Ideal Carehomes (Number One) Limited

De Brook Lodge

Inspection report

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Date of inspection visit:
10 April 2018
11 April 2018

Date of publication:
29 May 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 and 11 April 2018 and the first day was unannounced.

At our last inspection in March 2017 we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a lack of clear guidance for the use of 'as required' medicines and staff did not always sign to state they had applied topical creams. Staff had not received refresher training and supervision meetings. The service did not have a robust quality assurance system in place to ensure they were meeting the requirements of the fundamental standards.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe, effective, responsive and well led to at least good.

At this inspection we found improvements had been made in all three areas. However new breaches were identified with regard to risk assessments and care plans not being reviewed and updated during the transfer of the care plans to a new computerised system called PCS, which meant there was a continued breach in good governance. You can see what action we told the provider to take at the back of the full version of the report.

De Brook Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

De Brook can accommodate 52 people over three floors. At the time of our inspection 45 people were living at the home.

There was not a registered manager in post at the time of our inspection. A new manager had started working at De Brook the week before our inspection and had initiated the process to become the registered manager. 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.

De Brook was introducing a new computerised care planning system called PCS. However, at the time of our inspection, the vast majority of care plans and risk assessments continued to be paper files. The paper care plans and risk assessments had not been reviewed since January or February 2018. Some care plans had been updated where people's needs were known to have changed; however others had not. This meant the care plans and risk assessments may not be reflective of people's current needs.

Significant improvements had been made in the quality assurance systems used at the home. Audits and monitoring were now in place for falls, nutrition, medicines, pressure area care, infection control and staff

training and supervisions. Actions taken after each incident, accident or audit were recorded and monitored to ensure they were completed. However it had been noted in managers meetings in December 2017 that the care plans and risk assessments needed to be reviewed and kept up to date during their transition to the PCS system and this had not been done.

People received their medicines as prescribed from trained staff, whose competencies in medicines management were observed annually. The temperatures of the clinic rooms and medicines fridge were not consistently recorded. We have made a recommendation that the medicines audit is reviewed so they cover all areas of the national guidance for the management of medicines in care homes.

Health and safety checks were made and equipment was serviced in line with national guidance and the manufacturer's instructions. Water was sampled for Legionella's disease; but a written Legionella's risk assessment was not in place and boiler water temperatures were not checked. We have made a recommendation that the service consults the national Health and Safety Executive and Department of Health guidance for controlling Legionella in healthcare settings.

People we spoke with, and their relatives, said they felt safe at De Brook and were positive about the staff at the home. Staff supported people with kindness and respect. People were supported to maintain their independence by completing tasks for themselves where they were able to.

We saw there were sufficient staff on duty to meet people's assessed needs, although agency staff were being used at the time of our inspection to cover staff vacancies.

A safe recruitment process was in place. Staff had received the training they needed to effectively meet people's assessed needs. A new training matrix enabled the manager to track what training was due to be refreshed and make arrangements for this to be completed. New staff completed training that met the standards of the care certificate.

People were supported to maintain their health and nutrition. A new scheme had been started whereby a GP visited the home each day with a view to reduce the number of hospital admissions by treating minor ailments quickly. The GP was positive about De Brook, stating the staff were knowledgeable about the people they supported and were able to provide the information they required.

People enjoyed the food served at De Brook. The chef knew people's nutritional needs, the food was well presented and people could have seconds if they were hungry. The menus we saw were not for the correct day and were not in an easy read or pictorial format so more people would be able to access the information. We have made a recommendation that national guidelines are followed to provide key information is available in different formats to enable more people to be involved in their care.

A new 'lifestyle' manager had been appointed to co-ordinate and arrange activities within the home. They were in the process of devising a timetable of activities for each floor. Trips out were arranged and there was a bi-monthly 'pop-up' themed restaurant evening.

Dementia friendly signs were used to support people to orientate themselves around the home. Reminiscence items and old photographs of local places were on each floor.

