Methodist Homes

Brockworth House Care Centre

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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 30 June, 1 July and 2 July 2015 and was unannounced.

The service cared for people who lived with dementia and who had mental health needs. It could accommodate up to 52 people and at the time of the inspection 51people in total were cared for.

The service's manager had been registered with the Care Quality Commission since December 2013. 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 found the provider was not meeting the legal requirements in the following areas: care was not always

Summary of findings

provided safely, care was not provided in a way that met people's individual needs, people were not always treated with respect and dignity, care was not always delivered in a caring and compassionate way and care records were not always kept up to date and accurate. You can see what action we told the provider to take at the back of the full version of the report.

We also made three recommendations; to review the staffing numbers to ensure people's needs could be met in a personalised way, review the effectiveness of the staff training and implement any necessary improvements around training required for the support of people with specialist needs such as dementia.

We found people's needs were not always met because staff skills, knowledge and practices varied. Staff had been provided with training but, at times, this learning was not applied in practice. The need to recruit new staff had been the registered manager's main challenge since the new year. This had resulted in the employment of several new staff who needed additional support. Existing staff did not always have the skills to support new staff. Recent appointments had been made to secure a senior management team within the service. This would provide the registered manager with the support she needed.

There were mixed views about whether there were enough staff to meet people's needs. The registered manager confirmed the recruitment process now meant the home was fully staffed with the appropriate numbers of care staff. Additional recruiting was taking place to make it easier to cover staff annual leave and sick leave. Staffing numbers were continually reviewed by the registered manager who considered there to be enough staff in number to meet people's needs. We found people's needs were met but not necessarily when people wanted them met or when they needed to be met. Care was delivered in a task oriented way and not in a personalised way with little time in-between tasks. People had access to activities but there were several people left for long periods of time without meaningful interaction despite the involvement of activity staff and volunteers.

There were times when people were not treated with dignity or respect. People were always provided with the privacy they required. People's medicines were managed safely and people were protected against the inappropriate use of medicines that can sedate. Staff were provided with guidance on how to deliver people's care but this was not always up to date. People had access to health and social care professionals and to specialists when required. People were supported to have a balanced diet and to receive enough drinks. People's relatives predominantly spoke on their behalf and they were involved in the planning of their relative's care. People who lacked mental capacity were appropriately assessed and decisions, which were made on their behalf, were made in their best interests.

Environmental risks were managed and good maintenance arrangements were in place. Other regulators visited to check on food safety standards and fire safety for example. Requirements and recommendations from these agencies were addressed. Accidents and incidents were monitored and action taken to avoid these happening or to avoid reoccurrences.

The provider had arrangements in place to support the registered manager and to monitor the overall performance of the home. This process had not successfully identified some of the issues we found during the inspection. A new senior management team was now in place to address the shortfalls in the service. The service was also advertising for a permanent administrator who would provide further support.

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?

Requires improvement

The service was not always safe. People were not always protected against risks relating to safe moving and handling. These were not fully assessed or managed correctly by the staff.

There were enough staff to meet people's needs but they were not always met in a timely manner.

Good recruitment practices protected people from the employment of unsuitable staff.

Arrangements were in place to make sure people received their medicines appropriately and safely. Where an improvement had been identified as necessary staff were addressing this.

Staff knew how to report concerns relating to the potential abuse of people.

Is the service effective?

Requires improvement

The service was not always effective. People did not always receive the care and support they needed.

Staff had received training relevant to their work but this knowledge and appropriate practices were not always embedded when delivering people's care. Arrangements for monitoring staff practices required improvement.

People who lacked mental capacity were appropriately assessed and if needed decisions were made in their best interests.

People received appropriate support with their eating and drinking and were provided with a diet that helped maintain their well-being.

People's health care needs were met and they were supported to have access to appropriate specialists when this was needed.

Is the service caring?

Requires improvement

The service was not always caring. People were not always provided with caring and compassionate support.

Staff did not deliver care in a person centred way and people were not always treated as individuals or with respect.

People's dignity was not always maintained but people's privacy was respected.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not always able to be responsive. Care plans were personalised and reviewed but the content had not always been altered when people's needs had changed. Care was not always delivered in line with people's care plans.

