GCH (Brackenbridge House) Ltd

Brackenbridge House

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on the 6 and 8 July 2015 and was unannounced.

Brackenbridge House is a residential home and is part of Gold Care Homes. It provides accommodation for up to 36 older people in single rooms. The home is situated within a residential area of the London borough of Hillingdon. At the time of our visit there were 35 people using the service.

At the time of the inspection the home did not have a registered manager. We were informed that a registered manager from another care home managed by the provider was being transferred to Brackenbridge House by the end of July 2015. 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.

Summary of findings

We spoke with the people using the service, relatives and care workers to obtain feedback about the service provided.

The provider met all of the regulations we inspected against at our last inspection on 21 May 2014.

People we spoke with told us they felt safe but there were not enough staff to meet people's care and support needs.

Medicines were managed and administered safely in a safe and caring manner. We saw that delays in administering the medicines occurred due to the systems in place and how the medicines were stored. We have made a recommendation in relation to the management of medicines.

There were processes in place to keep the home clean and tidy but we identified issues with the storage of continence products.

There were effective policies in place to deal with concerns related to the care provided. Each person had a plan in place identifying the support they needed in case of an emergency. We saw assessments had been carried out for each person to identify any possible risks in relation to providing their care.

Some staff had not completed training identified as mandatory by the provider as part of their induction or as a refresher course. Staff had not had supervision sessions or annual appraisals in line with the provider's policy in relation to supporting staff.

We found the service had made appropriate applications to meet the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA) but they had not incorporated this information into the person's care plans. The provider did not inform the Care Quality Commission when the applications in relation to DoLS had been authorised.

People told us the care workers were very nice and treated them with dignity and respect but they felt the care workers did not have the time to spend with them due to their work levels.

The activities provided in the home were not meaningful, were not based on people's interests and did not encourage engagement with other people.

Detailed assessments were carried out before a person moved into the home and the care plans took account of people's needs and wishes. The care plans we looked at had been recently reviewed.

The provider had systems in place to monitor the quality of the care provided and these provided appropriate information to identify issues with the quality of the service but some audits did not look in detail at the issues.

We found four breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to staffing levels, staff training and support, activities and care plans including information on DoLS. We found one breach of the Care Quality Commission (Registration) Regulations which related to notification of DoLS authorisations. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Some aspects of the service were not safe. People using the service felt safe but there were not always enough care workers to meet people's care needs appropriately and safely.

Medicines were managed and administered safely in a safe and caring manner but the system in place for administering the medicines caused delays.

The home was clean but an issue with the storage of continence products was identified and resolved.

Requires improvement

Is the service effective?

Some aspects of the service were not effective. Staff had not received the necessary training and support they required to deliver care safely and to an appropriate standard.

Care plans did not include information related to any Deprivation of Liberty Safeguards in place.

People gave mixed feedback regarding the choice of food available. People were given a choice of what they ate.

Requires improvement

Is the service caring?

The service was caring. Care workers treated people with dignity and respect when providing care and support.

Care workers supported people where possible to maintain their independence but were sometimes too busy to spend additional time with the person.

Care plans identified people's preferences in the way their care was provided. The person's spiritual and cultural needs were also identified.

Good

Is the service responsive?

Some aspects of the service were not responsive. Activities provided by the home were not meaningful and engaging.

Detailed assessments were completed before a person moved into the home. The care plans identified the person's wishes and needs in relation to the care provided.

People knew how to make a complaint and there was a complaints policy and procedures in place.

Requires improvement

Is the service well-led?

Some aspects of the service were not well-led. The provider did not notify the CQC when DoLS were authorised.

Requires improvement

Summary of findings

The provider had various audits in place to monitor the quality of the care provided.

Staff felt supported in their role by the deputy manager.

Brackenbridge 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.

This inspection took place on the 6 and 8 July 2015 and was unannounced. The inspection was carried out by two inspectors, an expert by experience and a pharmacy inspector. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the notifications we had received from the service, records of safeguarding alerts and previous inspection reports.