The service was working within the principles of the Mental Capacity Act (2005). People's capacity to make decisions was assessed and applications made for Deprivation of Liberty Safeguards where applicable.

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.

Risk assessments had not been regularly reviewed to ensure they were current.

People received their medicines as prescribed. We have made a recommendation with regard to medicines audits following national guidance.

Staff were safely recruited and there were enough staff to meet people's assessed needs.

Is the service effective?

Good

The service was effective.

Staff received the training to support people. Staff supervisions were planned, but not all staff had had regular supervision meetings.

The service was working within the principles of the Mental Capacity Act (2005).

People's health and nutrition needs were met. We received positive feedback about the food.

Is the service caring?

Good

The service was caring.

People and their relatives felt they were supported with kindness, dignity
and respect.

Information about people's life history, likes and dislikes was recorded so staff had the information to form meaningful relationships with people.

Staff knew people's needs well and promoted their independence where possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans had not been regularly reviewed to ensure they reflected people's current needs.

A new 'lifestyle manager' had been appointed to co-ordinate activities. People enjoyed the trips out arranged by the home.

People's wishes at the end of their lives were recorded.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Meeting minutes showed the home was aware of the need to review the paper care plans and risk assessments during the transition to a computer based care planning system but had not done so.

Significant improvements had been made in the quality assurance system. Any actions required were recorded and monitored to ensure they were completed.

Notifications were made to the Care Quality Commission as required.

De Brook Lodge

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 checked 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 10 and 11 April 2018 and the first day was unannounced. The inspection team consisted of two inspectors and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of services for older people. One inspector returned for the second day of the inspection.

The provider had completed a provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We found the PIR was reflective of the service provided at the home.

Prior to our inspection visit we reviewed the information we held about the service. We looked at the statutory notifications the home had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. We contacted the local authority safeguarding and commissioning teams. You can see their feedback within the body of the report. We also contacted Trafford Healthwatch who told us they had conducted a recent 'enter and view' visit at De Brook. The report was positive about the care and support provided at the home. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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 observed people's mealtime experience and interaction between people using the service and staff throughout the inspection.

During the inspection, we spoke with six people who used the service, four people's relatives, eight members of care staff, two visiting health professionals, the lifestyle manager, one housekeeper, the chef, the care manger, quality assurance manager, care manager, deputy manager and the new home manager.

We looked at records relating to the management of the service such as the staffing rota, policies, incident and accident records, three staff recruitment files and training records, six care plans, meeting minutes and auditing systems.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in March 2017 we found a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there was a lack of clear 'as required' (PRN) medicines guidelines and missing signatures to show topical creams had been applied. At this inspection we found improvements had been made. PRN guidelines were in place which provided details of how people would communicate, either verbally or non-verbally, that they required PRN medicines to be administered. The medicine administration records (MARs) were fully completed. A new computerised care planning system called PCS was being introduced at the home. This prompted the care staff via a hand held device which people required creams to be applied. The staff confirmed via the hand held device when this task had been completed.

We noted the temperature of the clinic rooms and medicines fridges had not been recorded on a daily basis as required. The temperature of the refrigerator should be kept between 2 and 8°C with all other medication stored below 25°C. If stored at the wrong temperature, medicines may lose their efficacy. A temperature recording sheet was in place but was not being used. We discussed this with the new manager and area director who said they would ensure the clinic room temperatures were recorded.

Guidelines state that boxed and bottled medicines should be dated on opening to ensure they are used within the manufacturers' guidelines for storing opened medicines. The majority of the boxed and bottled medicines we saw were dated on opening; however we saw two eye drops which should be destroyed four weeks after opening had not been dated. This meant the staff would not know when the eye drops should no longer be used. We discussed this with the new manager and area director who said they would check when these had been opened, ensure they were dated and re-iterate with senior staff the need to date boxed medicines on opening.

Covert medication is the administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food or drink. As a result, the person is unknowingly taking medication. We looked at records for two residents who were administered covert medication and saw GP authorisation and pharmacy instructions were in place as required.

