Masterpalm Properties Limited

Brierfields

Inspection report

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Tel: 01616815484

Date of inspection visit:
29 September 2016
30 September 2016
03 October 2016

Date of publication:
09 November 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Brierfields is a single story care home in the Failsworth area of Oldham, registered to provide care and support for up to 37 people. At the time of our inspection there were 25 people residing at Brierfields and one person who was receiving day care.

All bedrooms have single occupancy and ensuite toilet and sinks. There are two enclosed quadrants providing a garden area accessible to people who used the service with a ramp for wheelchairs .Car parking is available within the grounds.

When we visited the service there was no registered manager in place. 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 identified nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and two breaches of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report. We found that the home had not been managed well, and that this had led to a number of concerns. One care worker we spoke to told us, "All checks had gone, there was no accountability; we just had to get got on with it."

We found that staff understood the needs of people who used the service but this was not reflected in care plans, which were drawn up without consultation with people who used the service and their relatives. Risks were not always identified and when they were, they did not lead to a corresponding change in the care plan.

The service did not have systems in place to ensure that safeguarding concerns relating to people who used the service were appropriately followed up, or that protective measures were put in place to ensure the safety of people who used the service.

There were no systems in place to store or file documents. For example, staff files were incomplete, there was no admission and discharge register to document who was admitted to the home and when, and you was discharged and to where, and no central record of Deprivation of Liberty Safeguarding authorisations or requests. We were unable to locate maintenance checks for essential equipment or building requirements.

When we checked staff personnel files we saw that one person did not have proof of checks relating to their character and fitness to work with vulnerable adults.

People who used the service told us that they had never been asked their views on the delivery of service or completed any questionnaires that might influence the way their care was provided.
They told us that if they raised a concern this was dealt with effectively but there was no central file to

monitor or record any complaints received by the service or how the service responded, or learnt from the complaint.

Staff were unclear about any training they had received, and there was no central system to determine if staff had attended courses or if they required any training in specific areas. There was no evidence that new staff had undergone a full induction, and staff told us that their supervision had been sporadic and that they had never had an appraisal. The new manager had prioritised staff supervision and had begun a timetable of three monthly supervision for all staff.

The service did not tell the Care Quality Commission about incidents where we should have been informed, for example, any accidents or emergencies or if a person who uses the service dies. This lack of notification means we cannot be assured that the right action has been taken. It also shows a culture that is not open and transparent with the Regulator.

We found that there were sufficient staff and that people who used the service were treated with respect and kindness by staff who knew them well.

People told us they liked the food and we saw meals were fresh and well presented. Their dietary needs were taken into account, and they were given choices of what to eat.

Procedures were in place to manage people's medicines safely and there was good access to health care professionals.

The service employed an activities co-ordinator and people told us that there was a variety of activities each day.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff files did not show people had been recruited safely

Risks were not always identified and care plans did not always provide guidance to minimise risks

People told us they felt safe

Procedures were in place to manage people's medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not had appropriate supervision, appraisal or training.

Consent was not always sought from people who used the service

Staff knew the likes and dislikes of the people who used the service.

People told us that they enjoyed the food on offer

Is the service caring?

Requires Improvement

The service was not always caring.

Care plans did not always reflect people's preferences and had not been drawn up in consultation with them.

Staff were attentive to people's needs.

Privacy was respected by staff who responded to people in a kindly manner

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was no system in place to analyse complaints.

Care files did not always reflect people's needs.

People were supported to maintain their independence.

The home employed an activities coordinator and people told us that there was enough for them to do.

Is the service well-led?

Inadequate

The service was not well led.

There were no systems in place to manage the overall governance of the service.

There was no registered manager.

There was no method of seeking feedback from people who used the service, their relatives, staff or other stakeholders.

Brierfields

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 29, 30 September and 3 October 2016 and was unannounced. Prior to the inspection we received information from the coroner informing us of a coronial investigation relating to an incident at Brierfields. Coronial enquiries and CQC enquiries are ongoing.

