Bramble Lodge Care Home Limited

Bramble Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 12 and 13 October 2015 and 22nd December 2015. The first day was unannounced which meant the staff and registered provider did not know we would be visiting. The registered provider knew we would be returning for the second and third day of inspection.

Bramble Lodge can provide accommodation for up to 41 people who need help and support and is situated in a residential area within Middlesbrough. Bramble Lodge is a purpose built building over two floors. There are stairs and a lift to assist people to the first floor. Care and support was provided to people on the ground floor living with a mental health condition and on the first floor for people living with a Dementia. At the time of our inspection there were 35 people living at the home.

At the time of our inspection, the manager had been in post since June 2015 and their application to become a registered manager for the service was in progress. 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.

We previously inspected Bramble Lodge on 22 January 2015. At that inspection we found the service was not meeting all the standards which we inspected. We found that the management of medicines was not always appropriate; some medicines had been unavailable for people who needed them and medicine records had not always been completed. Care plans on the mental health unit did not detail 1:1 sessions with people and monthly evaluations of care plans contained limited information. Care plans lacked evidence of care and support should be provided which also enabled people to live to their full potential.

At the start this inspection we could see that the service had not responded appropriately to breaches in records and medicines as identified in our last inspection in January 2015. On the last day of inspection we could see that the service had implemented new procedures for the management of medicines but further improvements to records were required.

At this inspection we could see that safeguarding alerts had been made when needed. Records had been completed appropriately. All staff knew how to respond to a potential safeguarding alert. Staff knew the procedures to follow if they had any concerns and if they had information they needed to share.

Risk assessments were in place for people and for the day to day running of the service. This meant that the service had acted appropriately to reduce the risks of harm to people, staff and visitors.

There were sufficient staff on duty to provide care and support to people and to ensure the smooth running of the service. People and staff told us that there were enough staff on duty to meet people's needs safely. We could see that staff had been through a thorough recruitment process which included an interview, reference checks and a disclosure and barring service check.

Appropriate arrangements were in place to manage medicines. Medicine administration records were fully completed and good stocks of medicines were in place for people. Guidance for 'as and when needed' medicines was available.

People and staff had access to the equipment they needed. We found that equipment was well-maintained.

We could see that staff had completed a variety of training, such as fire safety, infection control and manual handling. Some training had not been completed by all staff; however we could see that this training had been booked in to be completed in the near future.

Supervision and appraisal was not up to date for all staff; however we could see that planned dates had been put in place. An action plan had been put in place by the service to make sure that the registered provider's guidelines for staff receiving supervision and appraisal would be met by April 2016.

Mental capacity assessments had been appropriately carried out and deprivation of liberties safeguards had been carried out for people who needed them. Records showed the reasons for this decision making and the people involved.

The staff team at the service worked together to monitor people's weight and to provide appropriate support with nutrition and hydration when needed. People spoke positively about the menu provided at the service.

Health professionals regularly visited the service to provide care and support to people and this was reflected in people's care records. Consent had been sought when people were given vaccinations.

We could see that staff had a good relationship with the people they cared for. Staff had good knowledge about people's life histories and demonstrated a good understanding of how people's health conditions affected them on a daily basis. Staff provided encouragement and support to maintain people's independence.

Records did not always show if people who used the service were involved in planning their care and making decisions. We found gaps in people's records and records relating to the running of the service.

The service had not responded appropriately to breaches in records and medicines as identified in our last inspection in January 2015.

People knew how to make a complaint if they needed to and staff were aware of the procedure they needed to follow if they received a complaint. Information to make a complaint was on display at the service.

A new manager was in place at the service and they had submitted an application to the Care Quality Commission to become a registered manager. People who used the service and staff spoke positively about the manager and felt able to discuss any concerns with them.

A skilled staff team was in place at the service. Staff worked as a team to provide care and support to people.

The service had good procedures in place to monitor the quality of the service. Regular audits had been carried out; however medicine and record keeping audits had not highlighted the gaps which we had during our inspection. Feedback was regularly sought from meetings and surveys.

Accidents and incident's had been recorded and analysis had been carried out to identify any patterns and trends to minimise the risk of harm to people who used the service and staff.

We found one breach in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the premises and equipment and records. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were managed safely for people and records had been completed correctly.

