Sursum Limited

# Sursum Limited Bramley House

## Inspection report

Bramley House
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Wiltshire
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Tel: 01747860192

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

Bramley House provides accommodation and personal care for up to 37 older people, some of whom may have dementia. At the time of our inspection, 33 people were living at Bramley House. The home was last inspected in March 2016 and was found to be meeting all the standards required.

This inspection took place on 4 and 8 April 2018 and was unannounced on the first day.

We found a breach of Regulation 11 Need for Consent. The process of gaining consent for people who lacked capacity was not followed. There were no mental capacity assessments or best interest decision making documentation to accompany applications to authorise a Deprivation of Liberty Safeguard.

We have made a recommendation about the management and storage of some medicines.

We have made a recommendation for the provider to seek guidance on care planning for people whose needs are changing.

Risk assessments were not reviewed regularly and there were sometimes not enough staff.

The staff required more regular and up to date training to equip them with the appropriate skills to care for people with particular needs. Staff did not receive regular one to one supervision to identify training needs and to support their well-being.

There was a registered manager in post at the home. '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.'

People said they felt safe living at Bramley House and safeguarding procedures were in place. Staff were knowledgeable about safeguarding and their responsibility to whistle-blow if required.

People were supported to have control of their daily lives and we observed staff giving people choice. Staff knew people's preferences and people told us staff were kind and caring.

The home environment was pleasant and decorated tastefully. It had recently undergone some refurbishment and improvements had been made. This included a large, light communal area known as the orangery, a large safe and level access garden and extra en-suite rooms. There were plans in place for a hairdressing salon and new baths and lighting in the downstairs bathrooms.

There was a range of activities available for people. The home had pets, which people and their relatives enjoyed and plans in place for specific events, to include people and their visitors.

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

**Requires Improvement**

The service was not always safe.

People received their medicines as prescribed but these were not always administered safely. Some recordings, monitoring and other documentation were missing or inconsistent.

Medicines were not always stored safely. The temperature of the medicines room had reached or exceeded the required temperature.

Risk assessments were in place but had not been reviewed regularly. The information on how to reduce the identified risks was limited.

There were not always enough staff.

People were protected from the risk of infection and robust procedures were in place to prevent cross infection.

Safeguarding processes were in place and people told us they felt safe living at Bramley House.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Mental capacity assessments and best interest decisions were not recorded in line with the principles of the Mental Capacity Act (2005).

Staff had not received up to date and refresher training, specifically in the areas of dementia care and behaviour that challenges.

Staff did not receive support from one to one discussions with their line manager to assess competencies, training needs and development and maintain well-being.

The home worked closely with other professionals and had developed good relationships with the GP surgery and pharmacy. People had access to other health services.

People were offered choice and care plans recorded people's preferences.

## Is the service caring?

Good

The service was caring.

People told us the staff were kind and caring.

There were positive and compassionate interactions between people and staff.

Staff ensured people's privacy and dignity was respected.

## Is the service responsive?

Good

The service was mostly responsive.

People received care according to their assessed needs however, staff were not always responsive to peoples changing needs.

Person centred recordings were inconsistent. We have made a recommendation about this.

The service had a range of activities available, pets (that lived in the home) and a level, safe outside space to access.

The service was working towards the 'gold standards framework' for end of life care procedures.

## Is the service well-led?

Requires Improvement

The service was mostly well-led.

Quality assurance checks and audits had not been undertaken regularly.

Governance systems were not always effective, however new systems had been put in place to monitor the service.

The home had a strong ethos of kindness and teamwork and this was evident throughout the staff group.

The operations manager had recognised areas to improve and had developed new procedures and schedules.

# Sursum Limited Bramley House

**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.

We carried out a comprehensive inspection which was brought forward due to information gathered from members of the public, the local authority safeguarding adult's team and from other people who notified us of their concerns. One particular identified risk was discussed prior to the inspection. The provider assured us they had mitigated the risk and acted appropriately.

We found the service to be in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This inspection took place on 4 and 8 April 2018 and was unannounced on the first day. The inspection team consisted of two inspectors.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to tell us about.