The inspection team consisted of two inspectors and an Expert by Experience. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Before this inspection, we reviewed the previous inspection report and notifications that we had received from the service. We also contacted the local authority safeguarding and quality assurance team to obtain their views about the service.

We asked the provider to complete a Provider Information Return (PIR), prior to this inspection. 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. However, they did not return this form to us.
During this inspection, we spoke to four people who used the service, and relatives of three other people, and had general conversations with other people who used the service and their visitors.
We spoke with the new manager, who had recently begun to work at Brierfields and two managers from sister homes (who were providing some management cover to the home), as well as the registered provider. We interviewed two senior care staff, two care staff and the cook, and spoke to two visiting health care professionals.

We looked around all areas of the home, looked at how staff cared for and supported people, and looked at food provision.

We looked at the care records for seven people, three medicine administration records and nine staff personnel files.

Inadequate

Is the service safe?

Our findings

People told us that they felt Brierfields was a safe place. We spoke to four people who used the service who confirmed that they felt safe in the Home. One person told us, "The [staff] look out for me; they always check and see if I'm all right and make sure I am safe", and a relative informed us that they felt the home was, "As safe as can be."

Brierfields had a vulnerable adults safeguarding policy, and when we spoke to staff they were able to demonstrate a basic understanding of the signs of abuse, and informed us that if they were to witness any abuse that they would report it immediately. During our inspection we saw evidence that concerns had been raised, including one that the manager raised following an incident during our inspection. However, when we asked to see a log of safeguarding concerns, the manager was unable to produce one, or tell us how many safeguarding alerts had been raised. This meant that the service could not monitor any patterns or trends, and there was no record of any instances of alleged abuse. In the course of our inspection, we found two instances of concern resulting in harm to people who used the service. When we asked if these instances had been reported to the local authority, staff were unable to tell us. We contacted the local authority safeguarding team who informed us that neither incident had been raised with them.

This was a breach of regulation 13 (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Systems and processes must be established to prevent abuse of service users and investigate immediately on becoming aware of any allegation or evidence of such abuse.

There were no clear systems for the safe recruitment of staff. We looked at nine staff files and saw that the information they provided was inconsistent. Whilst eight of the files we reviewed contained their application form, only four contained proof of identity, three did not contain references. References provide a vital way to check the character and suitability of a candidate before they begin work.

We also saw that three staff files had no record of further checks through the Disclosure and Barring Service (DBS). The DBS is a service that identifies people who may be barred from working with children and vulnerable adults and informs the service provider of any criminal convictions recorded against the applicant. These checks help the registered manager to make informed decisions about a person's suitability to be employed in any role working with vulnerable people. Before allowing a candidate to work with vulnerable people they must be cleared through this process. Further inspection found that checks had been made on two of the staff members, but the manager and staff were unable to locate a DBS check for one care worker. The manager agreed that this worker would not work unsupervised until such time as their character had been formally checked through the appropriate channels.

The above examples demonstrate a breach of regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Recruitment procedures must be established and operated effectively to ensure the person employed is (of good character).

We asked to see any records to show that equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions, and maintenance checks were carried out to ensure the safety and well-being of everybody living, working and visiting the home. We saw some old records, including fire inspection records from February and October 2014, gas safety records from 2013 and 2014, and legionella testing from August 2013. The manager informed us that more current records were held at the head office, however when they spoke to the owner they could not be located.

The above examples demonstrate a breach of regulation 15 (1) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: All premises and equipment must be properly maintained.

We saw that the home had adopted a generic approach to managing risks to people who used the service. We looked at seven care files and saw that some risk assessments had been completed, for example, risk of falls. One care file we reviewed showed the person had been assessed as 'high risk' of falls, but there were no control measures to manage the risk, and their mobility care plan only referred to the fact that they used a walking chair. In another file, a Waterlow score, which gives an estimated risk of a person developing pressure sores, identified the person as being at 'Very High Risk'. There were no control measures about managing the risk, and this person was observed sitting in a wheelchair without a pressure cushion for over five hours. Despite the high Waterlow score, the skin integrity care plan stated that there were no problems with skin. Another care file we looked at had a 'Moving and Handling' risk assessment. Despite a note on the template stating that this should be completed by a trained professional, such as a registered physiotherapist or a manual handling facilitator, it had been completed by a care assistant.