The service had responded appropriately to safeguarding. Risk assessments were in place for the day to day running of the service and for people who needed them.

Appropriate arrangements were in place to recruit and induct staff which included a Disclosure and Barring Check and references from previous employers.

Is the service effective?

Good

The service was effective.

Supervision, appraisal and training were not up to date for all staff however planned dates had been put in place and an action plan developed.

The service had followed procedures to determine whether people had the capacity to make their own decisions. When people needed to be deprived of their liberties, we could see the reasons for this and who was involved in this decision making process.

Carers and kitchen staff worked together to make sure action was taken to support people to maintain their weights and to meet their dietary requirements.

Is the service caring?

Good

The service was caring.

Staff sought people's consent before any care was provided. People's dignity was maintained when care was provided.

People spoke positively about the care and support they received from staff.

Staff prompted people to maintain their independence and gave people lots of encouragement. People were given choice about what to do and when they wanted to do it.

Is the service responsive?

Inadequate

The service was not consistently responsive.

Care plans were in place for all people; however information was limited at times. Care plans were not always specific to each person. There were gaps in reviews of care plans and risk assessments.

Appropriate systems were in place to manage complaints.

Activities were in place for people. Funds had been raised by the activities team to purchase activities equipment for people to use.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People, staff and relatives spoke positively of the new manager and an application was in process for them to register with the Care Quality Commission.

On the fourth day of inspection action had been taken to improve the standard of medicine records, however further action was needed to improve care records and records relating to the day to day running of the service.

The service sought feedback to monitor the quality of the service. Meetings for staff, people and their relatives had taken place. Surveys had been carried out. Audits were carried out, however had not highlighted any concerns with medicines and record keeping.

Bramble Lodge Care 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 12 and 13 October 2015 and 22 December 215. The first and second day were unannounced, this meant staff and the registered provider did not know we would be visiting. The third and fourth day were announced. One inspector and one pharmacy inspector was involved in this inspection.

Before the inspection we reviewed all of the information we held about the service, such as inspection history and notifications we had received from the service and also information received from the local authority who commissioned the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also spoke with the responsible commissioning office from the local authority commissioning team about the service.

The provider was not asked 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.

Over the three days of our inspection we spoke with seven people who used the service and three relatives. We spoke with the operations manager, manager, deputy manager, two nurses, five carers, two domestic staff, two kitchen staff, the activities co-ordinator and an administrator. We looked around each area of the service, observed care and support in communal areas and reviewed three care records in detail and records which related to the day to day running of the service.

Good

Is the service safe?

Our findings

At this inspection we saw that a personal emergency evacuation plan (PEEP) was in place for each person who used the service and was colour coded according to risk, however did not contain the information needed which was specific to each person. For example, we could see from the care records that one person was diabetic and could experience breathlessness at times, however there was no mention of this in this person's PEEP. We could see that another person had mobility difficulties, but the PEEP did not specify what these difficulties were or how and when support should be given. Another PEEP stated that one person was "immobile" and stated that this person should be assisted into a wheelchair by one staff member. There was no information about how to evacuate this person safely; we were unsure how one staff member could safely assist this person into a wheelchair given that they were "immobile."

Management checks of water temperature records and fire checks had not been completed in June 2015. Operational manager checks of water temperature records and fire checks were required to be signed each month; however records showed that they had only been signed for in March 2015. Review of fire safety records by the local fire authority each quarter had also not been carried out. Risk assessments for falls, lifting, bathing, wheelchairs, waste, aggression, health and safety, stairs and pregnancy had been completed, however they had not been signed by the staff member completing them or dated. This meant that we did not know if these risk assessments were accurate or up to date.

There were gaps in the interview forms for two staff members who had started working at the service during the last year. For both staff members we saw that the date and time of the interview had not been recorded. The name of the interviewer had not been recorded and we could not see if a person who used the service had been involved. In the application forms for both of these staff members, there were gaps relating to qualifications, shift patterns, external commitments, annual leave and start date. No scoring for any of the interview questions had been carried out. Scoring is used during the interview process to determine the suitability of the potential staff member. An induction record for one staff member had not been signed by the registered manager between weeks five and ten of their induction. An induction record for another staff member had been signed off as completed by the registered manager but not by the staff member the record related to.