People had opportunities to partake in activities but some people did not receive the level of interaction they required.

Where people were unable to be involved in planning their care, their representatives did this on their behalf.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed.

Is the service well-led?

Requires improvement 

The service had not always been well-led. Improvements had been made to resolve this but these needed time to embed and have a positive impact.

The provider had monitoring arrangements in place but these had failed to identify some of the shortfalls identified in this inspection.

There were arrangements in place to seek the views of relatives on behalf of those who use the service.

Appropriate information was shared with the Care Quality Commission.

Brockworth House Care Centre

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 30 June, 1 and 2 July 2015 and was unannounced.

Two inspectors and an expert by experience carried out the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. In this case, this person had experience in looking after people who live with dementia.

Prior to the inspection we reviewed information we had received about the service from members of the public and other agencies. We also reviewed significant events which the service had reported to us.

During the inspection we spoke with six people who used the service and met several others who were unable to tell us about their experiences because they lived with dementia. We therefore gathered information about people's experiences of living in the home in other ways.

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 to us.

We spoke with four relatives and 11 members of staff. We also spoke with the registered manager and two representatives of the registered provider. We reviewed 11 people's care records which included their care plans and risk assessments. We also looked at additional records such as the GP communication book and a selection of medicine records. We reviewed records relating to people's mental capacity assessments, the monitoring of people's behaviour and food and fluid intake records. We looked at the recruitment records of five staff and the staff training record. We also looked at a selection of records relating to the management of the service. These included a selection of audits, maintenance records, policies and procedures and accident and incident records.

The service's registration certificate and current employer's liability insurance certificate were on display. We read a selection of information held in the reception area which was aimed at visitors and professionals. This included specific information about the services provided at Brockworth House Care Centre along with the company's values statement.

Requires improvement

Is the service safe?

Our findings

Relatives told us they generally considered there to be enough staff and they felt people were safe. Additional comments included, "There are always times when residents need more", "There's not always someone in the room (the lounge)" and "I think staffing levels have got better recently".

One member of staff told us there were not enough staff on duty and others said there were but at times they "struggled" to get everything done. One member of staff on one unit told us it was particularly difficult to get everything done between 12pm and 2pm. We responded to one person's call for help from their bedroom between these hours. This person said they wanted to use the toilet and were told by staff they would "have to wait" and "there are not enough staff available right now". The person said, "I can't wait" and we asked staff to help the person, which they did. Another member of staff said, "The way the rota works, there are not enough staff on some shifts, we do struggle."

Our observations found care staff to be very busy carrying out their work in a very task orientated way. They had very little to no time to spend with people unless they were carrying out a specific care task. People were attended to but not always when they wanted to be or when they needed to be. It was not possible for staff to provide people with the personalised care they really required.

The registered manager said they had addressed this issue by recruiting new care staff, however until these staff had been ready to start work it had been difficult to maintain effective staffing numbers at all times. The registered manager explained that existing staff had offered to work additional hours and agency staff had been used. One member of staff referred to this period of time as being "difficult" but said, "It is much better now." The registered manager told us they continuously reviewed the staff numbers in relation to people's needs. They now considered there to be enough staff on duty to meet people's needs. They also considered the service to now be fully staffed but said they still needed to recruit additional care staff in order to make it easier to cover staff annual leave and staff sickness. They were currently advertising for these positions.

People were put at risk during some unsafe moving and handling manoeuvres. This was because staff failed to assess the person and situation immediately before attempting to manoeuvre them. Staff also failed to listen to people and provide them with an explanation of what was about to happen. We witnessed four people moved unsafely. For example, one person (and staff member) was at risk of falling, because the person's wish not to move was not respected. Other decisions to move people resulted in two people being held up just from their arms between staff and other staff needing to quickly put a chair behind the person to prevent them from lowering to the floor. The chair and person were then dragged to where staff wanted them to be. We spoke with a nurse about one person's standing ability and they confirmed this varied. They also confirmed the person had not yet been assessed regarding the need for a hoist to assist them despite there being times when they were unable to take their own weight. This lack of assessment and clear guidance for staff when the person was unable to take their weight resulted in this person being at risk of injury.