Furthermore, care plans did not identify specific risks associated with people's behaviour or routines. For example where a person regularly slept in the communal lounge there was no consideration of the risks or consequences of this behaviour.

The above examples demonstrate breaches of regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: good governance systems and processes to ensure compliance were not maintained..
When we asked people who used the service, they stated they were all happy with the cleanliness of the home, with one person noting that bedding was changed often.

We looked around the home and found that it was well lit, and free of any unpleasant odours. Communal areas were kept clear of obstacles to minimise the risk of accidents. The home had been built around two secure quadrangles, which could be accessed by people who used the service, and we saw one person who used the service sitting in one quadrangle relaxing and enjoying smoking a pipe. One quadrangle was well maintained, whilst parts of the second were overgrown with shrubs. During our tour, we found a number of health and safety risks. For example, in one shower room we found a broken shower chair with jagged edges. Although this was not being used it could cause a hazard, so we asked the manager to remove it, which she did. We also found and removed a box containing nail varnish and nail varnish remover, which had been left in a sitting room, and could be a health risk for people living with dementia; a cupboard containing hazardous cleaning solutions such as bleach and disinfectants was left unlocked, and jigsaws and games stored unsafely on a high bookshelf. The manager agreed to remove these. A broken pane of glass in a corridor had already been reported and we were told a new replacement pane had been ordered.

Most communal toilets were well equipped with soap and paper towels, but we noticed one communal toilet had run out of paper towels. We asked the domestic staff to restock this. We saw disposable aprons and hand gel were available, and used by the staff when attending to personal care tasks, administering medicines and serving food. Pedal bins with appropriate colour coded bin liners further reduced the risk of

cross contamination.

When we looked around the home we saw that some steps had been taken to prevent injury or harm, for example, each room had call bells mostly next to people's beds. We saw one room where the call bell was not by the bed but closer to an easy chair. When we asked the person who used the room about this, they told us they preferred it that way.

We found that personal emergency evacuation plans (PEEPs) had been developed for the people who used the service. These plans explain how a person is to be evacuated from a building in the event of an emergency evacuation and take into consideration a person's individual mobility and support needs. Each bedroom door was marked with a simple colour coded circle to indicate the level of mobility for the room occupant. This would assist any personnel unfamiliar with people who use the service to help in an emergency. One member of staff we spoke to informed us that there had never been a fire drill whist they had worked in the home, but was able to explain what they would do in the case of an emergency.

Residents were supported by a stable staff team, many of whom had worked at Brierfields for a number of years, and knew the residents well. We saw that there were enough staff and people told us that the staffing ratio reflected the needs of the residents. We looked at staff rotas, which showed that there were generally four care staff on duty during the day with three waking night staff. In addition, the staff operated a 24 hour on call system, so if an emergency arose a member of staff would be on hand to provide additional support. Care staff told us that regular staff generally covered any sickness. The service was able to rely on staff who were familiar with the people who used the service, and we were told that they had never had to use agency workers.

We asked staff if they felt there were sufficient numbers, and they agreed that there were; one told us that, "We've got enough staff, so we can take our time with people. It means we can get to know them; they are so interesting and can teach us so much".

A senior carer told us that tasks were delegated to ensure that there was always someone in the main areas to ensure people remained safe. However, we noticed on four separate occasions that the main living area was left unattended for up to five minutes each time.

Medicines were ordered and provided by the pharmacy using a monitored dosage system with blister packs. This minimised the risk of giving the wrong dose to people and provided an efficient system of storing and accounting for medicines.

A locked medicines room was used to store two medication trolleys - one for morning and lunchtime medicines and a second one used for evening and night-time medicines - and all other medicines for the service. Room and refrigerator temperatures were checked daily and a record of temperatures was kept, in order to ensure medicines were stored at the correct temperature. If medicines are stored at the wrong temperature, they can lose their potency and become ineffective. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs, for example, morphine or pethidine.
We saw controlled drugs were stored in a further locked cabinet, and the controlled drug register was countersigned when administered. We checked the balance of controlled drugs for two people and found them to be correct.