During the inspection we spoke with 17 people using the service, three relatives and visitors and eight staff members. We also spoke with the deputy manager and regional manager.

We reviewed the care plans, risk assessments, daily records and emergency evacuation plans for 15 people. We also looked at the Medicine Administration Record (MAR) charts for people using the service. We looked at the employment records for four staff members. Other records we looked at included 20 accident and incident reporting forms and various audits. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also carried out general observations around the home during breakfast, lunch and throughout the day in the lounge area.

Requires improvement

Is the service safe?

Our findings

People using the service told us they felt safe when receiving care but some told us they had concerns about safe care at night. Two people said "Staffing is the main problem" and "I don't feel safe at night, there are not enough staff". Other people told us "There are not enough staff and they keep leaving". They also said "We have to wait a long time if we press our buzzers" and another person added "Especially in the night, it's sometimes 20 minutes". We were also told by another person using the service "I have waited for the toilet 10 minutes and was told, in a minute or we are in a meeting." When we were talking to people using the service they told us about their frustration regarding the lack of staff but there was a great deal of support for the care workers who they say were doing their best.

A relative told us "There are not enough staff here; it's an accident waiting to happen. I have been coming here for five years, the girls are run ragged, some residents need two carers, they should put cameras in." Another relative said that they thought that the home was safe but "There are not enough staff." A person using the service told us they had raised their concerns regarding staffing levels with the management and "We have been told that we are up to strength as per Government guidelines, yet I still have to wait 10 to 15 minute for someone to come." A relative told us "The call bell has sometimes been as long as 45 minutes before it has been answered. On Saturdays sometimes I can't get in because there are no staff near to let me in. Clearly they cannot cope."

Staff also told us about their concerns related to staffing levels at the home. Care workers told us "There are more residents with higher needs but we don't have staff to cope with this." "At 11.30 am 11 residents are still getting up for breakfast. There are a lot of wheelchair-bound residents." Another member of staff said "It's got harder, it used to be residential but people have higher needs now but the staff level hasn't changed. I feel we don't provide the care they should be given" and "There's been a decline in the last 3 years. No one is willing to give us more staff – everyone is complaining about it".

The deputy manager explained there were five care workers on duty on the morning shift from 7 am and four care workers on the afternoon shift from 2pm. There were two care workers providing support overnight. There was one senior care worker covering each shift and they would start at 2pm. They would then sleep at the home overnight and be on call if the two care workers needed additional assistance or if any medicines needed to be administered. This senior care worker would then continue to work until 2pm the following day.

From the 35 people living at the home, 10 people were identified as requiring two staff to provide personal care and to use a hoist to move them. This meant that four care workers working as two teams were needed to support ten people leaving a single care worker to support the remaining 25 people. The senior care worker was responsible for administering the morning medicines and we observed this took them up to three hours to complete.

Our observations during the inspection supported the feedback from people using the service, relatives and staff in relation to staffing levels. We saw one person had not been brought down for breakfast until 11am and then stayed in the dining room as they were due to have lunch at 12 noon. We also saw that people were left for up to 30 minutes in the lounge without care worker support. During meals we saw care workers had to leave the dining room to support people with personal care which meant that there were no care staff present. This also resulted in people who were being supported to eat having to wait for their meal until the care worker returned. We saw one person asked to be taken to the toilet and was told by a care worker who had finished their shift that the person would have to wait until after the handover meeting as the hoist had to be used. The person waited for 15 minutes before two care workers were available to provide support.

There were not enough care workers available to provide appropriate support to meet the varying levels of need experienced by people using the service. This meant that people had to wait for the care they required and at times did not feel safe.

The above paragraphs demonstrate a breach of Regulation 18 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were in stock and available for people who needed them. The system for ordering and receiving medicines had recently changed and staff were able to describe to us how they did this to ensure that people did not run short of medicines. Medicines were stored safely, including controlled drugs which need additional security

and medicines that require cold storage. We looked at some people's medicines records and saw that they were clear and easy for staff to follow. A record was made at the time of administrations or codes used for any medicines omitted. Creams were applied by care staff and were recorded on a separate form which included a body map describing where each cream was to be used. One person we spoke to told us how the carers always did their creams in the morning when they were supporting them to get dressed. Senior care staff told us and we saw that they had received medicines training including additional training to cover the new system that had been introduced.