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

Some staff did move and assist people appropriately. On one occasion we observed staff assisting a person. Their approach and support resulted in the person being moved safely and without resistance.

Risks relating to the development of pressure ulcers were well assessed and actions implemented to reduce further damage to people's skin through pressure. For example, care records gave staff guidance on what care to deliver. In one person's case this included repositioning the person every two to three hours which records confirmed had taken place. People had appropriate pressure relief equipment in place and on-going levels of risk were monitored. People's risks in relation to them falling were monitored and action taken to either help prevent a fall from taking place to start with or try to prevent a reoccurrence. Several people were at risk of falling from their beds and injuring themselves. Where bed rails had been assessed as unsafe to use, because of potential limb entrapment or the person climbing over them, alternative equipment had been put in place. For example, beds that lowered almost to the floor and padded floor mats to run alongside the bed.

Requires improvement

Is the service safe?

All staff had received training in safeguarding people from abuse and this training was updated yearly. Staff spoken with were able to describe various potential forms of abuse as stated in the Department of Health's document 'No Secrets'. They told us they would report any incidents or allegations of abuse immediately to the senior member of staff. Senior staff were aware of the local County Council's safeguarding help line and were aware of their responsibility to report any safeguarding concerns to relevant external agencies. The registered manager shared safeguarding concerns with the county council's safeguarding team and investigated any issues arising when appropriate. The provider had policies and procedures in place designed to safeguard people from abuse and harm. Where necessary staff disciplinary action had been taken to protect people from harm and poor practice.

People were protected from those who may not be suitable to care for them. Staff recruitment records showed all relevant checks were carried out before staff worked in the home.

People's medicines were managed and stored appropriately. One senior member of staff was responsible for ordering medicines and generally co-ordinating the running of the medicine system. They had designated time to do this. Records showed that all medicines received and returned to the pharmacist were accounted for. People's medicine administration records (MARs) were well maintained, meaning staff signed for each medicine they administered. There were unclear administration instructions on some people's MARs for some medicines. Staff told us they were trying to resolve this issue with a local GP. This had not resulted in any incorrect doses being administered. People's medicines were reviewed regularly by visiting health care professionals. One person's medicine doses were reviewed by their Consultant Psychiatrist during our inspection who was happy with the current doses being prescribed.

We looked at how medicines which can sedate people were managed. Some of these medicines were prescribed for regular use and others were prescribed for use "when required" (meaning administered at the discretion of a registered nurse). In some cases people had a regular dose of a medicine and were also prescribed "when required" doses of the same medicine. People who presented with distress or behaviour that could be perceived as challenging sometimes had these medicines prescribed. The provider had monitoring arrangements in place for the use of such medicines in order to protect people from potential misuse. People's MARs showed "when required" doses of these medicines were used very little. There was however a lack of robust guidance attached to each person's MAR in relation to "when required" doses of medicines should be used. Although some records stated the maximum numbers or doses of "when required" medicines to be used over a 24 hour time period, some did not do this. This shortfall had been identified by the nurses and was being addressed. A representative of the provider told us guidance for staff was to be put in place and this would include what each person's distress and challenging behaviour may look like. It would also state other behaviour strategies should be considered before staff resorted to using a "when required" dose of medicine.

People lived in a clean environment where arrangements were in place to prevent the spread of potential infection. An infection control audit had been completed in January of this year. It stated that all appropriate procedures and practices were in place to prevent the spread of infection. To promote good infection control three members of staff held roles as infection control leads. It was their job to raise awareness on the subject and keep staff updated in good practice. We saw staff using plastic aprons and gloves to prevent cross contamination when attending to people's personal care and we saw frequent hand washing taking place. The environment looked clean and we observed cleaning taking place throughout the inspection. One bedroom had a strong offensive odour; the reasons for this were explained to us. Carpet cleaning alone was not managing the odour so there were already plans to replace the floor covering. Carpets were cleaned on a rotational basis and when needed. We witnessed the cleaning team preparing to clean a carpet after a spillage of body fluid. At the time of the inspection carpet in one of the corridors was being replaced for the same reasons. The registered manager explained that despite signage and guidance some people who lived with dementia had extreme difficulty in recognising appropriate toilet facilities which resulted in occasional accidents. Appropriate advice from external health care specialists had been sought about this. One relative said there were "excellent levels of cleanliness; any accidents are cleaned up straightaway."