Each person requiring medicines had a Medication Administration Record (MAR). This is a form, which records the details of any medicines prescribed, when they are taken and if they are refused. All medicines

received were recorded on the MAR, which also included details of the medication, and dose required, and details of their general practitioner (GP). We looked at three MAR charts, which showed that staff accurately documented when they had given a medicine. This showed that people were given their medicines as prescribed; ensuring their health and well-being were protected.

Two of the people who used the service we spoke to received medicines and said these were administered on a timely basis but said they were not informed what the medicines were for. Medicines were administered by senior care staff who had received specific training on handling medicines; we spoke with one senior carer who informed us that they had completed medication training and confirmed that they were happy with the training received. The manager of a sister home informed us that they had completed competency checks on all senior carers administering medicines in line with a standard operation procedures.

Before our inspection we were made aware of concerns about administration of medicines. We observed one medication round during our visit. The senior carer giving out medicines wore a lilac tabard to indicate that they were giving out medication. This meant that they would not be disturbed whilst handling medicines. We saw that they were not disturbed. Hand-wash and a paper towel dispenser were available on the medication trolley along with gloves and protective aprons. We saw that the care worker checked the MAR chart to ensure that they were giving out the correct medicines, and passed the medicines to the person to whom they were prescribed in a disposable cup, and provided a drink to help wash the tablets down. Once they were sure that the medicine had been taken, they recorded in the MAR chart that the medicine had been provided. We saw that medicines were given in an appropriate timely and person centred manner.

Requires Improvement

Is the service effective?

Our findings

The people who used the service we spoke to and their relatives were particularly complimentary towards the staff. One person who used the service said, "Not an unkind word can be said against the staff". Another enjoyed the fact the staff would have a bit of fun with people who used the service.

They told us the staff were all competent at their job. One person who used the service said, "It was difficult to get people to the job". They explained that they believed the job of carer was not always attractive but felt that that Brierfields had attracted good, competent staff, recognising the challenge of recruiting people to such jobs. A visiting relative told us, "All the staff are good at what they do."

When we spoke with staff they showed they had an in depth knowledge and understanding of the needs of the people they were looking after, for instance, when asked one care worker was able to provide a detailed account of the history, likes and dislikes of a particular service user.

Staff, however, were unclear about any training they had received which would help them to carry out their roles correctly. We were informed that they had received some training 'attached to their weekly payslip' and they had been told they would be given a 'module' to complete each week for 15 weeks. This related to the Care Certificate. This is a professional qualification linked to the National Occupational Standards and aims to equip health and social care staff with the knowledge and skills which they need to provide safe and compassionate care. It consists of a series of fifteen modules. However, when we spoke to staff they were unclear as to what this was, and informed us that the modules stopped abruptly after about four weeks. Some of the staff we spoke to were able to tell us what training they had completed, and one person told us that they were supported to complete an NVQ Level 5 course. However, another told us they had not received any training in the past two years.

We found some training certificates in a filing cabinet, which showed that some staff had training in manual handling, infection control, first aid basic food hygiene, health and safety, fire safety, safeguarding adults and dementia awareness. We also saw records to show senior care workers had been trained to administer medicines and we saw evidence of recent competency assessments. However, when we asked the manager if they kept an overall record of training undertaken, they were unable to produce one, and there was no overall matrix to determine what training staff had undergone and when refresher training was due. Such a record would help to identify any gaps in staff training and help identify training needs.

There was very little to demonstrate that care staff had undergone an induction. In one staff file we saw a note to say one person had completed an induction when they started working at Brierfields, but this was undated. The person had been working at the home for over five years. We did not have an opportunity to speak with any new staff but we were told by one person that induction consisted of, "Spending a couple of days shadowing".

The new manager had prioritised staff supervision and had begun a three monthly timetable of supervision for all staff. Supervision meetings provide staff with an opportunity to speak in private about their training

and support needs as well as being able to discuss any issues in relation to their work. One person we spoke to had been formally supervised by the new manager but went on to say that previous supervision had only occurred rarely. They told us that their previous supervision had been, "A waste of time. In and out in five minutes". We found some records of supervision which were hand written and uninformative. Staff told us that they had never received an annual appraisal.

