GCH (South) Ltd

Brackenbridge House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced inspection of Brackenbridge House on 3 and 4 July 2018.

Brackenbridge House 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.

Brackenbridge House is part of GCH (South) Ltd. It provides accommodation for up to 36 older people in single rooms. The home is situated within a residential area of the London Borough of Hillingdon. At the time of our visit there were 33 people using the service.

The registered manager had joined the home at the end of April 2018 and had been registered with the CQC shortly before the inspection. 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 previously inspected Brackenbridge House on 5, 6 and 11 September 2017 and rated it Requires Improvement. We identified breaches of Regulations in relation to safe care and treatment (Regulation 12), safeguarding service users from abuse and improper treatment (Regulation 13), good governance (Regulation 17) and staffing (Regulation 18).

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 'Is the service safe?', 'Is the service effective?', 'Is the service responsive?' and 'Is the service well-led?' to at least good.

During this inspection we found improvements had been made in relation to safeguarding service users from abuse and improper treatment (Regulation 13) and staffing (Regulation 18). Improvements had not been made in relation to safe care and treatment (Regulation 12) and good governance (Regulation 17).

The provider had a policy and procedure in place for the administration of medicines but this was not always followed by care workers to ensure people always received their medicines safely.

The provider did not have an effective system to review Incident and accident records and did not always identify actions to reduce potential risks to people using the service. Risk assessments were not updated to indicate if there was a change in the person's support needs. This meant the provider could not ensure the learning from the investigation into incidents and accidents was used to reduce the risk of reoccurrence.

The provider had a range of audits in place but some of these were not effective and did not provide appropriate information to enable them to identify any issues with the service and take action to make

improvements.

In general people felt safe when they received support but they gave examples of times when they had not always felt safe. The provider had a process for responding to safeguarding concerns which had not always been followed previously but records were now being maintained.

People and staff told us additional staff were required to provide support at the home and the registered manager confirmed they had considered the staffing levels and care worker numbers were being increased. The provider had a robust recruitment process in place to ensure only suitable staff worked at the home.

The registered manager had identified which care workers were not up to date with their training and had arranged for this training to be completed as soon as possible. Regular supervision sessions with line management were now being scheduled.

The registered manager had reviewed everyone living at the home and ensured Deprivation of Liberty Safeguards (DoLS) applications had been made when appropriate to ensure people were supported to have maximum choice and control of their lives, and in the least restrictive way possible. The policies and systems in the service supported this practice.

An assessment of a person's care and support needs was carried out before they moved into the home. People had access to a range of healthcare professionals, when they needed healthcare support.

People we spoke with, in general, were happy with the care they received and felt the care workers were kind and caring.

The religious and cultural needs of people were identified in their care plans and were being met by the current arrangements in the home.

The care plans identified the person's wishes as to how their care was provided and were regularly reviewed. Activities were not always meaningful but a new activity coordinator was being recruited at the time of the inspection to help improve the provision of activities.

We found two breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches relate to safe care and treatment of people using the service (Regulation 12) and good governance of the service (Regulation 17). Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

The provider did not ensure medicines were managed safely

Incident and accident records were not reviewed and actions were not identified to reduce possible future risks.

Risk assessments were not updated and reviewed following an incident and accident to reflect a possible change in the person's needs.

The provider had a recruitment process in place to ensure care workers had the suitable skills and experience to provide appropriate care to people.

In general people felt safe when they received support but they gave examples of times when they had not always felt safe.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Where care workers were not up to date with their training the registered manager had arranged a schedule for this to be completed. Whilst regular supervision sessions with line management had not always taken place, these were now being scheduled.

We saw the service was working within the principles of the MCA, and DoLS applications were made to ensure people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

Assessment of people's support needs were carried out before the person moved into the home. People were supported with their healthcare needs as required.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

People we spoke with, in general, were happy with the care they received and felt the care workers were kind and caring. However, the way the service was provided did not show a caring approach. People had to constantly endure a less that adequate level of care and support because of lack of consistent management and leadership at the service.

The religious and cultural needs of people were identified in their care plans.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

The care plans identified the person's wishes as to how their care was provided and were regularly reviewed.

People did not always benefit from activities that were meaningful and stimulating. A new activity coordinator was being recruited at the time of the inspection to help improve this aspect of the service.