Thickeners, used to reduce the risk of a person choking if they have difficulties swallowing, were appropriately stored in locked cupboards in the kitchen areas on each floor. This meant they were not accessible to people.

Controlled drugs were appropriately stored and recorded. Controlled drugs are certain medicines that due to their risks of misuse or abuse are subject to more stringent legal requirements in relation to their storage, administration and destruction.

We saw monthly medicines audits were completed; however these had not identified the lack of clinic room temperatures. We recommend the audits are reviewed so they cover all areas of the national guidance for the management of medicines in care homes.

People told us they felt safe living at De Brook. One said, "Do they bully me? Do they heck. The staff look after my safety and my belongings quite well." Relatives we spoke with also thought their relatives were safe. One said, "Residents are safe here."

Staff were aware of the providers safeguarding procedures and said they would report any concerns directly to the new manager or other senior members of staff. They told us they had received refresher training in safeguarding vulnerable adults and were confident any concerns they raised would be acted upon.

We saw people's care records identified risks to their health and wellbeing, including the risk of falls, moving and handling, pressure ulcers and mal-nutrition using the Malnutrition Universal Screening Tool (MUST). We saw referrals had been made, for example to the falls team, where appropriate. The service was moving all care records onto the new PCS computer based system; however the vast majority of care plans were still paper based at the time of our inspection. We saw that the risk assessments had not been reviewed since either January or February 2018. We did see that some risk assessments had been updated where there had been a large change in people's needs, for example following a fall or time spent in hospital. However not all risk assessments were updated which lead to conflicting information being available for staff. One person's needs had changed following a hospital admission in January 2018. We saw a referral had been made to the dietician due to their weight loss. However the nutritional risk assessment was rated as low and the MUST score was 0. This meant the information was not consistent across the risk assessments

We checked the systems that were in place to protect people in the event of an emergency. We found personal emergency evacuation plans (PEEPs) were in place for people who used the service. However we saw that not all of these contained up to date details of the support people would require in the event of needing to evacuate the building in an emergency. For example one person's needs had changed since they had returned to the home from hospital. Their care plan stated they needed the support from two members of staff to use a stand aid to transfer, however the PEEP was dated 4 December 2016 and stated they were able to mobilise using their frame with one member of staff. This meant the information available for the emergency services was not accurate, increasing the risks for people in the event of an evacuation from the building.

We discussed this with the area director. During the inspection they informed us that additional resources would be made available to populate the PCS computer system with people's risk assessments and care plans. The paper risk assessments needed to be reviewed to ensure that the information being input to the PCS system was accurate and contemporaneous.

This meant staff may not have up to date information about people's current needs. This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to 2 (a) (b).

Where required guidance was in place for staff to support people who may display behaviours that challenged the service. This included techniques staff could use to divert the person's attention a give them time to calm down.

We found the staffing levels were sufficient to meet people's assessed care and support needs. People and relatives we spoke with told us they thought there were enough staff on duty. One said, "You usually have to wait only a few minutes (for support), but it depends how busy they are." Relatives also thought there were enough staff. We saw that domestic staff assisted with serving breakfast to enable the care staff members to continue to support people who wanted to get up.

Rotas showed there was a consistent level of staff at the home. Two staff each day started work at 7am so they were able to work with the night staff supporting people who wanted to get up. However we were told, and the rotas showed, that agency staff were being used to cover staff vacancies. One relative told us, "I think there are enough staff, yes. But sometimes there are a lot of agency staff; a lot lately."

The new manager said they had interviews for new staff arranged and other staff had recently been recruited and pre-employment checks were currently being completed. Staff told us that regular agency staff were used where possible so that they were able to get to know people's needs. One agency staff member told us, "I always work with a permanent member of staff who tells me what support people need." However staff also told us that they found it more difficult working alongside agency staff as they had to be told what needed to be done by the permanent staff members.