The above examples demonstrate a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing. People employed must receive the appropriate, training, supervision and appraisal as is necessary.

We were told that 'handover' meetings between the staff were undertaken on every shift. Handovers help to ensure that staff are given an update on a person's condition and should ensure that any change in their condition has been properly communicated and understood.

We were present for one handover meeting on the second morning of our inspection and we found that good and comprehensive information was passed on about each person, including any changes in needs, interactions over the previous shift, or issues arising. Where people who used the service required monitoring, for example, people requiring anti-coagulants, or if there had been a change in medication, this was discussed and noted. One person had complained in the night of feeling sick, and a referral was made to the general practitioner (GP). This was also noted.

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (MCA). The 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.

We saw in care files that a number of requests had recently been submitted to the supervisory body (local authority) following capacity assessments to determine why people might have needed a DoLS authorisation. This helped to make sure that people who were not able to make decisions for themselves were protected. However, there was no central record to show if a request had been made, if it had been authorised or when it might be due for renewal so we were unable to check if all the people who used the service had been properly assessed.

Moreover we saw that decisions were sometimes taken on behalf of people who may have lacked the capacity to make the decision themselves without following the appropriate guidelines. Decisions made were possibly the most appropriate and least restrictive, but there was no formally documented decision process to show how the decision had been reached, for example, there was no evidence that a "best interest" decision had been held to determine how best to support a person who used the service to continue to smoke cigarettes, and no formally documented rationale which had considered the least restrictive option available.

We also saw evidence that consent was not always sought, for example, we observed two people being

moved to other parts of the home in wheelchairs without staff seeking appropriate consent first, and we saw that a care worker switched channels on the TV without first checking that people who used the service were watching. When one person objected, they quickly apologised and turned back to the original channel.

The above examples demonstrate breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for consent. Care and treatment must only be provided with the consent of the relevant person.

People told us that they enjoyed the food at Brierfields and we found that portion sizes were ample and the food smelt and tasted good. Meals were well presented with use of texture and colour to provide encouragement and interest in the food.

We were told that people's feeding and eating abilities had not been taken into account on previous menus; one relative informed us that they were particularly concerned that grilled gammon had been offered, which a number of people who used the service were unable to chew. The chef told us that they had met with the new manager and addressed a number of changes, such as amending the main meal time to a more suitable time for people who used the service, and there had been a full review of the menu to take into account the needs and preferences of the people who used the service. They showed us a list of likes and dislikes of all the people who used the service and told us that they had used this to formulate the new menu. They told us "It's their home, we're working for them. If they want it, and I can get hold of it, I'll put it on".

The kitchen displayed information about specific dietary needs and the specific requirements of people living at Brierfields. At the time of our inspection, nobody required a fortified diet but we saw a number of people had been prescribed build up drinks to supplement their diet but the chef was unaware of this, as there was little communication between kitchen and care staff.

The menu we looked at showed a choice of meal at lunch and teatime, and we saw that people could choose a cooked breakfast, cereal and toast at breakfast. Throughout the day, people who used the service were offered a range of drinks with support and encouragement to take regular fluids. Snacks were always available and a supper was provided, consisting of cakes or a light snack.

All the people who used the service that we spoke to felt their health needs were being managed and monitored by staff, and when we spoke to them, they confirmed that they had easy access to both doctors and nurses when required.

We saw from handover notes that regular appointments with healthcare professionals were kept, and if a health need was identified, this was recorded in the person's daily notes with a record to show that the care staff had made the appropriate referral, for example to a dietician or continence advisor. In the case files we reviewed, we saw evidence of dental and optical checks.

We spoke to two visiting district nurses, who told us that they believed the staff at Brierfields were generally proactive, and would notice and report any changes in behaviour or condition. They also told us that staff were approachable, would listen and act on advice.

Requires Improvement

Is the service caring?