We watched senior carers giving medicines to people. This was done in a safe and caring manner. People were supported to take their medicines in a way that they were comfortable with and staff were able to answer their questions and concerns. For example we saw one senior carer prompting a person to take their medicines one at a time, explaining what they were for as this is what the person wanted. However we noted that the medicines were stored in two trolleys which the staff member giving the medicines had to be in control of. This proved difficult when people were in different areas of the home. The medicines round started at 8am and did not finish until nearly 12 noon. The lunchtime medicines then had to be given from 1pm until 2:30pm. Care staff were careful not to give medicines that needed specific dose intervals too close together and to give medicines that had to be taken at a specific time at the correct time. However we noted that some people who had been prescribed medicines for pain, prescribed four times a day, had their last dose at night around 10pm and then were not offered another dose until after 10am the next day. This may mean that they were not comfortable or in pain. If people specifically requested pain relief earlier this was supplied. We were told that this was a new system; however no additional staff support had been allocated to this time to allow medicines to be given in a timely way.

Systems were in place for the cleaning of the home On the first day of the inspection we saw the carpets in the corridors and lounge areas had food debris on them and had not been cleaned. The deputy manager explained that the person who was due to do the cleaning at the home the day before the inspection was not at work. During the day we saw the domestic support staff were cleaning the home and had a clear process in place to ensure all areas of the home were cleaned appropriately. On the second day of the inspection we saw the communal areas of the home and the bedrooms were clean. People we spoke with told us the home was usually clean and tidy. During the inspection we saw that the home had a large stock of incontinence products that were stored in people's bedrooms and bathrooms. We saw in one bathroom there were two open packs and four sealed packs of incontinence pads being stored next to the toilet. We raised this with the deputy manager and the regional manager and alternative suitable storage for these supplies was identified before the end of the inspection.

We saw the service had effective policies and procedures in place to deal with any concerns that were raised about the care provided. Information on the procedure was included in the staff handbook. Staff we spoke with were aware of the principles of safeguarding and how they would protect people using the service from abuse. Staff were also aware of the whistle blowing policy and procedure that were in place. They could describe how they would raise concerns with the service and with external organisations.

We saw plans were in place in case of an emergency requiring people using the service to be evacuated from the home. There was a personal evacuation and egress plan (PEEP) in each person's care folder. This reviewed the person's mental and physical ability as well as their hearing and vision and assessed their ability to react to a fire alarm and leave the building independently or if they required assistance from staff. It also identified how many care workers were required to help the person leave the building and if any specific equipment was required such as a hoist or wheelchair. The information was linked to the moving and handling risk assessment and was reviewed every six months. We saw all the emergency plans we looked at had been recently reviewed and clearly identified the person's support needs.

Some of the people using the service had emergency call bells on cords around their neck so they could easily alert staff if the required assistance. There were also call bells in people's bedrooms that were accessible.

The provider had a clear process in place to record and investigate any incidents and accidents. Staff completed a record form when an incident or accident occurred which included details of the event, if the person was moved and any actions taken. We looked at 20 incident and accident forms that were completed during 2015. We saw staff completed a body map chart if any injuries were identified

Requires improvement

Is the service safe?

following an accident. The deputy manager completed a monthly analysis of the number of falls which was broken down by type of fall, location and if it was witnessed by staff. This information was used in the review of the care plans and risk assessments.

We saw there were a range of risk assessments that had been completed for each person using the service. During the inspection we looked at the care folders for 13 people using the service and we saw these risk assessments were initially carried out when the person moved in to the home and were reviewed every six months or sooner if there had been any change in the person's care needs. We saw an assessment was completed for each person reviewing their risks of slips, trips and possible scalding when using the bath or shower. Other risk assessments included reviewing if the person was at a higher risk of pressure ulcers, falls and malnutrition. A moving and handling risk assessment was also carried out to identify any issues for staff when supporting the person to move around the home. The risk assessments we saw were detailed and they were up to date. This range of risk assessments provided information for staff on areas of concern and they can appropriately support the person using the service when providing care.