In addition, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the two days of our inspection, we spent time observing care throughout the service. We spoke with four people and three relatives. We also spoke with the operations manager, the deputy manager and five

members of staff.

We looked at six people's care plan records, the medicine administration records (MAR's) and three staff files. We also looked at other information related to the running and quality of the service. This included audit checks, staff training and support and complaints management documentation.

Requires Improvement

# Is the service safe?

## Our findings

Medicines were mostly managed safely. There were photographs of people at the front of the Medicine Administration Records (MAR's). Having photographs of people assists staff to recognise people they might not be familiar with, which minimises the risk of error.

When people had declined to take their medicines this had been documented, but there was nothing written to show how many times that staff had tried again. The operations manager discussed this with staff at the time of our inspection.

People's preferences in relation to how they preferred to take their medicines had been documented in care plans, but this information was generic and not readily available for the staff that administered them. During the inspection the home took steps to correct this and had added information about people's preferences to their MAR's.

One person was having their medicines crushed. There was a 'consent to crush medication' form in place. This listed the medicines the person was prescribed and included comments such as 'capsules to be opened' and 'medication to be crushed and put into yogurt.' It had been documented it was the person's request to receive their medicines this way. The home confirmed that staff gain the person's consent verbally each time they administer their medicines.'

Crushing medicines can alter the way they work and because of this it is good practice to gain pharmacist advice before doing so. Information did not show that the pharmacist had been involved in the decision. Although the printed instructions on the MAR stated that one of the medicines could be crushed this was not the case for all. This meant there was a risk that staff were administering medicines 'off licence' without pharmacist advice.

Some people had been prescribed additional medicines, such as pain relief on an as required basis (PRN). The reasons why people might require these had been documented in some care plans but this was not consistent. Additionally, the information was not person centred because it did not describe when and why people might need pain relief or whether they were able to vocalise that they were in pain.

New charts had recently been introduced for staff to document when they had given PRN medicines and the reasons why. However, the information on these forms was of limited value to staff because they had not been completed in full. For example, staff had documented a pain killer had been given because the person was 'complaining of pain.' They had not specified, on these records, where the pain was or whether the medicine had been effective. This meant it was difficult for staff to identify trends in relation to when and why people might need additional medicines. However, shift handover notes did show that people's pain had been discussed and that follow up visits with the GP had been organised when people were observed to be experiencing pain.

We observed part of a medicines round. The staff member administering medicines asked people if they

were happy to take their medicines, ensured they had a drink, and waited to check they had swallowed them before signing the medicine administration record (MAR).

All of the MARS we looked at had been signed in full which indicated people had received their medicines as prescribed. However, there were some handwritten entries on the MAR's that had not always been signed or countersigned. Having a second member of staff check and sign confirms accuracy of any transcribed entries. One entry we looked at was incorrect because the volume of medicine in the bottle had been written instead of the required dose.

Medicines were not always stored safely. Although medicine trolleys were kept locked and secure, the temperature of the medicines room on the first floor was 26 degrees centigrade (on the day of our inspection). The temperature was recorded twice a day and records showed that on the five days prior to our inspection the temperature had reached or exceeded 25 degrees on all five days. 25 degrees is the maximum recommended temperature for storing medicines. The provider's medicines policy stated 'the temperature should be recorded daily and should be no higher than 25 degrees.' The medicines room had no ventilation. Staff said they used a fan or air conditioning unit to reduce the temperature when high, but this had not been documented. Staff had also not documented if or when they had rechecked the temperature to ensure it was below 25 degrees. After the inspection, the home informed us that they had installed an air conditioner in the medicines room, which kept the room at a constant temperature of 20 degrees.'

We recommend that the provider consider current guidance on the safe management and storage of medicines and take action to update their practice accordingly.

People were not always protected from risk. The risk assessments we observed did not give staff consistent guidance and had not been always been regularly reviewed. One person had a urinary catheter in situ. It had been documented 'fluid intake is very poor' and 'needs to be encouraged to drink.' This person was having their fluid intake monitored, but assessing whether they had been given enough to drink was not clear. Records showed this person had not drunk anything. On other days the recorded fluid intake was as little as 5 millilitres. The records did not show staff had identified the poor intake or whether they had escalated their concerns. This meant there was a risk that people were not always provided with enough to drink.