We saw that a safe recruitment process was in place. Staff files included an application form. Any gaps in employment were noted and explored at interview. References were obtained and appropriate checks had been made with the disclosure and barring service (DBS). The DBS checks to ensure that the person is suitable to work with vulnerable people. This meant the people who used the service were protected from the risks of unsuitable staff being recruited.

All accidents and incidents were recorded and people were observed for a 72 hour period following an incident or accident to monitor their health and wellbeing. All accidents and incidents were reviewed by the manager or care manager. We saw evidence of new equipment being obtained, for example sensor mats being put in place to alert staff if a person was getting up. Referrals were made to the falls team or dementia crisis team when required.

Falls were monitored and analysed using the Accidents, Incidents and Near Misses (AIMS) spreadsheet. All incidents were logged on the system, including the time and location of the incident. If one person was involved in more than one incident this was highlighted automatically by the AIMS system. This enabled any patterns to be identified. Actions taken to reduce any repeat incidents were noted.

This meant the manager and area director had a clear overview of all incidents and accidents within the home and a record of actions taken to reduce further occurrences.

We observed the home to be clean and free form malodours throughout our inspection. Staff wore appropriate personal protective equipment (PPE), for example gloves and aprons. All sluice rooms and storage rooms were securely locked, meaning people did not have access to potentially harmful chemicals.

We saw evidence that equipment was maintained and serviced in line with national guidelines and the manufacturer's instructions. Weekly checks were made on the fire alarm and emergency lighting system; however these had not been fully recorded since 16 March 2018. We spoke with the maintenance person who confirmed the checks had been completed but not recorded. Monthly checks were also made of the call bells, window restrictors, wheelchairs and the general maintenance of all bedrooms. These checks had all been recorded.

Contact information and guidance was seen for staff to deal with any emergency situations such as a gas or water leak.

We saw annual water samples were tested for Legionella's disease; these were seen to be clear. Water outlets that were not in regular use were flushed each week. However a written Legionella's risk assessment had not been completed and the hot water temperatures leaving and returning to the boiler were not taken.

We recommend that the service follows the national Health and Safety Executive and Department of Health guidance for controlling Legionella in healthcare settings.

Good

Is the service effective?

Our findings

At our last inspection in March 2017 we found a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff had not completed the refresher training identified by the service and had also not received support through supervision meetings with their line managers.

At this inspection we found improvements had been made; some supervision meetings had been held; however further work was required regarding staff receiving regular supervisions.

Staff told us they had completed two weeks of training when they had started working for De Brook. This covered the requirements of the Care certificate, which is a nationally recognised set of principles that all care staff should follow in their working lives. Staff then shadowed experienced staff for one to two weeks to get to know the people living at the home and their needs. Staff also told us, evidenced by the training matrix, that refresher training was provided. The training matrix automatically highlighted when training was due to expire, giving the service time to make the required arrangements for the care staff to complete refresher training.

The area director showed us details of a new training programme for new staff introduced in January 2018. This was a series of training courses over the first three months of their employment. This had been introduced as staff had fed back that they found it difficult to retain all the information from the two full weeks of training. On appointment new staff would complete manual handling training, have an in house induction at the home and shadow experienced staff members. The training courses would be planned into their first three months of their employment. The provider had appointed a training manager for the company who organised a three month rolling programme of training courses throughout the year meaning staff were able to start their training whenever they joined the organisation. Feedback from the local authority commissioning team was that induction books were in place for new staff but were not currently being used to monitor the training and induction of new staff.

This meant new staff had the training they needed and the time to get to know the people living at the home and their support needs before being part of the rota and working independently; however new staff induction learning was not always recorded.

We received mixed feedback about staff supervision meetings. Some staff told us they had regular meetings with their line manager and said these were open meetings where they were able to raise any ideas or concerns they may have. However other staff said they had not had any or many supervisions within the last twelve months. One staff member said, "I did two weeks training when I first started but I have not had a supervision" and another told us, "I have not had a supervision since I started working at night (six months ago)." However another staff member told us, "I have had two supervisions so far (in six months)."