Our findings

One relative we spoke to talked of the affection they felt was shown to their relative, and told us, "Staff are caring, and they know [our relative]. They seem to like her, and some love her to bits". Another told us "the staff here are great. They can't do enough. I am so glad [my relative] is here; they are fantastic! There is one person he has really hit it off with: a fantastic carer!"

Although the care staff employed at Brierfields showed genuine empathy and affection for the people who used the service, they did not always consider the needs and wishes of people. For example, we saw two people being moved from the lounge area to other parts of the building without first checking that they wanted to be removed, or seeking their permission.

We were also told by a visitor that they had found their male relative wearing a pair of women's leggings that did not belong to him, which indicated a lack of dignity and was degrading.

People told us they thought that care staff were kind and caring. One person who used the service told us "the staff are fun and affable; it's like a family". Another told us the staff, "Made time for the residents. I am impressed as to how they show affection to everyone".

We saw that people were addressed by their preferred names and spoken to in a friendly manner, making eye contact and touch where appropriate. Interactions between care staff and people who used the service were respectful and caring. For example, we saw one person being assisted out of an armchair. The care worker chatted to them first, explained what they wanted to do and why, and gently helped them to get up, escorting them by the arm to help with mobility. Throughout the interaction the care worker maintained conversation and provided encouragement. We further observed examples of appropriate interaction and conversation between staff and people who used the service indicating a degree of familiarity and understanding of the needs and wishes of people who used the service. We saw that when the person who used the service for day care was becoming anxious, the staff provided reassurance and used calming distraction techniques to help reduce the anxiety.

We saw that people were not left on their own unless they wanted to be and we observed caring relationships where staff and people chatted about things that were important to them, such as, television, family and food preferences. There was a friendly atmosphere at Brierfields and we saw that people smiled often and looked cared for in their appearance.

Staff were attentive and responded to people in a sensitive, kind and caring manner. We observed positive interactions; including laughing and sharing jokes, chatting and care staff sitting quietly with people who used the service involved in conversation. The care workers we spoke with demonstrated a good knowledge of the people who used the service, their lives likes and histories.

We asked staff how they ensured people maintained their privacy and were treated with dignity and respect while providing care and support. One staff member told us they would always close the doors and ensure

that people were covered up whilst assisting them to wash and dress, to protect their dignity.

People were encouraged to form friendships, and we saw evidence that people had developed new friendship groups since they moved in to Brierfields. Staff also supported people to maintain relationships with family and friends. Feedback from visitors was positive about the care provided, and the relatives we spoke with had no issues about the quality of care. There were no restrictions on visiting and those visitors we spoke with told us that they were always welcomed and supported when they visited. They informed us, and we saw, that staff knew them and greeted them by name. Visitors told us that the staff were always available, friendly and knowledgeable. A visiting professional told us that they would respond to questions, and if they were unsure about the required information, they would find someone who could give them the correct information.

We observed that people were asked discreetly about their personal care. When people needed assistance with personal care, we observed that staff ensured they closed doors in bedrooms and bathrooms.

People's privacy and confidentiality was maintained. If people wanted to they could have a key to their room. We spoke to one person who locked their room when they were not using it. Staff were aware of the need for confidentiality and we saw they were discreet when talking to professionals.

Requires Improvement

Is the service responsive?

Our findings

When we asked people who use the service about complaints they told us that they felt confident that any concerns raised would be addressed and one person told us that they had made a complaint which was, "Quickly sorted". Similarly relatives we spoke to told us that they had raised issues about care provision and that these had been followed up appropriately. However, when we asked to look at the complaints and compliments log we were told that there wasn't one. This meant that there was no system to record any action taken in response to complaints received, no system to properly record, track and investigate issues of concern, and no opportunity to track and identify complaints and compliments to determine any trends or actions which would prevent a reoccurrence.

This was a breach of regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Receiving and acting on complaints as there was no accessible system or process established to identify, receive, record, handle and respond to complaints.

One care plan we looked at made reference to a person having a pressure cushion in place, but we saw this person sitting in a wheelchair without a cushion for a long period of time. When we raised this with a care worker they responded, "Well they should be", before wheeling the person away to another part of the home without seeking consent first.