This meant that there was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in January 2015 we found that the service was not safely managing medicines. This meant there was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2) (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. When we checked a sample of 'boxed' medicines for six people at the last inspection, we found that they did not match up with the medicine records. This meant we could not be sure if people were having their medicines administered correctly. We found that systems for ordering and obtaining prescribed medicines had not been effective and this increased the risk of potential harm to people. There were gaps in some medicine records date of opening of short time medicines had

not been recorded; this meant we could not be sure if they remained safe and effective to use. An audit completed by the service prior to this inspection had not identified the discrepancies found during this inspection.

During the first day of this inspection, we could see that action had not been taken to address the concerns with medicines identified in January 2015. We asked the service to take immediate action to improve their standards to manage their medicines at the service. On the third day of inspection, the manager and deputy manager told us that new systems had been put in place.

We looked at the medicine administration records for four people, talked to staff and people living at the service. We looked at how medicines were handled and found that the arrangements put in place had been significantly improved. Records relating to medication were completed correctly which minimised the risk of medication errors. Regular audits for medicines had been completed.

We could see that medicine stocks had been properly recorded when medicines had been received into the service or when medicines were carried forward from the previous month. This is necessary so accurate records of medicines are available and care workers can monitor when further medication would need to be ordered. We could see that appropriate stocks of medicines were available for people. The deputy manager told us they were responsible for ordering medicines. They also told us that each week, nurses on duty carried out checks to make sure that appropriate stocks of medicines were in place for people for the coming week.

We found that where medicines were prescribed to be given 'only when needed,' the individual when required guidance to inform staff about when these medicines should and should not be given, was available. Staff were able to provide good detail about us how and why the medicines were given.

Medicines were kept securely. Records were kept of room and fridge temperatures to ensure they were safely kept. Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss. We looked at how medicines were monitored and checked by managers to make sure they were being handled properly and that systems were safe. We found that whilst the home had completed a medicine audit recently it was not robust and had not identified the issues found during our visit.

The service told us that they needed to put more robust procedures in place for the management of topical creams. We could see that a body map was in place in people's rooms which showed where topical creams should be applied however records to show if topical creams had been applied had not always been completed. The deputy manager told us that care staff usually supported people to apply topical cream; however it was the nurse's responsibility to check if they had been applied.

The service used a dependency tool to calculate the number of staff needed to provide care and support to people based upon the needs of people who used the service. We could see from the staff rotas that there were enough staff on duty to safely care for people. All of the staff we spoke with during the inspection were happy with staffing levels in place throughout the 24-hour period. Some staff told us that there had been recent changes to the way their rota was put together. Some staff felt they had not been involved in this decision making; one staff member told us, "Our rota can be changed without any notice." Another staff member told us, "I'm not happy with the changes to the rota. The rota is changed and I'm not informed.

We looked at the recruitment records for the last six staff employed at the service. Each of these records contained an application form, interview questions and evidence of two references for each staff member.

We could see that a signed contract was in place and a Disclosure and Barring Service check had been sought prior to employment. This is a check to carry out a criminal record and barring check on people who intend to work with children and vulnerable adults, to help employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults.

Safeguarding alerts had been made when needed. A safeguarding log was also in place which showed the date the alert was raised with the local authority and with CQC. A brief overview of the alert was also provided. This meant the service was able to quickly identify information when needed and could identify any patterns and trends between safeguarding alerts. All staff we spoke with very knowledgeable about safeguarding and could give examples relating to the people who used the service which they could come across and which would constitute abuse. All staff had received up to date training and could easily describe the procedures they would need to follow to deal with a safeguarding alert; one staff member told us, "Safeguarding alerts could be raised because someone was given the wrong medication, treated badly or prevented from doing what they wanted to do." All staff we spoke with told us that they felt confident in raising any concerns which they had with either the nurse in charge or the registered manager and knew how to whistle blow [tell someone].

On our arrival to the service, the staff member checked our identification and asked us to sign into the building. This meant that the service were proactive in maintaining the safety and security of the building. All staff wore an identification badge, this meant that their name and role were easily identifiable to people who needed to communicate with them.