We discussed this with the new manager and area director who acknowledged that not all supervisions meetings had been held. The new manager told us they had planned supervision dates for the year and

would delegate care staff supervisions to the deputy managers and senior care staff. Staff we spoke with said that they felt supported by the senior carers, night manager, deputy manager and care manager. One said they were able to ask for a supervision meeting whenever they felt they needed one. This meant that whilst staff felt supported, not all staff had had regular supervision meetings, but the new manager had planned for these to take place.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Care files included assessments of people's capacity to make specific decisions, for example consent to their care and support at De Brook Lodge. Where the assessment indicated the person lacked capacity for the decision a DoLS application had been made. A new DoLS tracker had been introduced to monitor when applications had been made and when any granted DoLS were due to expire so that a further application could be made.

The manager and care manager had a good understanding of the requirements of the MCA. The staff we spoke with had completed MCA training and were aware of the requirements of the Act. This meant the service was working within the principles of the MCA.

We noted that some people's next of kin had signed consent forms on their behalf. Whilst it is important that relatives are involved in agreeing the proposed care and support, they are unable to sign consent on their relative's behalf unless they have an approved Legal Power of Attorney (LPA) for health and welfare in place. We discussed changing the wording on the consent form with the area manager to acknowledge relative's agreement with the care plans rather than signing their consent.

The manager or care manager completed a pre-admission assessment for all new referrals. This assessed their need and involved the person, their relatives where appropriate and other medical or social care professionals involved in their current care and support. Initial care plans were written from this information.

We observed the morning handover on the first day of our inspection. Each person's needs was discussed in detail. Verbal information about a new person's care and support needs (they were due to move to the home that day) was provided for all the day staff present. One staff said, "We're usually told (about new people) by [care manager] and we can look at the care plan. We have enough information to support them." Staff we spoke with said they would ask a colleague or the shift manager for information about a person's needs if they returned to work and a new person had moved to the home in the time they had been off work. One staff member said, "I had to take the lead last week to ask about [new person's] needs." We discussed this with the care manager who told us they would review how information was communicated to staff to ensure they were all aware of new people's needs.

This meant staff were aware of people's support needs, although they sometimes had to be pro-active to ask for the required information.

We observed lunch on all three floors of the home. The dining experience was seen to be calm and unhurried. People received the support they required to eat their food. People told us they enjoyed the food and they had a choice of meals; however the menus seen on the day of our inspection were not for the correct day. We observed people being offered second helpings if they wanted them. One person said, "The food is very nice. Better than most. It's hot, tasty, looks good, and there's ample. I'd give it 9 out of 10" and a relative told us, "The food looks good. [Name] eats where she is now, in the lounge."

The chef was knowledgeable about individual people's needs for a soft or fortified diet and had a list of people's requirements in the kitchen. The care staff informed them if a person's dietary requirements changed. The most recent inspection from the environmental health department in August 2017 had awarded the service a 5 (Very Good) rating.

We looked at how people were protected from poor nutrition and supported with eating and drinking. People were weighed either weekly or monthly and we saw referrals had been made to the speech and language team (SALT) and dieticians when people were seen to be at risk of malnutrition or were having difficulty swallowing. Where required the quantity of food and fluids consumed was recorded on the PCS system via the staff handheld devices. This meant people's nutritional needs were being met.

Each person was registered with a GP. We saw referrals had been made to district nurses, the dementia crisis team and other medical professionals when required. The home was involved in a new initiative whereby a GP visited the home every day. The aim was to reduce hospital admissions by addressing any health concerns early to try to prevent them from developing further. The GP was positive about De Brook and the staff knowledge of the people they supported, saying, "The staff here are so supportive every time we come in – this is one of the best homes I come into." The home were also positive about the initiative as any person who was feeling unwell could be seen by the GP straight away.

People's care files included details of any medical diagnoses and the support required for each medical condition. This meant that people's health needs were being met by the service.