We found that the provider had a robust recruitment process in place. The deputy manager explained that as part of the recruitment process two references were requested and an interview was conducted with the prospective staff member. New staff could not start their role until a Disclosure and Barring Service check had been received to see if they had a criminal record. During the inspection we looked at the records for four staff members and we saw that two suitable references for each person had been received, notes had been taken during the interview and a check for any criminal records had been completed. This meant that suitable checks were carried out on new staff to ensure they had the appropriate skills to provide the care required by the people using the service.

We recommend the provider review the current NICE guidance "Management of Medicines in Care Homes" in relation to organising medicine administration rounds.

Requires improvement

Is the service effective?

Our findings

People using the service we spoke with told us they felt that regular care workers had enough training. This comment was not supported by the training records we looked at. People were being cared for by care workers that had not received sufficient training to deliver care safely or to an appropriate standard. The provider had identified four training courses that they felt were mandatory for staff to complete annually so they provided safe and appropriate care. These courses were health and safety, infection control, moving and handling and safeguarding vulnerable adults. We looked at the training records for 36 staff including care workers, kitchen and domestic support staff. One senior care worker, eight care workers and two domestic support staff had not completed their annual refresher for health and safety. We saw the records for safeguarding vulnerable adults training showed that one senior care worker, three care workers and two domestic support staff had not completed the annual refresher course. We saw that care workers were supporting four people to eat during meals but appropriate training had not been provided for them.

The deputy manager explained that the mandatory training was not part of the induction process for new staff. When the new staff member completed their three day induction which included shadowing an experienced care worker and reviewing policies and procedures they would be allocated on to the next scheduled training course. We saw from the training records that a number of staff had not completed the mandatory training since they started their role. We saw that 12 care workers, one senior care worker and two domestic support staff had not completed health and safety training. In relation to infection control training we saw that nine care workers and two domestic support staff had not completed the initial course. The training records in relation to safeguarding vulnerable adults showed that one senior care worker, 11 care workers and two domestic support staff had not completed this initial training. We saw that up to six of these staff had been working at the home for more than six months without completing the initial training.

We looked at the supervision and appraisal records for 29 staff including care workers and domestic support staff. The deputy manager explained that all staff should have a supervision meeting with their manager every two months and an appraisal. We saw from the records that nine care staff had only completed one supervision session with their manager between January and July 2015. There were also eight staff that had not completed an appraisal with their manager of which four staff had not had an appraisal since 2013.

This meant that these staff had not received suitable training and support to enable them to provide appropriate and safe care for people using the service.

The above paragraphs demonstrate a breach of Regulation 18 (2) (a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had taken appropriate action to ensure the requirements were followed for the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) by making the relevant applications but these had not been recorded appropriately in people's care plans. DoLS provides a process to make sure that people are only deprived of their liberty in a safe and correct way, when it was in their best interests and there was no less restrictive option by which to provide support. At the time of our inspection there were seven people with DoLS that had been authorised by the local authority. We saw that each person using the service had a care plan which identified their mental state and cognition/psychological needs. We looked at these care plans for all seven people and saw there was no mention of the DoLS in the description of their support needs. The standard authorisation form identified that the purpose of the DoLS was to enable the person to receive specific care which included assistance with mobility, continence care, personal care and support with eating. We looked at the care plans for the areas of care identified on the authorisation form. There was no mention of the DoLS and any impact on the way care should be provided and how decisions should be made in the person's best interest. This meant that staff were not given sufficient information for them to provide appropriate care and support in line with the DoLS.