Care plans did not reflect the person or identify their specific needs. They were not person- centred and had been written without reference, consultation or involvement of the person concerned. All five of the people who used the service with whom we spoke were clear that nobody had asked them about their care nor had they seen a care plan. When we looked at care plans we found that they had not been drawn up in consultation with the people who used the service; were completed by a consultant to the service who was unfamiliar with the people in Brierfields, and did not reflect their needs. For example, the same phrases were cut and pasted from a template and in some instances sections that had no relevance had not been deleted. People's needs were not reflected in the general wording of the documents, and some had identical needs despite the clear differences in the people to whom the care plan belonged.

The above examples demonstrate breach of regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Person Centred Care. Care and treatment of service users must be appropriate, meet their needs and reflect their preferences.

One relative we spoke to expressed concern that staff did not refer to notes which would detail the person's needs and preferences. We saw that care files were kept in a locked cupboard. Whilst this ensured the confidentiality of the care notes, it meant that staff who needed information about people who used the service would have difficulty accessing it. We reviewed seven care files. They did not contain sufficient up to date information about people to inform care workers how to provide appropriate care. There was no evidence of a pre-admission assessment and very little background information about people's past lives, or things that may have been important to them.

When we spoke to one member of staff they admitted that they did not look at care records, because "They do not tell you anything." When we asked about specific care needs of people who used the service the information they gave reflected the information in the care plan, and they were able to indicate how their care was directed in accordance with the stated plan. They told us that they kept up- to- date by reading the daily logs, and any information about specific people who use the service was passed on during handovers. When we looked at the daily records we saw that the information they contained was thorough. Similarly, night time observation charts recorded any concerns or interventions. However, attempts to bring the information together to provide a full picture were sporadic. This meant that there was no clear system to monitor or track any changes in behaviour or identify any issues that might indicate a change in a person's needs.

People told us that when they needed to summon help using the call bells, they received a good and timely response. During our inspection we saw that staff responded quickly to any alarm calls. A relative we spoke to was impressed with the way staff responded to unplanned situations and told us that if there had been an accident with their relative, they were contacted right away. Staff would also escort people to hospital, and operated an emergency on- call rota to call in extra staff if a member of staff was needed to attend an unscheduled hospital visit.

When we asked, people who use the service they told us they were supported to meet their own needs wherever possible. A number of people who used the service were able to help themselves with personal care tasks and they told us that this was encouraged. However, we witnessed staff pushing two people in wheelchairs when their care plans stated that they were mobile. They were not encouraged to walk or use walking aids such as zimmer frames to promote independence.

Brierfields was equipped with an activities room and employed an activities co-ordinator who arranged activities for people who used the service such as bingo, singing or pampering sessions like nail polishing. When we spoke with people who used the service they told us that they felt there was enough for them to do. However on the days of our inspection the activity co-ordinator was on leave and there was no sign of any organised activity. One person who used the service told us that the new manager had asked them what pastimes they would like to see in place and was hopeful things would change.

Inadequate

Is the service well-led?

Our findings

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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. When we visited, however, there had been no registered manager in place since May 2016, but a manager been appointed by the service provider, and had been working at the home for less than two weeks at the time of our inspection, and was present throughout our inspection.

We found that Brierfields had been poorly managed, as systems in place to store or file documents were haphazard or non-existent, and there were and no structures, processes or systems to track, monitor and manage service provision. Systems in place to monitor the quality of service provision were not robust; audits did not allow for identifying concerns or provide action plans to improve the quality of service. There was no proper system to account for resident finances, so it had not always been possible to account for any cash kept on behalf of people who used the service. Where staff had bought items on their behalf, records and receipts had not been stored in an accountable way.

There was no method of seeking regular feedback from stakeholders such as staff/resident/ relative survey. We noted that there had been a relatives and resident meeting in June 2016, but no actions list or evidence of follow up to concerns. One relative we spoke to told us confirmed that this meeting had taken had taken place but no one actively sought their views or feedback, and when we spoke to people who used the service, they could not tell us of any examples of where feedback had been asked for. They had never completed any quality surveys or questionnaires about their service delivery.

