observed the kitchen area to be clean and well maintained and staff followed food hygiene procedures.

Safe recruitment practices were followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. For example, before staff were employed, criminal record checks were undertaken through the Disclosure and Barring Service. These checks are used to assist employers to make safer recruitment decisions.

Overall medicines were managed safely and records showed people received their medicines as prescribed. People told us they got their medicines when they needed them. A relative told us, "I think [relation] gets

their medicine on time and they have never run out." Some improvements were required to ensure staff had clear information about how to administer medicines that were prescribed to be given 'as needed.' Topical creams, such as those used to prevent and treat dry skin, were not always applied as directed. We looked at Topical Medicine Administration Records (TMAR) for four people, all of which failed to evidence that creams had been applied as directed. This failure to apply topical creams as directed may have had a negative impact on people's skin integrity.

The team at Braywood Gardens were working with health professionals to try and reduce the amount of medicines people were taking. The deputy manager told us this had a positive impact for one person who had successfully stopped taking a potent antipsychotic medicine.

People were protected from environmental risks. There were systems in place to assess and ensure the safety of the service in areas such as fire and legionella. There were personal evacuation plans detailing how each person would need to be supported in the event of an emergency such as a fire.

Requires Improvement

Is the service effective?

Our findings

There was a risk people may not have enough to drink. Fluid records did not evidence people were provided with enough to drink. We looked at fluid records for three people, all of which showed days where fluids offered were significantly below the recommended amount. One person was reliant upon staff to meet their hydration needs. Despite this, fluid records did not evidence that they were provided with enough to drink. For example, one record documented they were only offered 450ml of fluid in a day. There was no evidence that staff had identified and addressed days when the person did not drink enough fluid. We observed incidences where people had been provided with jugs of drink but not given a cup and we also observed people did not always receive effective assistance to drink when needed. This placed people at risk of dehydration.

People were at risk of unplanned weight loss. Food records were not always completed for people who were at risk of malnutrition and weight loss. Records showed one person had lost weight over the months prior to our inspection, their care plan also documented they had a poor appetite. Despite these risk factors, staff were not monitoring how much the person ate. This meant there was no system in place to identify concerns.

People were not always served with an appropriate diet. This was reflected in comments from some relatives and confirmed by our observations. A relative told us, "Sometimes the food isn't suitable for [relation] as they can't chew properly. No provision seems to have been made for this." We observed another person was served food and fluid of an inappropriate consistency and this caused them to cough. We have reported on this further in the 'Is this service safe' section of this report.

People were not always offered timely or appropriate assistance at mealtimes. This was reflected in relative's comments. A relative told us, "I come every lunchtime as I'm not confident that the staff have the time to spend with [relation] helping them to eat." Staff did not continuously monitor the dining room so they couldn't see who was struggling with food. We saw people struggling to cut up food and having difficultly chewing food which had not been effectively cut up. Staff did not always notice this so people were not assisted. In addition, people did not always have appropriate equipment to enable them to eat. One person was struggling to eat with a knife and fork; however, they were not offered an alternative. Another person was finding it difficult to load their fork, but they did not have a plate guard in place to assist them.

Mealtimes were not well organised. This was reflected in feedback from some people's relatives. For example, a relative told us food was sometimes cold by the time it had been transferred up from the kitchen and served to people. We also found people were not always offered timely assistance to eat, which resulted in their food being lukewarm.

This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

Peoples rights under the MCA were not always protected. Where people's ability to consent was in doubt their capacity had not always been assessed as required. One person's GP had recommended minor surgery; however, a decision had been made by staff and the person's relative 'on behalf' of a person not to proceed with this. Their capacity had not been assessed and there was no evidence that this decision had been made in the person's best interests. Another person had restricted access to some food and drink, again their capacity had not been assessed. This failure to assess people's capacity meant there was no evidence that decisions made were in people's best interests and were the least restrictive option. Where mental capacity assessments had been completed, they were not always detailed. This meant there was a risk people's rights may not be protected.