The environment was kept safe by the provider's maintenance team. Potential hazards and risks, including

Requires improvement

Is the service safe?

those relating to fire safety were managed through robust monitoring processes and by having appropriate maintenance/service contracts in place. The home had an emergency contingency plan.

We recommend that the service seek advice and guidance from a reputable source about establishing the appropriate numbers of staff to ensure people's needs can be fully met in a personalised way.

Requires improvement

Is the service effective?

Our findings

One person who used the service said "Some of the staff know what they are doing but not all of them." One visitor said, "I love it here, it's brilliant" and another visitor commented that they and other relatives were "generally happy" with the care being delivered.

People's needs were not met in a personalised or effective way at times. Staff were at times unresponsive and disengaged with what was going on around them. Some staff were able to quickly assess situations and manage them well and we saw many examples of this. However, other situations and needs of people were not managed well. For example, one person presented with behaviours that could be perceived as challenging. We observed a member of staff approach this person in the opposite way to that which the person's behaviour management plan stated. On this occasion this did not trigger a negative response from the person but the staff member's approach was also antagonistic rather than de-escalating in manner. Another situation resulted in people shouting at each other, this was responded to by a member of staff instructing them to stop in a raised and irritated voice. The conflict continued with others around getting upset. A similar situation occurred when two people were sat opposite each other. They verbally abused each other, very loudly, for 35 minutes and none of the five staff in the lounge/dining area took any action to defuse this situation. This again caused upset to people around as observed by one person crying intermittently and another's face wincing each time the shouting took place. These people were not offered any reassurance by the staff who were near to them.

The care and treatment of people was not always appropriate and did not always meet their needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the abilities and skills of the staff varied quite significantly and this had an impact on how well people's needs were met. Our observations showed that some staff did not understand the needs of people who live with dementia and lacked understanding in how certain legislation influences their own practices. Legislation such as the Mental Capacity Act 2005 and safeguarding people. Senior staff discussed with us the training staff received and training records showed that staff had received training relevant to their work. This training however had not resulted in good care practices. The registered manager told us a lot of new staff had been recruited since the new year and therefore some staff were not as experienced in meeting the needs of those who lived in Brockworth House Care Centre. Another member of staff explained how staff practices were monitored and observed and they had not observed the poor practices we had during the inspection. When we spoke with staff about their training they confirmed they had received training. One member of staff said, "They give you all of the training" and another said, "We get very good training here".

Amongst other training subjects the training records showed that 100% of staff were up to date in training related to safe moving and handling and safeguarding people against abuse. 90% of staff had received training in managing challenging behaviours and 98% had received training on the Mental Capacity Act 2008. All staff had completed induction training which also included an awareness of dementia care and managing challenging situations. The registered manager was aware of the new Care Certificate (an identified set of standards for health and social care workers to adhere to in their daily working life. Designed to give new staff introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support) and she planned to implement this. In doing this she also planned to introduce on-going competency checks for all staff in various areas of care practice. The latter would help to identify poor practice and plan more specific training for staff who required this.

The provider was planning to provide additional support for registered nurses who needed to meet the new validation requirements for continued registration with the Nursing and Midwifery Council (NMC).

The Care Quality Commission monitors the implementation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make decisions about specific areas of their care or treatment. When people are assessed as not having the capacity to make a decision, a best interests decision is made involving people who know the person well and other professionals, where relevant. At Brockworth House Care Centre most people had been assessed as lacking the mental capacity to make specific decisions about their care and treatment.

Requires improvement

Is the service effective?

Some people were able to give verbal permission for their care to be delivered. Many could only imply their consent which was shown through their behaviour or reactions. For example, where someone could not give verbal consent to have a bath, they happily went with staff to the bathroom and allowed them to bathe them. Where people were unable to give consent and refused care or treatment and where this care was needed to maintain their health and well-being, best interests decisions had been made. For example, one person refused their medicines and were unable to understand the importance of taking these. In this case the person's GP, in consultation with family members, had made a decision in the person's best interests that the medicine must be given to maintain the person's health and well-being. The recorded decision stated the person's medicines would therefore be given covertly (hidden in food or drink) to ensure its consumption. Records showed that people's mental capacity had been assessed in relation to everyday care activities, for example, personal hygiene. It was recorded that people's personal hygiene would be attended to in their best interests. Staff told us when people refused care this was often resolved by returning to the person later when they were better able to agree to the care being suggested. This was not always seen in practice.