Some assessments we observed for areas such as falls and skin integrity did not clearly inform staff about the level of risk. However, the plan guided staff on how to reduce the risk of falls, such as keeping the person's environment well-lit and free of clutter and ensuring they wore appropriate footwear.

Records we observed did not clearly inform staff of how other risks were to be minimised. For example, one person had been assessed as having a high risk of pressure sores. The plan detailed pressure relieving equipment that was in use, such as an air mattress and cushion, but the guidance for staff on how frequently the person should have their position changed was "assisted to change position regularly." The plan did not specify how often this should happen. This meant there was a risk that as people's needs changed the plans had not always been updated to reflect this.

People and relatives told us that there were not always enough visible staff. One person said, "they are overworked, always look too busy" and another said "whenever I've rung the buzzer, they [staff] came quickly. But the buzzers do seem to be going off a lot of the time." A relative said there "was not enough one to one time with people." Another said "there is a shortage of staff, particularly with the new rooms." The staff we spoke with expressed mixed views on staffing levels. One staff member said, "Usually we've got enough. They are advertising for more" and "It's difficult because people have higher dependency needs

now." Another staff member said "Early mornings and evenings we could do with extra staff."

Whistle blowers told us not all shifts were covered consistently, at times of staff sickness, leading to some shortages on some days. The home made use of staff from their domiciliary care service to provide staff cover. We also observed this during our inspection. The operations manager told us that they had identified a shortfall in staff and were actively recruiting. They had appointed three new care staff (one of whom would be a senior). They acknowledged that the staff were "tired and stressed."

Staff were recruited safely and the personnel files we observed contained all of the required checks. This included employment history, references and identity confirmation. All DBS requirements were in place. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

People were protected from the risks of infection. We observed personal protective equipment (PPE) being used and staff told us there were plenty of supplies. The bathrooms were clean and hygienic and fully stocked with paper towels, soap and hand sanitizer gels. The home recently had a flu outbreak (a different strain to the current immunisation programme). Staff had followed the appropriate guidance from Public Health England around infection control and containment. This included, the home being closed to visitors except those of very unwell people, warning notices, strict hand washing protocols and laundry being separated. The home had been praised by the local GP who said they had significantly reduced the spread of infection to other people.

People told us they felt safe living at Bramley House. One person told us, "Oh yes I feel ever so safe." We observed that safeguarding policies and procedures were in place and had been devised in line with the Wiltshire Safeguarding Adult Board. The flowchart of whom and how to make contact with the relevant authorities were displayed in the office and the staffroom.

Staff we spoke with said they had undertaken safeguarding training and knew the signs of abuse to observe for. They said they knew when to report concerns and how to report them. Comments included, "I'd report it, it would get investigated and the manager would report to the local safeguarding team" and "I would report it to the manager or the deputy." Staff were also knowledgeable about their responsibility to whistle-blow. Whistleblowing is the term used when a worker passes on information concerning wrongdoing. The wrongdoing will typically (although not necessarily) be something they have witnessed at work.

The service showed they learnt from incidents and made improvements. For example, following a recent incident new safety measures were put in place. There were new keypads on doors which led to the outside areas (the key pads release automatically when the fire alarm is activated.) New window restrictors were fitted and all areas of the home (including the new part of the building) had been checked by maintenance and the fire safety officer to ensure it was meeting requirements. The operations manager carried out their own internal audit and identified that the downstairs bathroom was not up to their required standard. A new bath and lighting were due to be fitted.

Requires Improvement

# Is the service effective?

## Our findings

The correct legal procedures around gaining consent for people who lacked capacity were not always in place. Deprivation of Liberty Safeguards applications stated that the person lacked capacity but there were no corresponding mental capacity assessments to show how their capacity had been assessed.

The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The Deprivation of Liberty Safeguards (DoLS) are part of the Act. The DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

Records showed those people who had representatives acting on their behalf. These were recorded in their care plans, but there were no confirmation copies of the court of protection registration documents. People had photographs in their care plans but there was no evidence of consent being requested or given.