Conditions imposed upon DoLS authorisations were not always complied with. Although DoLS applications had been made as required, action had not been taken to comply with conditions. One person had conditions which stated the frequency of welfare checks should be reviewed to ensure the person's privacy was respected. This had not been completed at the time of our inspection and the person was still subject to hourly checks. Another person's DoLS required that they had a personalised activity care plan developed, again this has not been implemented. This meant there was a risk people's rights were not upheld.

This a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection the management team addressed the concerns we had raised in relation to specific people. Further work was required to ensure all people's rights under the MCA were respected.

We found some care plans lacked information about people's specific health needs or the impact upon them. This lack of guidance meant there was a risk people may not receive consistent support in relation to their health needs. We also found that recommendations from health professionals were not always followed. We have reported on this in the 'Is the service safe' section of this report.

There were effective working relationships with external health professionals. The local Care Homes team (a team of registered nurses who support care homes in the area) visited regularly to monitor and respond to people's health needs and to support the staff team. A health professional told us this had resulted in a reduction in hospital admissions. There were also links with the local falls prevention team. They told us the home had engaged positively with them. This had resulted in a significant reduction of falls at the home.

Further work was needed to ensure that people had a positive experience when moving between services. Prior to people moving to Braywood Gardens, the management team assessed their needs. These assessments were focused on people's physical needs, and while they provided a good overview of this, further work was needed to ensure people's social needs were also considered. This was reflected in the

comments of a relative who told us their relation's move into the home had not gone as planned. They said, "There was a problem with [relation's] room when they arrived. It wasn't ready. All their stuff and belongings were piled up on the bed. It was not welcoming or reassuring." This meant there was a risk people would not receive person centred support when they moved between services.

Although nationally recognised assessment tools were used at Braywood Gardens, these were not used consistently or effectively. For example, one person had lost a significant amount of weight over the past six months and was known to have a poor appetite; however, there was no malnutrition risk assessment in place and consequently their food intake was not monitored. Where risk assessments had been completed recommended actions had not always been followed. Another person had been assessed as being at high risk of pressure ulcers. The risk assessment recommended a specialist mattress; however, this had not been implemented.

People's feedback about the competency and skill of staff was varied. Some people told us staff were well trained and skilled. However, other people told us staff lacked understanding in key areas, specifically, the needs of people living with dementia. A relative told us, "Sometimes I don't think staff understand dementia fully." This was confirmed by our observations. Some staff did not demonstrate insight into the impact of dementia or an understanding of how to communicate with people. For example, we observed staff trying to explain something to a person with dementia, the person said they did not understand, but staff continued to repeat the same information and did not try any alternative ways of communicating with them. Eventually the person walked away. Other people asked staff the same question repeatedly, staff appeared exasperated and on one occasion said, "Look we've already told you." We discussed this with the management team who told us dementia training was planned for the staff team. They had some staff who were 'Dementia leaders' whose role was to coach the staff team. They planned to provide more support to these staff to enable them to coach other staff.

In other areas, we found staff had sufficient training to enable them to meet people's needs. Staff were generally positive about the training they had. Records showed staff had received training in areas such as, health and safety, moving and handling and fire safety. Some staff also had training specific to people's individual needs. New staff were provided with an induction period when starting work at Braywood Gardens. Induction included training and shadowing more experienced staff. Staff told us they felt supported and records showed most staff had regular supervision of their work.

The home was adapted to meet people's needs. Aids and equipment had been installed throughout the home to enable people with mobility needs to navigate around the building and there was a call bell system to ensure people could request staff as required. There were communal lounge and dining areas on each unit which meant people had space to spend time socialising with friends and family. Throughout our inspection we observed that music was played loudly in communal areas of the home. This was not always turned down or off during activities and could be heard in people's bedrooms when they were watching TV. This could have been confusing or disorientating for people. For example, one person's care plan documented that loud and busy environments could be a trigger to their anxiety and behaviours, however, music was playing loudly outside their room. This had not been considered.

Inadequate

Is the service caring?

Our findings

Staff were not consistently kind and caring. Although we received some positive comments about some staff members this was based on the caring approach of individuals rather than a culture of person centred care. We observed that many staff interactions were focused on tasks. Conversations between staff and people living at the home were limited and functional. For example, one member of staff simply gave the person instructions when assisting them to eat, such as "open your mouth wider," but did not try to engage the person in any conversation.