Health and safety checks relating to the day to day running of the service were up to date. We could see that certificates were in place for things such as emergency lighting, fire equipment and legionella. We could also see that equipment needed to provide care and support to people, such as hoists were up to date. Three fire drills had been carried out during 2015; we could see that staff responded well during these drills and in sufficient time. Water temperature checks had been completed each month by the maintenance member of staff; we could see that action had been taken when maximum temperatures had been exceeded. Biannual water checks by an external contractor had not been completed between January and October 2015. This meant that service had not kept up to date with their own health and safety requirements. Maintenance tasks were recorded and showed when completed.

Risk assessments relating to the day to day management of the service had been carried out. These risk assessment included falls, lifting, bathing, wheelchairs, waste, aggression, health and safety, stairs and pregnancy. Risk assessments relating to people who used the service, such as moving and handling, falls, the Braden scale [used to predict pressure sores] and MUST [used to predict people at risk of malnutrition] had been completed each month by staff. This meant that staff could monitor the potential risks to people and take action when needed. However we did find some gaps where risk assessments had not been regularly reviewed, for example risk assessments for colitis and falling from a chair had not been completed every month for one person. A bed rails risk assessment for another person had been completed in May 2015 had not been reviewed since. A risk assessment was in place for one person because they placed themselves on the floor which could have caused themselves harm, however we could not see any guidance in place about how best to support this person to prevent harm to themselves and to the person.

Accidents and incident documentation had been completed each month. An audit of these identified the time and place of these incidents which assisted the service to put risk management procedures in place. During this inspection, we reviewed audits carried out between April and September 2015. We could see from these audits, that infection control audits included observation of hand hygiene; scores obtained during these audits were between 93 and 100%. This showed that infection control and prevention

procedures were highly maintained at the service. Care plan audits for 11 people had been carried out between June and October 2015; these were scored between 82% and 100%. Audits which scored under 100% identified that improvements were needed because some information was incomplete; we could see that action plans had been put in place to address this. This included six monthly reviews, staff signatures, body maps, risk assessments, life stories and pre admission information. We could not be sure how effective these audits had been because we identified consistent gaps within the care records which we looked at. Health and safety audits had been carried out every three months. Nutritional audits had not been carried out prior to May 2015.

Good

Is the service effective?

Our findings

At this inspection we found that hospital transfer records contained limited information about the person, for example, the record did not state the reasons why a person may have a Deprivation of Liberties safeguard (DoL's) in place. There was no information about what the person could do for themselves and if they had any difficulties with their sight, hearing or mobility. One person's record stated they had decreased mobility but no explanation was provided about what this meant. Records were not consistent, for example one record had the person's current height and weight, and another record did not.

This meant there was a breach of Regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the training records for all 49 staff working at the service. We found that the majority of staff had received up to date training in dementia care, diet and nutrition, fire safety, first aid, food hygiene, health and safety, infection control, safeguarding and the Mental capacity Act for example. Training had been arranged for the management of behaviours which can challenge; Parkinson's Disease, Stroke, Epilepsy, Diabetes and data management.

We also looked at the supervision and appraisal records of 25 staff. Supervision and appraisal are formal processes to support staff to carry out their roles effectively. We could see that supervision and appraisals were not up to date. The registered provider's visit records from April 2015 showed that "appraisals were 100% overdue" and "supervisions were 80% overdue." On the third day of our inspection, we could see that further supervision and appraisals had been carried out with staff and any outstanding had been planned. An action plan was in place for all supervision and appraisals to be completed in line with the registered provider's policy for six supervision sessions per year by April 2016.

All new staff undertook an induction at the service. This included getting to know people who used the service and shadowing more experienced members of staff. We could see that staff had familiarised themselves with policies and procedures relevant to the service and enrolled onto relevant training courses.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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 and whether any conditions on authorisations to deprive a person of their liberty were being met.

At the time of our inspection, there were 16 people who had a DoLS restriction in place; we could see that people had these in place to maintain their safety or to provide support with personal care, eating and

drinking and medicines management. The service had a record in place which showed when each person's DoLS restriction had been granted and when it was due to expire. This prompted the service to make sure that a review of these deprivations took place prior to the expiry of the restriction.

Some people had a 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) certificate in place. We could see who had been involved in this decision making process and the reasons why this decision had been made.