One care plan showed a person needed more support to make decisions. The care plan detailed how to support them to continue to make everyday decisions in order to 'promote [their] independence and respect [their] wishes'. The guidance was to offer 'more support', but did not detail what this meant other than, 'maybe speak to [the person] at a time when [they] are less confused'.

Some people had sensors in their rooms to alert staff as part of falls prevention plans, but there was no documentation in place to show that people had consented to their use. A consent form for one of these sensors was signed on behalf of an Attorney but there were no corresponding records in the daily log, giving this permission.

Staff had received training about the Mental Capacity Act but did not demonstrate a good understanding of the legislation. Staff we spoke with said they understood how to gain people's consent and knew to offer people choices. However, records showed they did not carry out mental capacity assessments when needed. Mental capacity assessments can be undertaken by staff that follow the correct legal procedures. One staff member said "Sensors are in place to stop people falling. We ask the family to consent or tell people why they're in place." This did not demonstrate consent to care was sought in line with legislation and guidance. The deputy manager began addressing the lack of documented mental capacity assessments at the time of our inspection.

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

Staff were not provided with up to date information to ensure they had the knowledge and skills to

undertake their role effectively. Staff undertook on line and booklet training by an external training provider, but this had not been maintained or refreshed regularly. The training matrix showed gaps in the provider's mandatory training schedule. Two staff members told us that they required more training in dementia care and in behaviour that challenges. A senior staff member said they required more training in care planning. A relative questioned the level and type of dementia training some of the staff had, as they felt this area was lacking.

One staff member told us, "we have some external trainers come in. We did some dementia training recently which was really good". Further training in dementia had been identified as a need by the management team. They said staff had recently benefited from training in fire safety from an external fire safety specialist. At the time of out inspection the operations manager had started to address the gaps in staff training and was focusing on mandatory training needs first.

Staff did not always have regular one to one meetings with their line manager. The staff we spoke with were unsure how often the provider expected such meeting to take place. Comments ranged from "every six months" to "yearly." Two staff said they had not had a supervision session during 2018 and one said "I think I'm due one now." This meant that areas around training, skills development and support were not identified or acted on in a timely manner. One staff member told us they received support from their mentor in relation to their style of learning and staff supported each other. The operations manager was beginning a new and regular schedule of supervision and appraisals at the time of our inspection.

People we spoke with had mixed comments about the quality of the food at Bramley House. One person said, "It's wholesome but very bland. I have to add my own spices and sauces to make it taste better. I don't think it's even seasoned." One person eating their lunch said, "[it] looked better than it tasted" and another said, "my only gripe would be the porridge is always lukewarm or cold. I haven't complained; I just leave it." Other people were more satisfied and said, "the food is very good here" and "the food is excellent. We get a choice of what to have." A relative told us that they would like their family member to be offered more fresh fruit smoothies.

We observed the lunchtime experience. The majority of people ate in the dining room although some people chose to eat in their rooms. People were offered a choice of meals and shown two plates of food to help them decide what they would like. There were menus on the tables and people were able to have a glass of wine if they desired. Staff offered to fill up people's glasses with water. On the day of our inspection, people were having fish and chips purchased from a local chip shop. The food looked and smelt appetising. Food was brought to the tables on trays and relatives were also able to eat with their family members. The tables were laid with fresh flowers and people had access to condiments. We saw staff asking people if they had enough or would they like more and did they need any assistance. There were bowls of fresh fruit and snacks and soft drinks available in the lounge and communal areas.

The operations manager told us that food moulds were available if people required their food to be pureed to ensure that it was presentable and attractive to eat. The catering staff were involved in care planning around people's likes and dislikes and different menu options available.

The documentation and  care plans we observed were of a varying level of detail and not of a consistently high standard. The home used a form of electronic care planning. Staff used hand held devices to document how they had supported people, but not all staff on duty had access to these. One member of staff said "I have to tell another member of staff what I've done and they'll input it for me. I don't know for certain that they actually do input it though."