Where the registered manager had considered the possibility that a person's liberty may have been deprived they had completed appropriate referrals under Deprivation of Liberty Safeguards (DoLS). In response to clarification by the Supreme Court in March 2014 they had also reviewed the level of control and supervision people were receiving and made appropriate referrals to the County Council (the supervisory body).

The provider's policy "Managing Behaviour That Challenges" stated that staff should be able to identify early warning signs and triggers and then de-escalate challenging situations. The policy stated that gentle and minimum physical intervention should only be adopted in situations where people are in danger of harm or harming others. It stated that any physical intervention must only be used to "guide or encourage, not to hurt or upset". One visitor told us they had seen behaviour that could be perceived as challenging and said, "The staff diffuse this; they change the subject or take one of them away". Several people presented with behaviour that could be perceived as challenging and records stated that some people had been physically challenging. Staff told us they had been hit by people. The registered manager told us people were often admitted to Brockworth House Care Centre because their previous care placement had broken down because their behaviour could not be managed. We witnessed some staff de-escalating situations before they became challenging but this was not always the case. At times people were spoken to brusquely and a de-escalating approach was not adopted. Staff did not always interpret early warning signs and then take relevant action.

Care staff described to us how they managed situations that were challenging. One member of staff told us, "If a person is trying to hit you it's best to keep stepping back out of the way. It's important to keep other people safe so sometimes you have to move people." A member of staff responsible for staff training told us all staff were provided with training in "safe holds and escorting". Staff were trained in the use of 10 different levels of hold which the trainer explained were to guide people. They made a particular point of explaining to us that these holds were not used to limit people's movement or in any way restrain them. They told us, if a person became resistive whilst in a "safe hold" staff simply let go in a way that was safe to do so. They demonstrated this and some of the holds to us. During the inspection we observed staff holding people's arms in the way they had been trained to do so. We observed staff putting an arm round people's waists and holding the arm closest to them. People were then walked towards chairs and directed to sit down. These actions were accompanied by a simple verbal command from staff such as, "Come and sit down" and "You need to sit down." All staff were taught how to "breakaway" from a person's grip, for their own safety, without causing injury to the person.

People's records showed they had access to health care professionals and specialists when needed. A local GP surgery provided a visit on a regular basis to review people's health needs and visits as required in-between. People received foot care and eye checks and the service could access NHS Dental care if needed.

People were supported to have access to food and drink. Some people required more help than others such as being reminded it was time to eat or being escorted to the dining room. Other people needed to be physically fed. Risks to people not receiving enough food and drink to meet their needs were identified and managed. People's weights were monitored regularly and if people started to lose weight the

Requires improvement

Is the service effective?

reasons for this were explored, the care altered and the GP informed. Sometimes this resulted in further support such as introducing a calorie supplement. We saw some people drinking their supplement drinks. All foods were fortified by kitchen staff by adding extra cream, butter and dried powder milk. During the inspection the weather was very warm and people were provided with plenty of drinks.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to the specialist needs of people living with dementia.

We recommend that the service seeks advice and guidance, from a reputable source, about monitoring the effectiveness of any training undertaken.

Requires improvement

Is the service caring?

Our findings

We asked visitors if they considered staff to be caring. One visitor said, "The residents come first that's the most important thing" and another visitor said, "They do the best they can".