De Brook had fully accessible baths for people's use. The home was well decorated throughout. Each person's room door had a stencil to make it look like the front door of a house and was a bright colour. People could choose to have a picture of themselves on their door to assist them to find their room on their own. There was appropriate signage with words and pictures for communal rooms such as the lounge, toilet and bathrooms. We saw there were reminiscence items in all areas of the home, including old photographs of the local area.

De Brook is a residential home. If people's needs changed and they required nursing care they would need to move to a nursing home. The care manager told us referrals were made to people's GP, dementia crisis team and social worker if their needs changed. A review of their care was completed to try to enable the person to remain at De Brook. If this was not possible the home discussed options with the person and their family. If the person lacked capacity to make a decision about their care and support a meeting was held to decide what was in the person's best interest. Information about people's care needs was made available to the new care provider. During our inspection we saw one person's needs were being assessed by a social worker with a view to moving to a new home that was able to meet their increased level of need. This meant the home supported people to remain at De Brook where possible and also assisted with any move to another care provider.

Good

Is the service caring?

Our findings

All the people and relatives we spoke with said that the staff were kind and caring. One person said, "The main thing here is staff are very nice; very kind" However they went on to say that staff did not always have the time to spend talking with people as they were supporting people with their needs, saying, "You don't get much chance to talk to the staff; they're too busy." A relative said, "I think staff are kind and considerate to the residents."

At our last inspection in March 2017 we found people's care files were stored in unlocked cupboards in the kitchen area on each floor. At this inspection we saw locks had been fitted to the cupboards. This meant that people's personal confidential information was securely stored.

Staff we spoke with knew the people living at De Brook and their needs well. They were able to describe people's likes, dislikes and care support needs. People's care files contained information about people's life history, past employment and hobbies.

We saw and heard positive interactions between members of staff and the people they were supporting. Staff spoke calmly with the people they were supporting to explain what they were doing and providing re-assurance. For example we observed one person being supported when transferring from their wheelchair to a lounge chair. The staff member was patient, encouraging and re-assuring so the person safely moved to the chair.

People we spoke with said the staff treated them with dignity and respect. We saw training had been provided for staff for dignity in care. Everyone we saw was well dressed. One person said, "Yes, the staff are very nice. Of course they treat me with respect; they always knock before coming in (the bedroom)" and another told us, "I think they treat me with respect. If I want privacy, I've got my own room whenever I want. I do what I want." Staff were able to describe how they maintained people's privacy and dignity when supporting them with their personal care needs. One staff member said, "I always ask people if they want a bath, shower or a wash. I make sure the doors and curtains are closed before I start." Staff were also aware of the people who had stated a preference for female care staff only to be involved in their personal care.

We also observed staff prompting people to do things for themselves where possible, for example when eating or mobilising around the home. One person told us, "They encourage me to do what I can. I've got my walking frame and I can get to the toilet." People's care files contained information about the things people were able to do for themselves and where they needed assistance.

This meant staff maintained people's dignity and privacy, supported them with respect and prompted them to maintain their independence where possible.

We found people's equality, diversity and human rights were being met. People's cultural and religious needs were noted in their care files. One person said, "The food's good. I'm vegetarian but they cope well with that." We saw representatives from two local churches visited each week to offer blessings and

communion for people who wanted this. Some people also went to the local church for mass and a coffee afternoon each week. All staff completed training in equality and diversity.

We saw that where people did not have relatives who could be involved in decisions about their care and support referrals were made for an independent mental capacity advocate (IMCA) were made. This meant that an independent person would be involved in any best interest decisions about the person's care, to ensure their rights were protected.

Requires Improvement

Is the service responsive?

Our findings

We looked at six care plans in detail. They included information about people's needs and guidance for staff to follow in how to meet the identified needs. For example information was provided regarding people's personal care, mobility, eating and drinking and health.