People were involved with a variety of health professionals as their needs changed. We could see that communication with professionals such as the GP and district nurses had been recorded. This meant that the service was able to keep up to date with changes in peoples care and advice and guidance given to them. However, we heard mixed reviews about how information relating to these visits was given to relatives. One relative told us that they were not always kept up to date about visits from health and social care professionals, missing items or reviews.

Some people had chosen to have influenza and shingles vaccinations; we could see signed consent forms in the care records of the people they related to. Independent chiropody and podiatry services were available to people living at the service. We saw evidence of planned dates on which these health professionals would be visiting.

People who used the service had hospital transfer records in place in case they required emergency hospital treatment. This record detailed the person's name, next of kin, current prescribed medicines and allergies. There were also details about the person's health history. This meant that appropriate care and treatment could be given.

The chef carried out the role of nutrition champion for the service. We could see a varied menu was provided to people using the service; written and pictorial menus were on display in each of the dining rooms. Kitchen and care staff worked closely together to make sure people's weights were monitored regularly and ensure action was taken when needed. The chef and a member of kitchen staff we spoke with were very knowledgeable about the specific needs of people and told us about how they increased the nutritional value of meals using cream for example. Both staff told us that alternative options were always available for people.

We spoke with staff about mealtimes. They told us that they had the time they needed to assist people with their dietary needs; however one staff member felt, "Meal times should be protected [no visitors or health professionals allowed]." People spoke positively about the food provided at the service, one person told us, "It's good, we get too much food. There's always a dinner." Another person told us, "The food is nice. The staff came in with homemade bread today and asked if I wanted to try some. They [staff] also bring you a cup of tea without being asked." Other people told us, "The staff bring me a cup of tea and the foods not bad." And, "We get plenty of food" And, "The food is good." One relative told us, "The staff will give X sandwiches they don't like. They know this because it's in her records." We spoke to the management team during our feedback.

The ground floor was for people living with a mental health and condition and the first floor was for people living with a dementia which could be accessed via stairs or a lift. People had enough space to move around the service and bedrooms were decorated according to people's personal preferences. We looked in people's bedrooms with their permission and could see that people had been involved in making their room their own. We found personal items such as photographs and pictures on display. The service was well maintained, however we could see that some aspects of the service were in need of updating, for

example, we notice a strong malodour from the carpet on the first floor for people living with a dementia. One staff member told us, "We could do with some decent furniture and new carpets." We spoke to the manager and operations manager about this and asked them to take action to replace this carpet. The operations manager told us that a budget was in place for refurbishment and this was currently out to tender.

Good

Is the service caring?

Our findings

At this inspection we found that there was a delay between the date care plans had been put together and the date by which one person's relative had signed them [on their behalf] to indicate that they were happy with the proposed plans of care. This meant that care and support had been provided to this person without the approval of the relative. For example, care plans for pain and incontinence had been written in December 2014, however had not been signed by relative [on behalf of the person] until September 2015] and a care plan for maintaining a safe environment had been written in February 2015 but had not been signed until September 2015.

We found that three people had care plans for maintaining a safe environment, diet, personal care, continence and sleep and rest care plan, however they had not been signed by these people. This meant that we did not know if these people had been involved in making decisions about the care and support they needed and if they had agreed to these care plans.

A care plan agreement for one person stated that they had capacity to sign their care plans, however we found eight care plans for this person which they had not signed to say that they agreed with the care being outlined in the plan. In another person's care plans, we could see a record had been made to say that verbal consent had been obtained because the person was unable to sign however the reason for this had not been recorded.

Over the three days of our inspection we saw that the bedroom doors of three people had been left open whilst they were sleeping. We asked the nurse of duty why this practice had occurred and they told us that this was carried out according to the people's wishes and this was documented in their care plans. We looked at these people's records and could not see any information about this. The management team told us they would take action to address this.