The above paragraph demonstrates a breach of Regulation 17 (2) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a policy and procedure in relation to MCA and DoLS and staff confirmed they had received training on

Requires improvement

Is the service effective?

the MCA and DoLS. Staff we spoke with understood the principles of the MCA in relation to supporting people using the service in decision making and encouraged them to make choices whenever possible.

We received mixed feedback in relation to the food and drink provided. Some people using the service complained that the food wasn't good and they got broccoli and carrots as their vegetable option every day but other people said the food options were reasonable. People said "There is a choice of two things and you get fruit; if you get desperate they will make you a sandwich" and "The food is not good, you get the same vegetables." We saw that if a person did not like the meal options available the chef gave them alternative options.

We saw that each person had a nutritional care plan which identified the persons food preferences and if they required a soft diet or if they had any allergies. Due to the size of the dining room the deputy manager explained there were two sittings for main meals and people told us they could choose during which sitting they had their meal but sometimes there were delays if the first sitting over ran due to people requiring additional support. This meant that sometimes people had to wait longer for their meal. We saw people were asked for feedback on their meal and this information was used to make changes to the way the food was prepared. We saw that food and fluid charts were completed for people and their weight was monitored monthly.

There was a menu on each table but it was just a list of the food available and did not provide any additional information or pictures. The regional manager told us the provider was in the process of identifying an improved list of meal options which were nutritious and varied to meet as many people preferences as possible.

We saw people had access to a range of healthcare professionals to help maintain their health and wellbeing. During our inspection we saw people using the service were visited by the district nurse and received treatment in their bedroom to maintain their privacy. When we looked at people's care folders we saw there were detailed notes for any visits by the General Practitioner (GP) and district nurses. There were also copies of any letters received from the hospital with the details of any appointments and treatment received.

We recommend the provider review guidance on developing a suitable menu that meets the nutritional needs of the people using the service.

Good

Is the service caring?

Our findings

One person said "We have no grumbles about care workers." A relative said that "Care staff are really good and some staff have been here a really long time. The staff are respectful." People using the service and their relatives told us they liked the regular staff and made the following comments "Staff are very nice and very pleasant", "The kitchen staff are very obliging", "Regular staff are top rate but agency staff are different" and "Lovely staff." People using the service told us the care workers treated them with respect and they always knocked on their bedroom door before coming in.

People were supported by kind and gentle staff. We saw care workers understood people's individual needs and limitations and communicated with them in an empathetic and appropriate manner. One person did tell us about communication issues with some care workers as they had a visual impairment. The person told us that some care workers often did not say when they were leaving the room so the person continued to carry on the conversation even though they were on their own. Also some care workers did not describe the food on the plate at meal times so the person could visualise what they were eating. When this happened, it prevented the person from eating without support and maintaining their independence.

The amount of time that staff spent with individuals to help promote their independence, and support their emotional rather than physical needs was limited as staff were often busy providing support for people with higher need levels as well as other tasks including administration work and updating care records. One relative told us "The carers have to clean as well as look after the residents; it's not the girl's fault that they are rushed. It's a nightmare." A care worker told us "I get to know the residents by reading their life history and talking to them while getting them up or putting into bed. We have cleaning duties as well so there's no time to sit with residents." Other care workers said "I get to know people by reading the care plans and talking to them. As time goes on you bond with them" and "I got to know people by talking to them. I have quite a good relationship with a lot of them." One person using the service did tell us "The staff weren't happy because they are short of time and they get short tempered. They are polite; they only get annoyed when they are overtired."

We saw evidence in the care plans of people's preferences relating to food, social activities and night time routine. Each person had a pack in their care folder which provided care workers with information about the person's family, things that might worry them and how to help them relax.

We asked care workers how they promoted people's independence and they told us they supported people to wash themselves, choose their clothes and food options as they were only there to assist people. They also told us they encouraged people to go out and take part in activities. We also asked the care workers how they maintained a person's privacy and dignity when they provided care. They told us they ensured the person's bedroom door was shut during personal care and they did not open the curtains until the person was fully dressed. They also told us they always asked the person if they needed help before providing it and they were careful when using the hoist to ensure the person was appropriately covered.