The provider had a complaints process and people were aware of how to raise concerns.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

Records relating to the care of people using the service did not provide an accurate and complete picture of their support needs as information was not consistently recorded.

The provider had a range of audits in place but some of these did not provide appropriate information to identify areas of the service requiring improvement so these could be addressed.

People and their relatives had opportunities to provide feedback on the quality of the care people received and the provider acted on this.

Brackenbridge House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 3 and 4 July 2018 and was unannounced.

The inspection was carried out by one inspector, a medicines inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider had completed a Provider Information Return (PIR) in August 2017. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information sent to us in the PIR and notifications we had received from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

During the inspection, we spoke with seven people who used the service, one relative of a person using the service, the registered manager, the deputy manager, regional manager, five staff including care workers and the chef. We also looked at records, including four people's care plans folders, four care worker records, medicines administration records and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

During the previous inspection in September 2017 we found the provider had a policy and procedure in place for the storage and administration of medicines but this was not always followed by senior care workers. At this inspection, we found that some improvements had been made but issues were still identified with the administration of medicines.

There was a total of nine senior care workers who administered medicines for people living at the home. Evidence was provided for four senior care workers with certificates to show they had completed their medicines administration training. A training spreadsheet showed the dates of completion of this training for the other senior care workers but evidence of completion (Certification) was not available. We saw evidence that one senior care worker had completed the competency assessment, however, the registered manager was unable to provide the competency assessment for the other senior care workers. The registered manager explained the records could not be located at the time of the inspection but they confirmed after the inspection the competency assessments had been completed for all senior care workers.

Central Alerting Systems (CAS) alerts were received by the home and kept in a file but there was no indication if they had been actioned. Some of the CAS alerts were also missing from the file. The CAS is a web-based system which cascades patient safety alerts to the NHS and social care providers.

People's allergies were recorded on the medicines administration record (MAR) charts; however, the allergies were not reflected in the care plans accurately, often missing or a different allergy stated altogether. Where the person had a discharge summary following a stay in hospital any allergies were recorded but this was not reflected in the care plan. For example, the care plan only indicated the person had a food allergy but the MAR sheet and the discharge summary had identified a specific medicine for pain relief as the allergen.

There were several incidences where the signature of the senior care worker from the MAR was missing. In some instances, the MAR chart had just not been signed, but the administration was recorded on the accountability count log. The fact the medicines administration was not being signed consistently on the MAR can lead to errors occurring.

Controlled drugs (CDs) for people were recorded in dedicated controlled drugs register and stored in an appropriate cupboard that complied with legislation for CD management and storage. There were two people who were prescribed controlled medicines and each person had a separate CD register. The Old CD register we saw during the inspection still had stocks recorded on some pages. These stocks had been returned to the pharmacy when they were deemed no longer required but the running balance had not been zeroed. The manager agreed to look into this matter when we discussed this we them.

With the exception of one steroid cream that we found in the drug trolley, all other medicines were stored correctly. The steroid cream we identified must be stored below 15C so should be kept in a fridge. The

medicines storage was clean and air conditioned however, the temperature monitoring was being recorded for the maximum temperature only despite having a form that required the recording for maximum and minimum reading. On the day of inspection, no records were available for ambient temperatures recorded for 1, 2 and 3 of July. These had not been recorded as a new temperature proforma had not been generated.

This meant the provider was still not ensuring medicines were stored and administered in an appropriate and safe manner.

The provider had a process for the recording and investigation of incidents and accidents but at the previous inspection we found this was not always being followed. During this inspection we saw the process was still not being followed.

The incident and accident form for one person who had a fall had been reviewed by the registered manager but, the provider's process required 72 hours of observations to be completed but the records showed this had only been carried out for six hours. There was no reason given to indicate why observations were not carried out for the full 72 hours.

We saw the records for another person who had experienced a cut to the head. The care workers were told by NHS 111 they should carry out observations on the person but there were no records of these being done. The person might therefore have been put at risk, because their condition was not being appropriately monitored for any deterioration so appropriate action could be taken promptly.

Incidents and accidents were usually appropriately recorded but there were no records of incidents and accidents that happened during April 2018. The registered manager was unable to confirm if any had occurred during that time.