The care records for one person documented that staff had provided incontinence care at 06.10, but the next entry for this was not until 16.10. This showed a total of 10 hours between care intervention. The operations manager said the timings were not an accurate reflection of care provided because staff did not always electronically document care in real time. This did not ensure care was always provided in accordance with care plan guidance.

Not all relatives were happy with the level of attention to detail to their family member's care. They said they felt they were constantly reminding staff to do things in the way the person preferred. They said they would also like to be more involved in the care planning and reviewing of their family member's care and for their family members to be engaged in everyday activities, such as folding laundry, laying the table etc.

People benefited from access to other health care professionals and organisations. The home had forged close links with the local GP surgery and pharmacy and was fully supported by them. People were able to attend hospital appointments, have eye and hearing tests, dentistry and chiropody. The home had support from the community mental health services and out of hour's services. Records showed that people were reviewed by the GP or the community nurse regularly. One person said "I went to the hearing clinic yesterday; the staff took me." There were Treatment and Escalation Plans (TEP's) in place which the GP had discussed with the person and/or their relative. TEP's are a national initiative to ensure that every patient has their levels of care intervention considered and formally documented.

Bramley House was an older building which had recently had improvements to add extra space and rooms and a large level access enclosed garden. People had been involved in the development of the garden and the orangery and had chosen plants and where to plant them. The home was arranged over three floors and there was an accessible lift for people and staff. The décor was fresh and homely. There was a warm and welcoming atmosphere with only pleasant odours.

The lounge areas were bright, spacious and clean and we observed people enjoying sitting in the communal areas.  One person was easily able to access the downstairs communal areas whilst independently using their wheelchair. Much of the furniture had curved edges to avoid injuries, radiators were covered and there were grab rails in appropriate places. There was a small 'resident' shop to purchase toiletries at cost price for convenience.

People's rooms were bright and clean and were decorated with their own belongings, pictures and furniture to make them familiar and comfortable. People were encouraged to bring their own belongings. There were pets in the home, a dog, a cat, a pair of guinea pigs and some new bantams. People spoke fondly of the animals and enjoyed having them around. A relative told us, "I love that there are animals around, just like at home."

Good

# Is the service caring?

## Our findings

People spoke highly of the staff and relatives told us that the staff were caring and their family members were treated with dignity and respect. Comments included "The staff are all very helpful and sympathetic"; "The staff are all so helpful and cheerful. They're very kind, everyone is."; "I think they're all very good" and another said, "I feel very well looked after, they are very kind."

Thank you cards from relatives of people said, "thank you for all your kindness to [my family member]"; "thank you all so very much for the wonderful care and kindness you gave [my family member] and "to all the staff at Bramley House to say thank you for all your kindness and patience in our care of [my family member] I am grateful to every one of you." An email stated how much better the person had been since "being so well looked after…it has been a huge weight off my shoulders knowing that [they had] been in good hands."

There were further comments from relatives about their family member's care. These included, "the care is very good, I can turn up at any time" and "[my family member] has settled in well, the atmosphere feels like home, there are no smells. We are very pleased." Another relative said, "staff are cheerful"," the orangery is lovely" and "the staff [were] so nice, fantastic and really helpful. They are lovely with [my family member]." The continuity of staff and the fact that many staff members had worked at Bramley House for a long time was described by a relative as "extremely valuable". Staff members described the whole staff team as, "really hard working" and "a really good workforce."

Staff knew people well and could tell us people's preferences, likes and dislikes. A staff member offered a person a piece of fruit and said "there you are [name]; I know how much you like pears." We observed staff acknowledging how people liked to take their tea or coffee and whether they liked to have word puzzles, a paper or listen to music. In the lounge, one person chose to play some music they liked on an old record player. This was also being enjoyed by others in the lounge and there was interactive friendly chat between them and staff about it. A staff member said how much they "love getting to know people." People's birthdays were listed in the staff room and were acknowledged and celebrated. The home had also signed up to 'Wiltshire safe places'. This is a scheme ran by Wiltshire Council. 'The aim of the safe places project is to establish safe places across Wiltshire that provides a safe environment for people who may require some additional support when out and about in the community'.