The provider's values included, "treat others, especially the most frail and vulnerable, with the dignity we wish for ourselves" and "we respect each person as an individual". We did not always observe this to be the case. People were not always treated in a caring or compassionate way and examples of this have already been given in this report. People's dignity was not always maintained and staff were not always respectful. For example, we observed one member of staff take a seat alongside a person in one of the lounges. The person smiled at the member of staff who had looked at them. In turn the member of staff did not smile back and did not converse with or acknowledge the person in anyway. Whilst feeding one person, another member of staff did not smile or converse with the person once. This included times when the person's face demonstrated they were distressed by the noise they were hearing. Another staff member, whilst carrying out the same task, predominantly looked out of the window and attempted to give another mouthful of food to the person when they were chewing. At one point the person turned their head away to avoid this. A member of staff mopped the floor around one person's feet without providing them with an explanation of what they were doing or providing reassurance. The person was making communicating noises during this which were not acknowledged or responded to. Another person had sat in front of their visitor for 25 minutes with the remains of their meal around their mouth and down their clothes protector. Staff were constantly in and out of the room but had not acknowledged this. In this case we asked the person's permission to wipe their mouth and we removed their tabard, which they let us do. Their visitor thanked us and said they did not like to see their relative like that.

One member of staff described people's behaviour that could be perceived as challenging as them "kicking off". This was an unprofessional and disrespectful description of the behaviours that sometimes present themselves in people who live with dementia.

People were not always treated with compassion, respect and dignity. This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, we did also see examples of staff caring for people where a gentle, compassionate and respectful approach was adopted. For example, one member of staff gave one person reassurance by talking gently to them. The person did not respond to the member of staff verbally but showed their well-being by holding onto the member of staff's hand and stroking it whilst walking with them. Another member of staff showed genuine affection towards a person when carrying an activity out with them. The staff member demonstrated good listening skills and they laughed with the person. This member of staff improved this person's sense of well-being and showed them they mattered. We also observed these skills being used by a member of the kitchen staff when they helped a person who said they did not really "fancy anything" to choose what they would have for tea. We observed two people enjoying a conversation with a volunteer. The volunteer demonstrated good communication skills and showed they were genuinely interested in what the people had to say. They spoke to the people in a respectful manner and gave them time to initiate conversation. We also observed staff knocking on bedroom doors before entering and providing personal care behind closed doors, therefore providing people with privacy.

Information about advocacy services were in the reception area. The registered manager explained that many people had family members who were happy to speak on behalf of their relative. Records showed this to be the case. They explained that where significant decisions needed to be made and a person did not have a representative to speak on their behalf, an Independent Mental Capacity Advocate (IMCA) would be requested.

We saw an example of one person being able to be independent. This person enjoyed walking in the garden and lying on the grass when it was sunny. Although at risk of falling they found any intervention from staff difficult. Staff explained they managed the person's risk of falling from a distance when the person used the garden rather than prevent them from doing this. This was done by staff being more vigilant about the person's whereabouts when they used the enclosed garden.

Requires improvement

Is the service responsive?

Our findings

Staff told us they did not have time to read people's care plans which were available in people's bedrooms. Whilst we found people's care records to be detailed and reviewed on a regular basis, the care we observed was not always in line with the records.

The recorded care needs and subsequent guidance for staff was not always fully relevant to people's needs. For example, this was seen in one person's care plans and behaviour management plans and another person's moving and handling risk assessment and other care plans. The behaviour management plans had been devised by involving specialist mental health care professionals and were in the person's bedroom for staff guidance. We observed two behaviours take place which had been identified on the behaviour management plans as requiring specific intervention by staff. The intervention we observed was not in line with these plans. The use of certain activities which were stated in this person's care plans, for use in reducing the two behaviours (and others) were not seen used during the inspection. When we spoke with the registered manager about this they explained some of the person's needs and behaviours had altered since the plans had been devised. They also explained that some of the activities had been tried but were no longer used. Reviews of the relevant care plans in this case stated "no change" indicating that the plans were still relevant. This showed that the review of the content of the care plans and behaviour management plans had not been thorough and the records not altered to reflect the person's current needs.

The moving and handling risk assessment and relevant care plan did not reflect the person's current needs and did not provide staff with sufficient guidance on how to manage these. Other daily interventions recorded for this person were not adopted during the inspection. Information about a person and guidance for staff is not is not kept up to date and accurate people are put at risk of inappropriate and unsafe care and treatment.