We saw there were care plans that had been developed to identify the person's spiritual and cultural needs and wishes. The care plan also identified what social activities the person enjoyed.

Requires improvement

Is the service responsive?

Our findings

People using the service told us they did not enjoy the activities that were organised at the home. One person we spoke with said "There is nothing to keep your mind active here. The activities are poor and I don't like being left in the lounge." Other people we spoke with felt the activities were boring and they did not want to be involved. The deputy manager told us the activities co-ordinator had recently left and a care worker had taken on the role. We saw the activities schedule for June which were displayed in the main reception and the dining room. The activities included crosswords, discussing the news, word games and reading books. During the inspection we observed one word game with some of the 21 people in the lounge which lasted 15 minutes. Following that activity there were no staff in the lounge for 30 minutes and people were left sitting on their own with the television on as background noise. We observed that people were left in the lounge for up to 30 minutes at a time with no interaction with care workers as they were busy providing support for other people. During the afternoon we saw an activity was called Health Scramble which involved anagrams on a white board which was propped up against the furniture in the lounge. We were told by people using the service that they thought the game was too hard and others said it was depressing. When a large number of people were in the lounge there was very little space and some people were unable to easily see the television or take part in activities. During the inspection we were asked by a number of people if we could change the television channel to a programme they preferred to watch. The care workers did not have the time to sit and talk to people and find out what they wanted to watch. There was a separate seating area overlooking the garden where we saw some people reading or sleeping. The range of activities provided were not meaningful for the people using the service and did not encourage engagement or promote mental stimulation.

The above paragraph demonstrates a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw detailed assessments were carried out before a person moved into the home to identify if appropriate care and support could be provided. The deputy manager explained that they visited the person and identified of their care needs were suitable for a residential care home or if they were more suited to a nursing home environment. The completed assessments reviewed the person's individual support needs including mobility, social and health issues and were used to develop the care plans and risk assessments. The person was also invited to visit the home for lunch and to meet the existing residents before they moved in.

People's needs had been assessed and individualised care plans were produced. These took account of people's needs and wishes. Each person had a care folder which included their care plans, risk assessments, personal history and information on their medical history. The care plans were detailed and clearly identified what the person liked and how they wished their care to be provided. The deputy manager explained the care plans were reviewed annually with the person using the service, their family and their social worker if they had one. There was also a monthly check carried out on the care plans to ensure they reflected the person's support needs and these were updated when necessary. We saw the care plans we looked at had a monthly review during the six weeks before the inspection and had been reviewed regularly throughout the year.

The care workers completed a record of the care provided for each person at the end of each shift. We saw the daily records were appropriately detailed and were up to date. They reflected the needs outlined in the care plan and any activities the person was involved in during the day.

We spoke to people using the service and relatives about the complaints process and two people told us that complaints were not always dealt with. There was a complaints policy and procedure in place. There was information on the complaints process in the service user guide that was given to people when they moved into the home. During the inspection we looked at the records for four complaints received during 2015. We saw copies of letters sent to the person making the complaint providing details of any investigation. The deputy manager explained they tried to resolve any complaints whenever possible. We saw the records clearly indicated the complaints were resolved appropriately.

The regional manager explained that the provider had a process for gaining feedback from people using the service, relatives, staff and health professionals. She told us that questionnaires were sent to one group every six months with the most recent survey being sent to relatives of

Requires improvement

Is the service responsive?

people using the service at the end of 2014. This meant that it could be up to two years before each group were asked to complete a questionnaire. We saw the questionnaires completed by the relatives and they were asked to comment on their experiences of contacting the home, administration, activities and staff. They could also comment on the service levels provided by the home and any suggestions regarding additional services. The results of the questionnaire had been analysed and we saw the majority of feedback showed that the relatives felt the service either met or exceeded expectation. The regional manager explained that the comments on the service they received from the relatives were reviewed and discussed with the deputy manager and with staff at team meetings.