At the previous inspection, when an incident and accident occurred, we saw the risk assessments were not always updated to identified if there had been a change in the person support needs. We found this was still the case during this inspection.

The incident and accident records identified one person had a fall in June 2018 but their risk assessments and care plan had not been updated to show this. The moving and handling risk assessment, which was reviewed three days after the person had the fall, stated the person was at no risk of falls.

We looked at the incident and accident records for another person which showed they had experienced two falls within a six-week period. The moving and handling risk assessment stated there was no history of falls and a falls risk assessment was not required. The risk assessment was reviewed a week after the second fall and indicated there was no change to the assessment. The falls had been noted in the skin integrity assessment and dependency level check but this information was not reflected in the moving and handling risk assessment.

This meant the provider could not ensure the learning from investigation related to incidents and accidents was used to reduce the risks of reoccurrence. In addition, there were risks that people's health and wellbeing may not be appropriately managed or planned for.

The above was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During the inspection we observed the senior care worker completing the morning medicines round and we

saw they ensured that the person had taken all their medicines before moving onto the next person by giving them adequate time to take their medicines. At the time of the inspection there was no one that required covert medicines administration. Covert medicines administration is the administration of any medical treatment in disguised form; this usually involves disguising medication by administering it in food and drink. As a result, the individual is unknowingly taking medication. The senior care worker showed good knowledge in relation to the administration of medicines covertly. Where a person had refused medicines, it was correctly recorded and the procedure for referring the person to their GP after three refusals was in place.

We asked people if they felt safe from abuse or harm while living at the home and they told us, in general, they felt safe. Their comments included, "With the carers, yes", "Yes, I do, they have been very good. The other day one took me for a walk in the garden" and "From abuse yes." A relative told us, "Yes, due to [family member] being bed bound, there is an alarmed mat."

The provider had a procedure for responding to any concerns that might be raised regarding the care provided but the records were not always detailed or up to date. We looked at the safeguarding folder and we saw there were no records made between January and May 2018. Our records indicated that there had been three incidents that had been reported to the local authority's safeguarding team but there were no records of these on file. We saw a record relating to a safeguarding concern reported since the new registered manager had started which contained background information regarding the referral and an investigation. The registered manager confirmed the information related to the other safeguarding concerns would be located and added to the folder.

We asked people if they felt there were enough care workers on duty to meet their support needs. We received a range of comments with some people stating they felt there were not always not enough care workers available. Their comments included, "No, they say there is but I don't think so. There is always a rush in the morning and not enough on nights and weekends", "They have so many other jobs so they get called away and we are left alone", "Yes, but sometimes I think there could be a couple more" and "Yes, I think so. All days are different, but we can always find someone when we need them." A relative told us, "Are there ever enough? I'm sure they could do with more, but there always seems to be someone there when my family member needs someone." We also spoke with care workers who told us they felt more care workers were needed. One care worker told us, "No we need more staff. It is hard and tiring work and we need someone in the lounge when we are busy. In the nice weather people should be able to go into the garden but they are constantly in the lounge."

At the time of the inspection there were 33 people living at Brackenbridge House with one person requiring the use of a hoist to help mobilise them. The registered manager told us there were two senior care workers and three care workers on duty during the day and one senior care worker with two care workers working at night. He confirmed that due to a recent increase in the number of people living at Brackenbridge House the number of care workers on duty were being adjusted and they were in the process of recruiting additional care workers who would be starting shortly after the inspection.

People living at the home could choose to have a pendant alarm around their neck which linked to the main call bell system and alerted care workers if the person required assistance. People gave us mixed feedback regarding the use of the calls bells with one person saying, "Yes, there's one by my bed and one I have on me. They could not have come faster." A second person told us, "Yes [I can access the call bell], on my neck and bed but they don't always work and they are never checked. I have had to shout for someone before."

During the previous inspection we saw keypads had been fitted to internal fire doors on the ground floor

and on the first floor to prevent people accessing other people's bedrooms. At this inspection we saw the key pad had been removed from the ground floor fire doors. During the previous inspection we saw a bathroom had been converted into a store room but it was not secure and still had a sign stating it was a bathroom but at this inspection we saw all store rooms were clearly secured and had clear signage.