A new computer based care planning system was being introduced at De Brook called PCS. This system will enable staff to view people's care and support needs via hand held devices. The PCS system will prompt care staff as to the care tasks that require to be completed and to record the support provided as soon as it has been completed. Senior care staff and deputy managers were able to monitor that care tasks had been completed at the correct time.

At the time of our inspection key support tasks had been put into the system to prompt staff and record the support provided. A few care plans had been loaded on to the system but most had not, therefore the paper care plans were the guidance documents used by staff as to the care and support people needed.

However we saw that the care plans had not been reviewed to check that the information was still correct since January or February 2018. We did see that some care plans within the files had been updated if there had been a change in a person's needs, but others had not. For example one person's needs had changed following spending time in hospital. The care plans reflected the change in the person's mobility on discharge, stating two staff were now required to assist with transfers. However we observed this person was now able to transfer with the assistance of one staff, although we were told by staff that this was variable and sometimes the person required a hoist to be used with two staff. This was not reflected in the person's care plan as it had not been reviewed.

This meant that the care files had not been regularly reviewed to ensure people's current care and support needs were reflected. This was a breach of Regulation 9 (1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to 3 (a).

We discussed with the area director that when people's support information was added to the PCS system it needed to reflect people's current support needs. The longer this process took the more chance there was that inaccurate information would be used as it had not been reviewed to ensure it was correct. During our inspection the area director obtained agreement for additional resources to be made available to put all care plans onto the PCS system. The target date for this to be completed was the end of May 2018.

People and their relatives told us they had been involved in their care plans, although this was not evidenced in the care files we saw. One person said, "I have been asked about changes in my care plan" and a relative told us, "We were involved in writing and reviewing it (the care plan) and we did sign it."

Each person had a future wishes care plan in place. This recorded brief information about the support people wanted at the end of their lives, for example consideration of medical treatment. We were told more detailed plans were compiled with people and their families when people's health started to decline. The

home involved the person's GP in discussing whether they wanted to be resuscitated and other wishes for the end of their lives. People and their relatives confirmed that they had discussed end of life wishes with the home.

People said they were able to make choices in their daily routine such as when they got up or went to bed and what clothes they wore. We observed staff asking people what they wanted throughout the inspection.

A new lifestyle manager had recently been recruited who was responsible for organising and leading the activity programme at De Brook. They were in the process of developing weekly schedules of activities for each floor. This was to include exercises, games such as dominoes, arts and crafts and also external entertainers. A 'pop up' restaurant with themed menus was arranged every two months. We saw in April a French themed menu was being offered.

People told us trips out of the home were also being arranged. The week before our inspection people had visited a local shopping centre for afternoon tea. Other trips had been to local attractions and more were planned. People told us, "I spend most of the time in my room and I'm content. I like the outings, especially the day trips. They went to the War Museum last year. I went to a concert at the church over there. They came and took me across the road in my wheelchair" and "I like some of the activities here such as the armchair exercises, and the entertainer who is coming soon, and outings. I went to Tatton Hall recently."

This meant the activities available for people to take part in should increase with the new lifestyle manager in post.

We saw, where appropriate, technology such as pressure pads were in place. These were used, for example, to alert staff if a person was getting out of bed so they were able to offer support and assistance.

We did not see any information, for example the menus or complaints policy, in an easy read or pictorial format to enable more people to be able to access this information. We recommend best practice guidelines are followed to provide key information is available in different formats to enable more people to be involved in their care.

We saw there was a formal complaints policy in place. All complaints received had been acted upon appropriately and in a timely manner. Notes of any investigations were kept as well as the response given to the complainant. People and relatives also told us they would speak directly to the staff or manager if they had an issue, rather than using the formal complaints procedure. One person said, "I talk to the staff if I have any concerns." This meant the staff team had responded to the verbal concern of the relative, thus avoiding the concern escalating any further.

Requires Improvement

Is the service well-led?

Our findings

The service had a new manager in place who was due to register with the Care Quality Commission (CQC). A deputy manager had been promoted to the care manager role which would provide continuity for the home.