Mealtimes were not always dignified experiences. Some people were assisted to eat by several different staff as staff kept being called away. One person was assisted by eight different staff members at one mealtime time, consequently, it took the person 45 minutes to eat their meal. Another person was being assisted to eat by a staff member who was also on the phone. We observed staff trying to assist multiple people to eat at the same time. This was not dignified. Food served to people who required a modified texture diet was not appetising and did not promote a dignified dining experience. We observed a member of staff mash all a person's food together. Care was not taken to separate different parts and consideration had not been given to the presentation of the food. This did not respect people's right or promote their dignity.

Staff did not always communicate clearly with people. Throughout our inspection we observed instances where staff did not demonstrate a good knowledge of how to communicate with people who were living with dementia or memory loss. Staff were trying to encourage one person to have lunch but the person was unable to understand them. Staff continued to repeat the information verbally to them and did not use any alternative approaches, consequently the person walked away confused and anxious. At lunch time staff brought food samples round to enable people to choose. However, staff did not make it clear these were samples and placed the plates down in front of several people, causing them to become confused.

Staff did not respond to reduce people's distress or anxiety. During our inspection we observed staff did not routinely respond to people when they shouted out for help, or when they appeared upset or distressed. Although staff were not being intentionally unkind they seemed to not notice when people were distressed. One person's care plan stated, "[Name] usually gets very upset and frustrated and shouts out 'I want to go home.' Lots of verbal reassurance should be given to [name] during these times to make them feel settled." We observed the person say, "I want to go home" eight times with no attempt from staff to settle the person. When staff did respond they were not always patient, kind or gentle. For example, we heard staff 'sshhing' people. This did not reassure people to reduce their anxiety.

People and their relatives told us that changes in the staff team meant they were not able to develop meaningful relationships. A relative commented, "Staff keep changing, I'm told this is the policy, they change shifts, floors, upstairs, downstairs. But [relation] needs to be able to recognise a familiar face. Staff don't know my [relation] and she doesn't know them." Another relative told us, "I'm concerned about the level of consistency in the care here. It's not there. There is no consistency and that's important for someone with severe dementia." A third relative told us, "There are increasingly random faces popping up and [relation] doesn't recognise them. It's the little things that start to trip up and in terms of making life

comfortable these are important."

People's rights privacy and dignity were not always upheld. Some relatives told us staff did not always act to ensure people's dignity. One relative said, "[Relation] sits there with their buttons undone. I think they should be watching [relation] and attending to them by doing them up." Another relative expressed concern about people's privacy. They told us the café area of the home was sometimes used for the dentist or optician while they were sitting in the café with their relation. Some people living at the home told us their privacy was not respected as other people living at the home frequently entered their room. We observed this during our inspection and found there were not always staff available to prevent this from happening. We also saw confidential personal information about a person's care needs stuck on the outside of their bedroom door. This was visible to other people who used the service and visitors. This did not respect the person's privacy.

People were not supported to be as independent as possible. Several relatives of people living at Braywood Gardens told us staff did not have the time to encourage and support people's independence. One relative told us this had a negative impact on their relation's mobility. Although care plans contained guidance for staff about how to promote people's independence this was not always followed. One person's care plan directed staff to assist a person to eat in a specific way to promote their independence and skill. We saw that staff did not initially provide any assistance which resulted in the person not eating, when staff intervened they did it for the person rather than promoting their independence as specified in the care plan.

This a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

On the third day of our inspection we saw work was underway to improve the issues detailed above. The dementia service manager was coaching staff to ensure people's needs were met in a timely, kind and caring manner. The overall atmosphere was calmer and the mealtimes we observed were more organised and dignified. We will assess the full impact of the improvements underway at our next inspection.

The registered manager told us people had access to an advocate if they wished to use one and there was information about advocacy displayed in the service. Advocates are trained professionals who support, enable and empower people to speak up. No one was using an advocate at the time of our inspection.

Requires Improvement

Is the service responsive?