This meant there was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with throughout our inspection spoke positively about the care and support they received from the staff team in place at the service. One person told us, "The staff are lovely." Another person told us, "I enjoy it in here. I feel safe. The staff look after me. I'm ruined." We also spoke with relatives during our inspection to capture their views about the care and support their relatives received, one relative told us, "The girls are lovely, they do listen to you. On the whole, I am happy that they look after my mam. They [staff] do care about her." Staff we spoke with told us that they enjoyed their role working at the service. One staff member told us, "I love the residents and my job. I know if someone is having a bad day and I try to support them with this. We are human beings, I think 'how would I like to be treated' and give the care I would like." Another member of staff told us, "I keep people safe, I look after them and make sure all of their care needs are met. I make sure they get enough to drink and give them a hug or stroke their hand when it's appropriate. This depends on the person." From observations during our inspection we could see that people received care and support when they wanted it. People told us that they could get up and go to bed

when they wanted to and could choose how they wanted to spend their day, one person told us, "I get up when I want and have a bath when I want."

We observed staff speaking to people in a caring manner; they were not rushed and were given encouragement to maintain their independence. People told us that staff were caring, that they were, "Well looked after by staff," and were, "Well cared for. One person told us, "I like living here. The girls look after me and make sure I have everything I need." Another person told us, "The staff look after me well." We spoke to one person who was leaving the service following their respite stay, they told us, "The manager said I can stay as long as I like. He is lovely. I have had a bed sore, but the staff looked after me and it has healed up now."

Care records did not show if people and where appropriate, their relatives had been involved in planning and making decisions around their care. People's records did not have any documentation from their care plan reviews about what they thought about their care and whether they wanted to make any changes.

We did see staff knock on people's doors before they were given permission to enter people's rooms. People and staff confirmed that personal care was given where privacy and dignity was maintained, for example, doors and curtains were closed and towels were used during personal care to protect people's dignity. When people were assisted with eating and drinking, staff took great care to ensure that any spillages were quickly dealt with. People were not rushed and were given the support they needed.

An advocacy service can provide independent information, support and guidance to people who need it to make decisions about aspects of their health and well-being. Information about advocacy support local to Bramble Lodge was on display within the home. This meant people could access support when they needed it.

Inadequate

Is the service responsive?

Our findings

At the last inspection in January 2015 we found that the service was not accurately and effectively maintaining records. This meant there was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach was identified because care plans lacked the detail needed to show that person centred planning was being used to support people in all aspects of their life. Care plans on the mental health unit did not show people's involvement in their care and records and did not evidence 1:1 sessions carried out with people. Monthly evaluations of care plans contained limited information and care plans lacked any evidence of how care, support and intervention was reducing and enabling people to live to their full potential.

At this inspection we identified gaps in each of the care records which we looked at. We found gaps in care plans and health assessments; although gaps related to one or two months throughout the last year rather than consistent gaps. Care plans which were in place for people didn't always contain the specific detail needed, for example, a care plan for pain did not include any information about the signs and symptoms of pain which the person could display. This meant that we could not be sure if staff knew when this person was in pain. Care plans to maintain a safe environment, diet, personal care and continence had not been signed by the people they related to or their relatives on their behalf. This meant that we did not know if the person had been involved in developing their care plan or had consented to it. Regular reviews of these care plans had not been carried out each month as directed on the record. Care plans for another person, relating to their mental health had not been signed them. We found that reviews of a risk assessment relating to contact with a relative had not been carried out every month even though this was a key area for risk of relapse. A care plan for Schizophrenia identified the possible signs of relapse which could be seen in the person, however did not include any information in how to support the person with this condition. A care plan for maintaining a safe environment contained very limited information; we could see that this person was vulnerable when out in the community, especially when they were unwell however the care plan did not include information about when the person was unwell and what support they may require at this time to reduce their risk of harm. Care plans for one person did not contain the information needed, for example, a care plan for delusions which affected mobility did not contain any guidance about how to support the person with their delusions or how to support them with their mobility to reduce the risk of harm. A care plan for personal care stated that this may decline if there is deterioration in the person's mood. There was no record of any signs or symptoms associated with this person's deterioration in mood or how best to prompt the person with their personal care. We could see from the person's care plan that one pair of the person's glasses were being fixed, however there was no date to show when the glasses were sent for repair or when they were due back.