People were at risk of receiving inappropriate care and treatment because records used for staff guidance were not kept up to date and accurate. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was little evidence to show that people had been given the opportunity to be involved in planning their care. People's mental capacity assessments however stated, in most people's cases, that people lacked mental capacity to be involved in decisions about their care. Care records contained information about people's life histories which had been gathered from family members which helped to personalise the care plans. There was evidence to show that people's representatives had been involved in the planning and reviewing of their relative's care. We spoke to one relative who confirmed this to be the case. The care records of another person recorded the process where a relative had been supported to understand that their relative was no longer able to make independent decisions and that they now needed to be more involved in this process on their behalf.

Another person's care plans stated "staff to provide newspaper and magazines daily". We did not see this provided for this person across the two days of our inspection. There was generally very little interaction with this person or others from the staff during our observations. The service employed two members of staff to provide activities and social stimulation to people. Staff told us the fifty hours allocated for this were not enough for the numbers and needs of the people. Volunteers also visited on a regular basis to talk to people. One volunteer told us they would take people for a walk in the grounds if they wanted to go but said people often declined this. A volunteer supported a couple of people into the garden during the inspection and we could see they really enjoyed this. One relative told us the garden was not used very often.

We spoke to one of the staff responsible for activity provision; they told us they were about to see who would agree to come for a walk with them. They told us the music therapy sessions were very popular and enjoyed by several people who would not otherwise engage in many other activities. They were also going to one unit to see who would engage with some craft work. We saw a knitting group taking place on one unit with people chatting. We observed a single session on a one to one basis with a person.

One relative said, "Activity-wise it's difficult, sometimes the music's a bit noisy; it's a shame the garden's not used more. There's not a lot of one to one". The relative told us there were regular sensory stimulation sessions, tea dances,

Requires improvement

Is the service responsive?

regular musical activities and visits by animals. During one afternoon the Pets As Therapy (PAT) dog visited and people enjoyed this. The relatives told us staff organised a Summer Fair. They said "Staff give it their all" and a person who lived at Brockworth House Care Centre agreed with this. We were told staff occasionally organised outings, for example, to Stratford Park in Stroud or to Gloucester Cathedral. The visitors generally felt there were not enough specific activities for people. Another visitor said, "Sometimes I think the activities need a hand, (name of person) loves gardening but sometimes they need a hand to do this". We were told that some volunteers had brought in hanging baskets for people to help plant up. We saw a few hanging baskets in the garden.

We found over the inspection period care staff were very busy moving from one care task to another. Although activities were being provided there were many people left for long periods of time without meaningful activity or interaction.

The registered manager was aware of the need for transparency and honesty when managing people's complaints or concerns . An open door policy was operated and anyone could speak to her at any time. One relative told us they would feel comfortable raising any issue with any of the staff or the registered manager. The provider's complaints procedure was within the "Welcome to Your New Home" brochure which was displayed in the reception area and given to all new admissions to the home. Complaints were to be directed to the registered manager. There were feedback forms for completion in reception for this purpose and for passing on compliments. The registered manager confirmed she had, at times, also communicated with relatives through email. Relative meetings were booked for every two months where dissatisfaction and concerns could also be raised. We spoke to two key relatives who visit regularly, one relative was aware of these meetings and the other was not. Between November 2014 and May 2015 four complaints had been raised. These had been acknowledge and replied to well within the provider's stated time frame and two on the same day of it being raised.

A recent communication issue between GP surgery, the Pharmacy and the care home resulted in several people not receiving their medicines. The registered manager told us relatives were informed about the situation as soon as staff were aware of it, an explanation given and information shared about how the situation was being resolved. The registered manager has also spoken to staff about the need for them to be open and honest about any mistakes that may occur and for the people involved or their representatives to be informed and an explanation given.

Requires improvement

Is the service well-led?

Our findings

Some staff told us they found the registered manager to be approachable others said this was not always the case. One member of staff told us they were very happy in their work and had found the registered manager to be "very understanding" and said "but I can only speak for myself". Another told us the registered manager had not been understanding or approachable. One relative said, "I speak to her (the Manager) most days. She's very approachable". We spoke with the registered manager about these mixed views and she was aware at times she could come across as brusque in manner. She explained that this was usually when she was frustrated, wanted something done quickly or when things had not been done correctly. She confirmed that this was something she had been working on. This showed that the registered manager was prepared to reflect on her own practices in order to improve these.