Our findings

People did not consistently receive personalised care that met their needs. This was reflected in comments from people's relatives. One relative told us, "It depends on who's on duty, this affects how [relation] looks. They usually shave [relation], wash them, put their teeth and hearing aids in. But this varies, some days [relation] looks fed up and unkempt. Some days [relation] hasn't got hearing aids in some days they haven't got their teeth in." We found staff did not always have a good knowledge of how best to support people. Although people had care plans in place we observed that staff did not always provide the care people needed. One person's care plan contained clear details of the support person required to orientate themselves at mealtimes. However, their relative told us, "(Staff) don't always do this, they don't always know. So sometimes this happens sometimes not." This was also supported by our observations throughout inspection. This placed people at risk of receiving inconsistent support that did not meet their needs.

Staff were not always responsive to people's needs. People told us staff did not always respond quickly to their requests for support. One person explained that they did not always receive assistance to go to the toilet when they asked. Staff said to them, 'you've already been' or 'I'll do you in a minute.' Throughout our inspection we also observed that staff did not always identify or respond to people's needs. For example, one person told us they were cold, we pointed this out to a member of staff who said, "[Name] is always cold" but did not address this. Another member of non-care staff pointed out the person may need a blanket; however, this was still not provided. This failure to identify and respond to people's needs meant they may not receive the support they required.

People and their relatives were not always involved in planning their care and support. Feedback about involvement in care planning was variable. Although some people told us they had been involved this was not always the case. One relative told us, "We haven't got a care plan, you should create one at the very start. No one's discussed how my [relation] is going to be looked after. We're just a number. There doesn't appear to be a structure in place, if there is, it isn't implemented. This is all about [relation's] needs and I don't feel they are being met fully."

This a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were needed to ensure people were given the opportunity to discuss their wishes for the end of their lives. Some people had end of life care plans in place; however, these plans mainly focused on people's health and medical needs and did not detail people's wishes. Despite this, we received positive feedback from visiting health professionals about the quality of end of life care. The registered manager told us improvements were planned in this area. Training was scheduled to give staff the skills and resources they required to discuss people's end of life wishes with them.

People were not always provided with appropriate opportunities for meaningful activity. Most relatives we spoke with told us there was not enough stimulation for their relations. A relative told us, "Stimulation here goes from poor to ok. Not many people join in and it should be tailored to their needs. It's a staffing issue." There was an activity coordinator who was responsible for providing opportunities to people and for

encouraging staff to engage people in activities. The provider told us they were also recruiting a second activity coordinator. Although there were some activities observed throughout our inspection, we found these were not always appropriate. For example, a word search activity did not take account of people's varying levels of ability and consequently most people present were unable to contribute. In addition, activities were not based upon people's individual interests. A relative told us, "[Relation] used to love watching horse racing. I've told staff this but they haven't acted on it or enabled them to watch any." We discussed this with the management team who told us they had already identified this as an area for development. They were working with the activities team to improve the quality of opportunities available to people.

People's diverse needs had been identified and accommodated. People's religious and spiritual needs were catered for. People who wished to practice their religion were provided with opportunities to do so at Braywood Gardens. People's cultural needs had also been considered. For example, one person sometimes reverted to their native language when they became distressed. The registered manager told us a member of staff who spoke the same language often supported the person to communicate and we saw this in practice during our inspection.

Improvements were needed to ensure people's concerns were acted upon. Formal complaints were addressed in line with the provider's complaints policy and most people commented that when they had made formal complaints these had been resolved to their satisfaction. In contrast, concerns raised informally were not recorded and consequently some people told us effective action was not always taken to resolve concerns. For example, a relative told us they had discussed their concerns about a lack of stimulation with staff on several occasions. They commented, "Nothing has changed." The management team told us would take immediate action to handle concerns in line with the complaints policy to ensure issues were resolved effectively.

Requires Improvement

Is the service well-led?