We observed that staff interacted with people in a kind and patient manner. We saw a member of staff orientating a person who was new to Bramley House, in a patient and friendly way. The atmosphere was calm and welcoming. People were relaxed around staff and were talking and laughing with them. We saw and heard positive interactions between people and staff. For example, we heard one member of staff knock on someone's door and call out "Knock, knock. Good morning, how are you today?" The person responded positively and sounded pleased to see the member of staff. A staff member told us, "it's caring; the most important thing is that it's their home."

People said staff maintained their privacy and dignity. We observed staff knocking on doors before entering

and explaining why they had come in. We heard staff ask people if they were ready to be assisted. People were supported to maintain their dignity in different ways. For example, a staff member told us "I would close the curtains, keep them covered up and encourage them to do parts of care they can do for themselves." We observed a member of staff speak quietly and gently to a person to explain that they needed some support. Another member of staff said they would always greet the person and ask how they liked to be addressed. They said "it's a friendly home; we're like a big family."

Staff spoke highly of the care they provided. They said "The care is good here. We're like one big family"; "Residents get lots of choice here. It's a very social place" and "People get good care here. They choose when to get up for example." One staff member said, "I get on with all of them."
A relative told us that "They always tell us if [my family member] has fallen or if [they] are unwell, they always let us know". One person said "I'm very independent but when I need help I just have to ask." Another person said "I'm happy with everything. The laundry service is excellent. As soon as I send something off, it's back again all clean and ironed."

During a recent outbreak of flu, people were kept informed and supported when others passed away. The deputy manager described it as being "very transparent." The home has developed a 'dignity champion' role for one member of staff who is specifically trained and will support the whole staff group with their knowledge and experience. To offer emotional support to people and the staff, the dignity champion had organised a thanks giving memorial service, in memory of those who passed away during the flu outbreak. They had invited people, their relatives, staff and visiting professionals to attend if they wished.

Good

# Is the service responsive?

## Our findings

People's care plans were not always reviewed regularly to meet people's changing needs and the level of detail and guidance was inconsistent. For example, in one person's plan it was documented they had recently had urine infections. The signs and symptoms of a urine infection had been written for staff to observe for, but these were limited and there was no guidance for staff on how to prevent a further infection. In another plan it was documented that if staff had concerns about a urinary infection they should take a sample, but the signs and symptoms were not documented.

Some people experienced episodes of anxiety, but plans did not always inform staff how to support people when they were anxious. In one person's plan the guidance for staff was clear about what might trigger the person to become anxious and the actions they should take. However, in other plans this was not the case. In one plan the only guidance for staff was "needs lots of reassurance." There was nothing written to inform staff what that meant. Another person's care plan stated that '[person] appears to be a calm lady, does not have any behavioural issues'. This plan was due to be reviewed at the end of May but the person's behaviour had been increasingly agitated for several weeks, resulting in physical aggression and some threatening behaviour. Staff had not considered this change in behaviour or updated the care plan accordingly.

However, for one person who required extra one to one support, care was provided by a senior staff member, they had regular walks in the garden and out into town to reduce anxiety. Contact was made with the local authority safeguarding team and with a specialist mental health team to gain support in meeting their need.

One person's care plan stated that they required a topical application, twice daily of cream for a skin condition. Reviews of this care plan were not always carried out monthly. The body cream chart in the care plan did not specify the name of the cream or where on the body the cream needed to be applied, there were several irregular dates over a two month period which had been signed off as achieved.

The home was responsive to people's needs during the recent period of bad weather. The management team organised the staff rotas to ensure those staff that lived locally were called upon first to support the home. They also used their four wheeled drive vehicle to shuttle staff to and from work safely. Some staff stayed overnight in order to maintain staffing levels.

People's care plans had full life histories which detailed their childhood, places of importance, family and things they liked to do. Specific person centred details were recorded such as '[person] liked to finish off [their] clothes with a neck scarf and liked to choose, co-ordinate and liked to present looking nice.' One life history was very detailed and had been completed by the person and their relatives. It contained a lot of detailed information on the person's early life and their past experiences. Some sections of care plans, were person centred, but this was not consistent. Personal hygiene plans were personalised in part and we saw that people's choices about how they liked to dress had been documented. However, other details such as the toiletries people preferred and their preferred times of getting up and going to bed had not always been included within the plans.