A temporary manager had been in place for the three months since the previous registered manager had left the service. This had meant that support for the staff team and oversight of the service had been maintained until a permanent manager could be recruited.

De Brook had had a series of managers over the last two years. We discussed this with the area director who acknowledged that this had been disruptive for the home and staff team. Changes had been made at head office level which meant that the area directors and quality manages now had responsibility for fewer homes than previously which meant they would be able to provide more support to the home managers. We were told the quality manager was due to visit the home at least weekly.

At our last inspection in March 2017 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as quality audits were not robust and actions identified had not been completed.

At this inspection we found significant improvements had been made. A robust auditing and reporting system was now in place. A schedule of monthly audits and checks were completed, including infection control, medicines, falls, pressure area care, staff supervisions and training and health and safety. Actions in place were clearly recorded, for example following a fall were sensors required to alert staff or referrals made to the falls team or GP. We saw that where equipment had been recommended for people, for example an air flow mattress, this was put in place by the service.

We were also shown a new audit that was being introduced following a local authority quality visit to monitor the response times to call bells. A mattress audit had started in March 2018 which had identified where new mattresses or mattress covers were required. We saw these had been purchased by the home. This audit was now to be completed each month. This meant additional audits and checks were added to the quality audit system where it was identified as being needed.

All audits were input onto the providers Key Performance Indicator (KPI) system. This was accessible remotely by the area manager and quality manager. They were therefore able to review the audits and actions taken to minimise the risk to people living at the home.

This meant the home manager, area and quality managers would be able to monitor the service and ensure actions are taken where required. However, as noted previously in this report the care plans and risk assessments had not been reviewed since January or February 2018 as they were due to be transferred to a new computer based system called PCS. We saw the minutes from a managers meeting in December 2017 where it was stated that the paper care plans needed to be kept up to date during the transfer of

information to the PCS system. This had not happened. We also saw that the lack of review of care plans was discussed at a seniors meeting in November 2017. This meant the issue with care plans not being regularly reviewed at the home was known by the area manager and the then registered manager. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to 2 (c).

We saw evidence that resident and relative meetings were held. A social committee met each month to discuss topics such as destinations for future outings and subjects for themed evenings for the pop up restaurant. People and relatives also told us they had completed surveys. One person said, "I've done those surveys. They're always asking; a long form comes through the post" and a relative told us, "We had a survey about a year ago." We were told the survey results were reviewed by the management team and actions agreed for any areas of concern raised in the surveys.

The new manger had arranged separate meetings for relatives and staff to introduce themselves. We saw staff meetings were held, including separate senior staff meetings. These were used to provide information about developments at the service and also for staff to raise ideas and concerns they may have. The staff we spoke with all said they liked their job and working at De Brook.

We noted that in the senior staff meeting held in February 2018 it was discussed about what the senior role entailed and how the area director thought they had been 'de-skilled' and were not completing all the parts of their job role. We discussed this with the area manager and new care manager who said that the previous care manager did tasks that should have been done by the deputy managers, who in turn did tasks the seniors should complete. The new management team were working to establish clear job roles with each person, with the new manager and care manager providing the support for them to do their designated tasks. We were told this would enable the manager and care manager to monitor the service and ensure identified actions were completed. A managers task list had been written to guide the new manager, care manager and deputy managers what needed to be completed on a weekly or monthly basis.

Services providing regulated activities have a statutory duty to report certain incidents and accident to the Care Quality Commission (CQC). We checked the records at the service and found that all incidents had been recorded, investigated and reported appropriately.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans had not been regularly reviewed to ensure they reflected people's current needs. Regulation 9 (1) with regard to 3 (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments had not been regularly reviewed and did not always reflect people's current needs. Regulation 12 (1) with regard to 2 (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Meeting minutes showed the home knew the care plans and risk assessments had to be reviewed during the transition to a computer based system but this had not happened. Regulation 17(1) with regard to 2 (c).