Our findings

Systems to ensure the quality and safety of the service were not always effective. Quality assurance and audit processes had not always been effective in identifying and addressing areas for improvement. For example, the infection control audit was not effective in identifying areas of concern. The Clinical Commissioning Group had conducted an infection control audit in early 2018, which identified several concerns. The infection control audit conducted by the management team the month before this audit had not identified any concerns and had been scored 100%. This was an ongoing issue as during our inspection we found some areas of the home were not clean and hygienic; however, this had not been identified in the most recent infection control audit. Care plan audits were not robust. These audits focused on the completion of documentation, but did not assess the quality of information in care plans. Consequently, it had not been identified that some care plans did not reflect people's needs. This placed people at risk of receiving support which did not meet their needs or ensure their safety.

Systems to monitor the day to day performance of staff were not effective. Daily audits were completed by the management team, these focused on areas such as; care, the environment and activities. However, these had not identified concerns found in our inspection, such as the lack of person centred care.

Audits conducted by the provider did not consistently identify areas for improvement. The provider conducted a monthly compliance audit. The most recent of which was conducted in September 2018 and had rated the home as good. Although some areas for improvement had been identified most of the concerns found throughout our inspection had not been identified in this audit. This failure to identify and address issues related to risk management, staffing and other concerns had a negative impact on the quality of the service provided at Braywood Gardens.

Where issues had been identified, improvements had not always been made or sustained. The local authority had conducted an audit at the home in September 2018. This had identified similar issues to those found in our inspection. Although some improvements were underway, key risks, such as pressure relief mattresses not being set correctly had not been prioritised for action and consequently we found this was a continued risk at our inspection. The failure to take swift action to address known issues exposed people to the risk of harm.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

People and their relatives gave mixed feedback about the quality of service provided at Braywood Gardens. Some people told us they were happy with the care and support provided, one relative told us, "It's next best thing to [relation] being in their own home." However, in contrast, other people were less positive. One relative said the home was, "Too big to care."

There was a registered manager in place at the time of our inspection. They were supported by a team of senior staff. Overall people, relatives and staff were positive about the management team and told us they

were approachable. The management team kept up to date with best practice by attending local groups and forums and the provider sent regular updates about new developments in social care.

Staff told us they felt supported by the registered manager and had confidence they would address any concerns raised in an appropriate manner. One member of staff told us, "The managers are accessible and they have been helpful. You can go and talk to the managers." There were regular staff meetings for all designations of staff, these were used to share news and information with staff and to discuss areas of concern and improvements needed.

Throughout our inspection the management team were responsive to feedback and took swift action to address areas of concern, ensuring immediate risks were reduced. After our visit they provided us with an action plan based upon the feedback we provided.

People were given the opportunity to provide feedback about the running of the home and this was used to make improvements. There were regular meetings for people living at the home and their relatives. The management team told us they made these social events by providing fish and chip suppers and wine and cheese nights to encourage people to attend and contribute. Feedback from people and their families had been used to make positive changes to the home. For example, families had suggested a café, this had been developed in partnership with people living at the home. People were also able to share feedback and ideas in regular surveys. A recent survey had focused on food and drink and improvements had been made such as the introduction of fizzy drinks and more choice on the menu.

The home had good links with external health and social care professionals to ensure people's needs were met. We received positive feedback from two health professionals who told us the staff team were committed to improving the quality of support provided at Braywood Gardens.
One health professional commented, "They are always open to considering how to improve and how to move on. The home had links with the local community. Local people were invited into the home for events and there were partnerships with local schools and colleges to enable young people to complete work experience at Braywood Gardens. The home was also involved in a study with Nottingham University aimed to improving the assessment of older people's needs.

We checked our records, which showed the provider, had not notified us of all events in the home. A notification is information about important events, which the provider is required to send us by law, such as serious injuries and allegations of abuse. We had not been notified of some allegations of abuse referred to the local authority safeguarding adults team. We discussed this with the management team who assured us this was a mistake and said they would ensure notifications were made in the future.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online 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. The provider had displayed their most recent rating in the home and on their website.

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 People did not receive person centred support that met their needs or reflected their wishes. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated in a respectful or dignified manner. People right to privacy was not upheld. Independence was not always promoted. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always provided with safe care and treatment. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydration needs were not always met.

Regulation 14(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to ensure the quality and safety of the home were not always effective. Regulation 17(1)(2)

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