We recommend that the provider seeks advice and guidance on care planning to meet people's changing needs, from a reputable source.

The home was not fully compliant with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

Although communication plans detailed when people had sensory impairments, there was limited information for staff on how to meet people's needs. In one person's plan there was no guidance for staff to show how the condition of macular degeneration affected their daily lives. The care plan did not explain how staff should approach the person. It was limited to "ensure glasses are clean."

Another care plan was clearer as it had a pain assessment chart with visual diagrams of expressions and parts of the body, for people to communicate where their pain was and how bad it was, if they were unable to verbally communicate this. There was a date, time and weather board in one of the main communal areas which had pictures and words. This meant that people were able to orientate themselves in time and date using different methods.

People living at the service said they knew how to complain but had never had to. Comments included "I can't recall ever having to complain" and "I've never complained but my daughter would do it for me if needed." A relative told us that they would easily be able to raise a concern if they needed to, "if there is anything I need to talk about, it is always sorted."

The home was working towards the Gold Standard Framework for end of life care and care planning. They had not yet been accredited. One person's care plan showed that this area of care had been discussed with their LPOA but they had chosen not to complete it at this time. Another person's care plan stated that when their health deteriorated they had chosen to stay at Bramley House and not be admitted to hospital. Advanced plans we looked at showed that people had been involved in discussions about their preferences for if they became unwell and whether they wanted to be admitted to hospital at the end of their life or stay at the service. Special requests such as who they wanted with them and whether they had any religious needs were included; although religious denomination had not always been recorded.

There was a range of activities available for people to participate in. There were two activity coordinators employed at the home who had devised a programme of activities throughout the week. The programme was displayed on a small activities board in the communal area.

On the day of our inspection, a singer was providing entertainment. Lots of people attended and appeared to be enjoying themselves, singing along, with some playing tambourines too. People said "Very occasionally I'll take part in the activities. I might go on some of the trips if I'm interested" and "I like going to the activities. I'll go down later if I feel up to it. A good laugh and a giggle does you the world of good." One person told us, "there's a lovely library, gardening club, painting, all sorts to do, I enjoy it." The new outside space is a level access garden with steps and a ramp which people had been involved in designing and choosing plants.

The TV in the lounge had an internet device to access a wide range of films appropriate to the age and preference of people. The books in the library were regularly updated and changed. Some relatives had requested a family BBQ in the summer in the new garden. They had plans to build a wishing well and have front row seats at the carnival. As well as the resident animals, the home also has visiting dogs. There were

plans in place for one person to visit a local farm to see the animals. This person was a farmer and they had expressed to staff how much they missed the farm.

Requires Improvement

# Is the service well-led?

## Our findings

Governance systems had not been effective in addressing low staffing levels, lack of staff supervision, irregular care plan and risk assessment reviewing and addressing the legal requirements of the Mental Capacity Act (2005). There had been anonymous concerns raised about the lack of staff during day and night time shifts. Concerns had also been raised by members of the public concerning a particular incident.

The operations manager had begun to address all of these concerns and had put into place a schedule of audits to begin the improvements. The most recent audits identified training needs for all staff in the areas of manual handling, infection control and health and safety. Some staff required updated training relating to the handling and administering of medicines. A lack of regular supervision was identified and a schedule to begin in May was required to ensure staff had the appropriate managerial support. The low staffing levels had also been recognised and plans were in place to advertise, interview and recruit new members of staff.

The new electronic system of recording and care planning was not being used effectively as a consistent and up to date account of people's daily needs and outcomes. The system sent the registered manager alerts regarding people's mood, incidents or accidents and night checks, which required a response. This enabled the registered manager to keep up to date with people's care. However, the responses to the alerts were not always effective. For example, a night check alert on the electronic record stated 'sensor went off [person] was in the toilet and bed was wet, sheets and clothes taken off, assisted to wash her lower half and [person] started getting angry threw her hands around and told me to leave her alone'. The response from the registered manager was 'these incidents need to be recorded on behaviour charts (ABC) continue to encourage and give reassurance'. It was not clear what 'reassurance' for this person meant, or what changed as an outcome of this guidance.