There was a lack of clarity about roles and responsibilities, specific tasks were delegated to care staff but there was no monitoring or checks on these tasks. The service had a number of policies and procedures but these were stored in a locked storeroom where most staff could not access them.

The above examples demonstrate breaches of regulation 17 (1) (2) (a) (b) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance, as systems and processes were not established or operated effectively to assess, monitor and improve the quality and safety of the services provided; assess and mitigate the risks relating to health, safety and welfare, or seek and act on feedback from relevant persons or evaluate and improve practice in respect of processing information.

Services such as Brierfields have a duty to inform the Care Quality Commission (CQC) of any notifiable incidents which occur in their service. Between February and September 2016 we did not receive any notifications. During this time, there had been a number of incidents where we ought to have been informed, e.g., DoLS notifications, deaths, and serious incidents. However it is unclear how many should have been reported and there was no central log of incidents occurring.

This is a breach of regulations 16 (1) (2) (3) and 18 (1) (2) of the Care Quality Commission (registration)

Regulations 2009: notification of death of a service user and notification of other incidents.

The new manager had only been in post for a short time, but the people we spoke to showed confidence in her abilities, one person who used the service told us, "[The new manager] is making a big difference and is seriously getting to grips with the home", whist a visiting professional told us that they believed that there was more direction in the home; they had noticed that the new manager had implemented and made changes which had seen an increase in staff morale, and that staff "seemed happier and were more approachable." Visitors had also noticed a change; we spoke to one relative who told us that they had observed an improvement in the attitude and behaviour of staff, and that the home was much cleaner, and staff more cheerful.

When we spoke to people who worked at Brierfields, they agreed that there had been a lack of governance. One senior care worker told us, "Our only priority has been the residents. They are happy. Sometimes it's been hard because the systems didn't support us and we needed a rocket!" They felt that the new manager had begun to make positive changes, another member of staff said, "All checks had gone, there was no accountability, we just had to get got on with it, but now we are coming on in leaps and bounds, I'm learning to love my job again."

Throughout our inspection, we saw that people were well cared for. People who used the service and their relatives informed us that they believed the home was well ordered, one person told us, "The atmosphere is good in the home" and another that Brierfields was, "Organised and well run". They told us the new manager was visible and that both she and the staff were easy to approach. They told us that the staff knew them well enough to understand their moods, and recognised their likes and dislikes. Care staff re-iterated to us that the ethos was one of family, and that they wanted the people who used the service to be safe and content.

The manager believed that she had, "Inherited chaos. There has been no leadership so a multitude of things have gone wrong". We saw that she had already implemented a number of changes, for example, she has put actions in place regarding meal provision, introducing new menus more suited to the needs and preferences of the people who use the service. She has implemented a programme of staff supervision to begin to build an understanding and rapport with staff, and has arranged to meet with families to seek feedback on the quality of the service. She has liaised with other agencies such as the local authority quality assurance team to devise an action plan to improve the quality of service delivery and begun to arrange bespoke training for staff for example around dementia care and managing aggression.

Prior to our investigation, we were made aware that the death of an individual who had lived at Brierfields was the subject of a coronial enquiry. This matter is still on-going.

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 16 Registration Regulations 2009 Notification of death of a person who uses services There had been a number of deaths at Brierfields between February and September 2016, but is unclear how many, as no central register was kept at the premises. The Commission has not been informed of any deaths. regulation 16 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents There had been a number of notifiable instances at Brierfields between February and September 2016, including falls, hospital admissions and DoLS. The Commission has not been informed of any incidents. regulation 16 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not always sought from the relevant person and it was unclear how many people were subject to DoLS authorisations and consent was not always sought. regulation 11 (1)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment There were no maintenance logs to show equipment had been properly checked. regulation 15 (1) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints there was no accessible system or process to identify, receive, record, handle and respond to complaints. regulation 16 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Information in staff recruitment files was insufficient to determine if the person was of good character, and DBS checks were missing. regulation 19 (2)