We found gaps in the care records of one person; we could see gaps in the person's family tree, life story, dietary likes and dislikes and actions to take in the event of their death. We found that A4 lined paper was used to record information in some people's care records. Staff told us that this was due to a shortage of available records. An ABC chart for one person had not been signed by the manager as directed on the record. An ABC chart can be used to record behavioural concerns. 'A' stands for antecedents, that is, what

occurs immediately before the behavioural outburst and can include any triggers, signs of distress or environmental information. 'B' refers to the behaviour itself and is a description of what actually happened during the outburst or what the behaviour 'looked' like. 'C' refers to the consequences of the behaviour, or what happened immediately after the behaviour and can include information regarding other people's responses to the behaviour and the eventual outcome for the individual. It can also be a good idea to keep track of where and when the behaviour occurred to assist in identifying any patterns.

Each person who used the service had a 'statement of health and well-being' which staff recorded when people had been assisted with care and support, what diet and hydration people had consumed and what activities they had been involved in. On the second day of inspection we looked at these records for four people and found that two records did not contain the person's surname. From these records we could see that all four people had not been assisted with oral hygiene and only two people had any activities recorded, however this activity record related to personal care. We found that fluids had not always been totalled up; this meant it was unclear whether people had consumed enough liquid throughout the day. We saw for one person, their fluid intake was 1020mls; when we spoke to staff they told us that this person had been unwell. From speaking with staff and from looking at the record we could not be clear if any action had been taken to address this. All four of these records had not been signed by any staff member during the 24 hour period they related to. This meant that we did not know if staff were monitoring the effectiveness of these records. On the third day of inspection, we looked at 14 health and well-being records for one person between 01 and 30 November 2015, we found that all 14 records had not been signed by any staff member. We found significant gaps in the records, for example, these records showed that the person they related to had not been supported to wash for ten days or assisted with oral car for 12 days. From speaking with staff and observation of the person these records related to we could see that this person had received daily support with personal care.

We questioned whether all of the care plans we looked at were needed, for example we found that a care plan for a urinary tract infection for one person and a care plan for eczema for another person had been put in place when they were needed. However reviews of these care plans showed that these were no longer troublesome for the people they related to and these people were symptom free. This meant that staff had failed to take action to remove care plans which people no longer needed following a review of their care. Daily records were not always person-centred, for example, in one person's records, we saw "Settled all day, all needs met" had been recorded. We found that this entry contained limited information and was not person-centered. Person centred planning (PCP) provides a way of helping a person plan all aspects of their life and support, focusing on what's important to the person.

A monthly dependency tool for one person had only been carried out twice in the last year and not each month as identified on the assessment tool. A monthly review of one person's psychological health had not been carried out in February 2015 and July 2015. A sleep and rest care plan had not been signed by the person it related to, this meant that we did not know if the person had consented to the care and support identified in this plan. A record relating to the last wishes of the person in the event of their death was incomplete. This meant staff did not know what the person's wishes were and whether relatives wished to be contacted and when. Monthly 'assessment records' used to monitor blood pressure and pulse had not been completed regularly for one person. This record showed that this had been carried out for three of the last 12 months.

This meant there was a continued breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The operations manager told us that a working party was in place to look at the care plans used by the

service and changes would be made to show how people are involved in reviewing their care and support.

Some care plans were specific to the people they related to. We saw that a care plan for maintaining a safe environment for one person stated where the bed should be positioned. This meant that staff could support the person to keep safe. A care plan for incontinence detailed the type of incontinence pads which should be used during the day and at night. We could see that the type used during the day was different to the type needed during the night. This meant that staff supported the person to maintain their dignity and reduce risks to skin damage. Care plans such as pressure sore care, dementia, mental health, medicines, body temperature, cognitive impairment and sleep had been evaluated each month. A six monthly assessment to review the care and support which one person received had been carried out. This meant that staff remained up to date with the care and support which the person needed and wanted. We could see that the person was involved in this review. One person's recorded detailed when the service had been in contact with relatives to invite them to the person's care plan review and had kept them informed when a safeguarding alert had been raised for this person.

Daily records for one person were detailed. They reflected the person's care plans and detailed any difficulties which they had experienced with anxiety. This meant that staff were kept informed and could provide the most appropriate level of support and reassurance which the person may have needed. We could also see details about the person's dietary intake, medicines and visitors.