Meetings between the registered manager and her manager had helped with this and included going through the registered manager's monthly report to the provider. The monthly report contained information the provider required in order to both monitor the service and provide support where it was needed. For example, staffing information, numbers of admissions, deaths, pressure ulcer development, falls, complaints and the findings from various audits. The provider's annual program of audits was completed in order to monitor the service's performance against various requirements. Audits were carried out on areas such as health and safety, the kitchen and hospitality services, infection control and maintenance. The registered manager also carried out or delegated audits to be carried out on the medicines system, accidents and incidents and pressure ulcer development. We reviewed these with her and where necessary actions had been implemented to address identified shortfalls or required improvements. Care plans were audited by selecting a percentage each month we were informed that those audited recently were well maintained. This audit process however did not identify the shortfalls found in this inspection which were predominantly around staff practices and values.

We found the registered manager to be helpful, open and engaged with the inspection process. We also found they had been managing a service without key personnel in place. Despite support from the provider, difficulty in recruiting replacement and additional care staff and nurses had affected staff morale. The service had also been in need of a secure senior management team and new administrator. It was hoped that the very recent appointment of a deputy manager would help towards addressing some of the pressure the registered manager had been under. The deputy manager was being supported to learn various management and administrative processes as well as complete her induction training. There had also been a recent appointment of a clinical lead who now had an oversight and advisory role for all nursing and care decisions and practices. This role was partly shared with the deputy manager. Both these new positions were to be supported by the registered manager who had a good understanding of what was required as they were also a qualified nurse.

We were told these appointments gave a more robust and defined structure to the senior management team which would collectively identify and address any shortfalls in the service. The service was also advertising for an administrator/personal assistant to the registered manager. For some time administrative tasks had been carried out partly by the registered manager and then by an existing member of staff who had some appropriate skills. We found this person to be very welcoming and helpful to visitors who arrived at the home and who telephoned in.

The registered manager was very clear about her values and expectation and they sat in line with the provider's. These predominantly included people being treated with respect and dignity and the right to the best care possible. They were aware team spirit needed rebuilding. The recent change in staff rosters had affected this and had not been a popular decision. This action however demonstrated that both the provider and registered manager were prepared to take necessary action to protect and ensure the smooth running of the home as a whole.

The registered manager told us she communicated with staff when out and about the home, through the open door policy and during staff meetings and staff supervision sessions. The last staff meeting held in January was very poorly attended. The registered manager told us staff were able to speak to her at any time and she took any concerns raised by the staff seriously.

The registered manager was aware of her responsibilities which included that of overall business manager. She was supported to meet these responsibilities and was

Requires improvement

Is the service well-led?

monitored by her immediate line manager who visited on a regular basis. Both the registered manager and her line manager were very much aware of the challenges the service faced and knew its weaknesses and strengths. The registered manager was also in frequent contact with staff at the provider's head office and also networked with other registered managers within the provider's group.

The registered manager explained the service was kept updated in good practice and current legislation through communication from the provider's head office. Local specialists were called on for advice and up to date guidance in more specific areas of care. For example, community mental health practitioners, the Parkinson's Nurse and the falls awareness team.

People's views about the service were sought by the provider and were predominantly provided by relatives. These last gathered at the end of 2014 with only minor suggestions made to improve the service. These were addressed. The views of the staff and other visiting professionals had not been formally requested in the last year.

The registered manager ensured that correct and appropriate information was forwarded to the Care Quality Commission in the form of required notifications.

We recommend that the service seeks advice and guidance, from a reputable source, about monitoring the competencies and values held by the staff.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People's care was not provided in a safe way. Risks to people were not fully assessed before people's care was delivered. This was in relation to the safe moving and handling of people. Regulation 12 (1) and 12 (2)(a).

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People did not received person – centred care. They did not always receive care that was appropriate to their needs. Regulation 9 (1).

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not treated with dignity and respect at all times. They were not always treated in a caring and compassionate way. Communication with people was not always respectful. Regulation 10 (1).

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Care records were not always accurate and up to date. This applied to care plans, behaviour management plans and risk assessments.