People using the service and relatives could also provide feedback on the care and support they received at regular meetings held with the deputy manager. During the inspection we saw the minutes of a relatives meeting and a meeting with people using the service that had been held in the previous two months. The minutes detailed the issues raised at the meetings and the responses from the deputy manager and regional manager.

Requires improvement

Is the service well-led?

Our findings

The registered manager did not notify the Commission of authorisations in relation to Deprivation of Liberty Safeguards (DoLS). In preparation for our inspection we noted that we had not received any notifications in relation to DoLS authorisations that had been received from the local authority from the service from the 1 September 2014 to the date of the inspection. The manager was required to inform the Commission when an application made in relation to DoLS had been authorised by the local authority. During our inspection the deputy manager informed us there had been seven DoLS authorised since 1 September 2014. We saw copies of the standard authorisations issued by the local authority for all seven people but the deputy manager was unable to locate any notification forms related to these authorisations. Subsequent to our inspection, we were sent the notifications in respect of the seven DoLS authorisations.

The above paragraph demonstrates a breach of Regulation 18 (2) (d) of the Care Quality Commission (Registration) Regulations 2009.

The provider had various audits in place to monitor the quality of the care provided but some aspects of the audits provided an overview of the quality of the service provided. The regional manager explained that the manager would carry out an audit of up to three care plans per month. We saw the care plan audits from the three months prior to the inspection. The audit reviewed if all the risk assessments and care plans were up to date, the personal history document was completed and the records of any visits from medical professional were up to date. Actions were identified in a plan at the end of the audit with the timescale for completion.

The deputy manager explained they carried out a daily health and safety checklist. The areas on the checklist included if there were any odours detected around the home, were call bells in reach, did people have access to drinks and were staff appropriately dressed. We saw the daily health and safety audits that had been completed for the previous four weeks and saw that checks had been carried out each day.

A monthly provider visit report was carried out by the regional manager and during the visit we saw the reports for the four previous months. The regional manager explained that they carried out unannounced visits and completed a detailed assessment. They reviewed any audits, people's experience during meal times and carried out a visual inspection of the home. The audit also reviewed two of the issues we have identified in this report, staff training and activities. The audit identified if a training plan in place but not if staff had completed the training. It also identified if an activities programme was in place but not if these activities were meaningful for the people using the service. The reports we saw were detailed and included a record of any observations. There was an action plan at the end of each report which identified the actions required, who was responsible for them and a completed date. The date the action was completed was also recorded.

At the time of the inspection the home did not have a registered manager. The previous registered manager had left the home at the end of May 2015. The deputy manager was responsible for the day to day running of the home with support from the regional manager. During the inspection we were informed by the regional manager that a registered manager was being transferred from another care home managed by the provider to take on the role at this home. Since the inspection the regional manager has confirmed that the new manager was due to take up the role by the end of July 2015.

New staff were given an employee handbook when they started their role. The handbook included information of how the provider expected the staff member to behave including dress code, professional conduct, confidentiality and working procedures. The provider's mission statement was also included in the handbook. The aims and objectives of the home and a "Service Users Charter of Rights" were included as part of the "Service Users Guide".

We asked care workers if they felt they were supported to carry out their role. They told us "The deputy manager is supportive. He sits down and listens to you and he's got open door policy" and "He works so hard, good worker." They also told us "I feel listened to but not by the higher management. Manager trying to reorganise things to help." Another care worker told us they did not feel listened to at the senior care worker meetings and staff had given feedback on a new procedure which was increasing their workload but nothing happened.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The care and treatment of service users did not meet their needs or reflect their preferences.** **Regulation 9**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not maintain an accurate, complete and contemporaneous record in respect of each service user including decisions taken in relation to the care and treatment provided.** **Regulation 17 (2) (c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not deploy sufficient numbers of suitably qualified, competent, skilled and experiences persons.** **Regulation 18 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person did not ensure that persons employed by the service provider in the provision of a**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	regulated activity had received such appropriate training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person did not take proper steps to ensure the Care Quality Commission was notified when a DoLS authorisation was received from a supervisory body. Regulation 18 (2)