The home had recently experienced a difficult period of illness due to a flu outbreak which resulted in the unavoidable deaths of several people. This had impacted negatively on staff morale. The staff we spoke with said they had been through a traumatic time, and felt under pressure because of new people moving into the service. One staff member said "We've lost a lot of residents and staff. We're all feeling a bit low and a bit anxious about change." Despite this the staff we spoke with said they felt well supported. One said "I do feel valued. My manager says thank you and I know that if ever I need help I can ask for it."

The home worked closely with their local GP services and out of hour's services. The deputy manager said they had "fantastic support from their surgery and pharmacy" and from their senior management team who were very approachable and accessible during the (flu) crisis. The deputy manager spoke of the support given from the whole staff team at Bramley House, "fantastic support from management, if not here then on the end of the phone."

Documents showed that the registered manager ensured that the appropriate support was sought to provide guidance to staff for people with specific needs. For example, one person required a PEG. Percutaneous endoscopic gastrostomy (PEG) is an endoscopic medical procedure in which a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of nutrition when

oral intake is not adequate. The operations manager told us, "all staff have training to deal with a PEG. If there are any concerns we contact the dietician or Nutricia."

The operations manager described Bramley House as "a home for residents who choose to live here, we go above and beyond with particular activities" and "I always keep in mind that this is their home." The staff group viewed Bramley House as being very caring and family like. The re-development of the home, extra communal and outdoor space was seen as being a very positive outcome which would provide a comfortable home for people.

The operations manager said that there was lots of information sharing, particularly in relation to their ambition to be gold standard accredited in end of life care. They told us, "We all have a part to play and are always sharing [information] from housekeeping staff to the kitchen. Residents see staff differently and will say different things to a different person" and "I want to achieve accreditation by the end of the year." All staff were involved in a monthly flash meeting to share information and concerns. The home had full staff meetings every four months and senior meetings every other month. 'Resident' meetings were quarterly.

There was a suggestions box in the entrance for people, relatives and staff to leave anonymous feedback. We observed a suggestions file which documented any issues raised and the outcome. For example, a concern was raised about the plants being neglected in the entrance giving a negative first impression and one of the suggestions was to have artificial plants. It was decided to refresh and replace the existing plants which were then monitored by the housekeeping staff. Another relative suggested a bird feeder and bath near to the middle lounge for people to watch. The registered manager thanked the relative and purchased the items. We saw the results of a food survey completed by people and their relatives. Most people were satisfied with the food and there were useful suggestions for alternatives or variety which were passed onto the kitchen.

The operations manager acknowledged that systems and procedures had needed to be more structured. They had developed new schedules, timetables, use of an office diary to keep a checklist and tick things off. We were shown action plans and audits of care plans and health and safety that had already been undertaken. We were shown changes that had been made, such as the improvement of initial assessments for people, a new care plan format, improvements to the administration of medication, training being booked and supervisions being undertaken. She told us, "I feel the staff need leadership, guidance and support" The deputy manager said this was already filtering through and staff were feeling more supported. There was lots of praise for the management team and the planned improvements. "We want things to be good for the staff; we can't do this without you."

The operations manager will take back control of some areas which had been previously delegated in order to keep a check and balance of the system until she is happy that it is working well. These include the initial assessment of people and care planning. New champions in safeguarding and dementia friends have been identified from within the staff group alongside their dignity champion and they will be developing their roles with training planned in the next few months.

The operations manager had already put steps into place to improve the medicines concerns we raised on our first day. A pulse indicator had been purchased immediately and was being used and we heard the GP being called for guidance on administering the required medication during our second day of the inspection. A label reminding staff of this procedure was on the MAR. PRN protocols were mostly completed and person centred guidance was being developed on how the person likes to take their medicines. The electronic records now show on the person's front page if they have allergies or if they have a DNAR in place.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider did not have appropriate systems in place to ensure care and treatment was provided with the consent of the relevant people. |