The activities co-ordinator told us that there were undertaking an activities champion with dementia qualification. They felt this would better equip them with the knowledge and skills needed to provide appropriate activities for people living with a dementia. We could see that activities staff worked hard to engage people in meaningful activities but said they "Found it difficult to get people involved." The co-ordinator told us that they had a budget in place for activities which gave them greater flexibility with the things they could offer. We were told about recent fundraising events which had taken place and to which the local community had been invited. From this the service had been able to purchase a pool table and a table tennis table for people to enjoy. We were shown the Christmas programme for the service which included a travelling pantomime and singers. Activities records detailed what activities people had been offered and whether they had participated or declined. We could see that there were many opportunities for people to become involved in activities; however people were often reluctant to participate. From speaking with care staff, we found that they struggled to provide activities. From speaking to people, we found that people wanted to go out into the community more frequently. One person told us, "I would like to go on more outings." Another person told us, "I've not been out in ages."

People we spoke with were aware of how to make a complaint and told us that they felt confident in making a complaint should they need to. We could see that the complaints policy was on display at the service. From speaking with staff we found that they were knowledge about the procedures which they needed to follow should a complaint be received. We could see that records of complaints were in place and had been dealt with appropriately.

Requires Improvement

Is the service well-led?

Our findings

The manager had been in place at the service since June 2015. At the time of our inspection, an application to become registered manager was in place. One relative spoke positively about the manager and deputy manager in place at the home, they told us that they were very approachable and felt able to discuss any concerns with them. People spoke positively about the staff team, however one person told us, "Some staff are better than others." Another relative told us they had needed to speak with the manager about some concerns which they had. They told us that the manager listened to them and helped to resolve these concerns. Staff spoke positively about the manager. One staff member told us, "The manager is nice, all the staff are friendly and the residents are nice too." Another staff member told us, "We've been up and down during the last few years with managers. They each had different rules but the new manager seems okay."

During our inspection we saw staff working together as team. One staff member told us, "The staff team all work together and can rely on each other to help out when needed." Another staff member told us, "I like the way they [staff] manage the residents. We are caring people and the carers are good. They tell me what is going on with people."

Staff felt that there had been many changes over the last couple of years because they had been a number of different managers in place. Some staff felt that because of this, they had been many changes about how the service was run. Not all staff felt that they were kept up to date about this. Some staff told us that they did not have a voice about some changes which had been made, for example, all staff we spoke with during our inspection told us that there had been recent changes to the staff rota and that this was made without their consultation. One staff member told us, "The rota needs to be improved. We need more explanation and kept informed about what's going on in here." All staff we spoke with felt able to speak with the manager when they needed to. We could see that a meeting for people who used the service and their relatives had taken place in June 2015 and there was another planned soon; we could see that up and coming events and issues relating to the running of the service had been discussed. Monthly staff meetings were in place and were well attended by staff. Each person we spoke with was aware of the management team in place at the service and told us that they regularly saw the manager. Staff felt that the manager was able to give them the time when they needed it.

A quality assurance survey had been carried out by four relatives during the last year. Feedback was sought about staff, privacy and dignity, knowledge of people who used the service, communication, activities, security, food and laundry. We could see that feedback was positive and relatives had been happy with the care and support provided to their family member. A quality assurance survey had been carried out by five health professionals during the last year and feedback had been sought about the environment, the staff team and their knowledge about the people who used the service and communication.

The registered provider visited the service to monitor the quality of the service. Records were available for February and April 2015. This meant that we could not be sure if the registered provider visited the service each month. The manager could not confirm if the registered provider visited the service each month. These two audits both highlighted gaps in record keeping in care records and staff records. The April audit

highlighted that supervision and appraisals were overdue, however no action plan had been implemented to ensure that this was addressed.

At the last inspection in January 2015, we issued breaches relating to medicines and records. On the first day of our inspection little action had been taken to improve the management of medicines and the standard of records keeping. From our discussions, we could see that there had been a breakdown in communication between management staff leaving and commencing work at the service. This meant that although the service had sent the Care Quality Commission an action plan which detailed how they were going to improve the quality of records and to improve the ways in which they managed their medicines this had not been shared with the new management team in place at the service. This meant that the service had not adhered with their action plan, however following our first day of inspection; the service reacted quickly to the breach in medicines. New systems and procedures for the management of medicines were put in place. We could see that further improvements to record keeping were needed and were confident that the new management team in place at the service would take the action needed.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There were gaps throughout all records looked at during inspection.