We saw each person had a Personal Emergency Evacuation Plan (PEEP) which identified what support the person required to help them leave the home in case of an emergency and had been regularly reviewed.

We saw the home was clean, tidy and there were no malodours present. Care workers could access aprons and gloves when providing personal care. Care workers completed infection control training as part of the mandatory training programme.

The provider had a robust recruitment process in place to ensure care workers had the required experience and knowledge to work at the home. During the inspection we looked at the recruitment record for five care workers and we saw the paperwork required by the provider was in place. There were a number of checks including two references, notes from the interview and checks to confirm the person had the right to work in the UK.

Requires Improvement

Is the service effective?

Our findings

During the last inspection we saw the records for care workers did not indicate they had completed an induction when they stared to work at the home. In addition, the records indicated staff were not up to date with the refresher training identified as mandatory by the provider and regular supervision sessions had not been completed.

At this inspection we saw that some care workers were still not up to date with the mandatory training refresher. The registered manager explained they had reviewed the training records and had identified all the care workers with refresher training course which were overdue. They had arranged for these care workers to complete the overdue training over the next few months and ensure any competency assessment were also completed. We saw the training matrix which identified the scheduled dates of the planned refresher training courses.

The registered manager told us supervisions with care workers had not been carried out regularly in the past but he was now implementing a plan to ensure regular supervision meetings were held. These could be one to one meetings with the care worker or group supervisions and would be recorded. In addition, there would be regular staff meeting to discuss information about the people, how the service was being run and any good practice.

During the previous inspection we found, where applications for DoLS had been made up to six months earlier, the staff had not contacted the local authority for an update on the application and the outcome, to make sure that people were not being deprived of their liberty unlawfully

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager explained they had reviewed the records for all the people using the service and where the person had been identified as not having capacity the registered manager had checked with the local authority to see if a DoLS had been authorised. If the application had not been authorised, was delayed or was overdue the registered manager confirmed they had submitted a new application.

We saw checks had been carried out with the Office of the Public Guardian to identified if a Lasting Power of Attorney was in place for people using the service. A Lasting Power of Attorney can be issued in relation to either finance or health and wellbeing and legally enables a relative or representative to make decisions in the person's best interest as well as sign documents such as the support plan on the person's behalf.

We saw a record had been created to identify when DoLS applications were due to be made, when it was authorised and when a renewal was due to be sent. The care plans identified when a person may need support in making decisions and best interest decisions were recorded for specific decisions relating to the care provided for example the use of sensor mats.

This helped to show people's care was being provided within the principles of the MCA.

An assessment of the person's support needs was completed before they moved into the home to ensure the service could meet their care needs. The assessment included a review of the person's mobility, social and health issues and was used to develop the care plan and risk assessments. People were also offered the opportunity to visit the home for lunch and to meet the people already living there.

We asked people their views on the food offered at the home and if they had a choice. People commented, "I am a bit fussy but it is alright. Oh yes, two options, not a big choice", "It is not bad, sometimes it could be hotter", "Well, I am never very hungry, I suppose because you don't get much exercise. You don't feel hungry. I only eat when I feel like it. It is not bad", "Very nice and I am a fussy person. We get a menu to pick what you like from the options" and "It's very good. The chef is very good. There are different menus for each meal of the day."

We saw people could choose to eat their meals in the dining room, lounge or in their bedroom with care workers available to provide support if required. We saw some of the meal options which were available were not seasonal and we discussed this with the chef who confirmed the same menu was used throughout the year. During the inspection we saw one person was given soup and a sandwich for their evening meal. We asked the person what flavour the soup was and the person told us they believed it was mushroom but they were unsure. Some of the people we spoke with did comment that they would enjoy food that was a bit more "Summer like" as the weather was hot. We discussed this with the registered manager who confirmed the menu would be raised at the next residents' meeting. The chef explained they had a list of food preferences, allergies and any religious requirements for people living at the home. The chef told us when a new person moved into the home they would meet with them and their relatives to find out their food and drink requirements to ensure their records were accurate and they can meet the person's needs.

People using the service had access to a range of healthcare professionals. In addition to the GP and district nurses, people could access the dentist, chiropodist and optician. We saw copies of recent opticians' prescription in people's care plan folder. When a healthcare professional visited a person, a multidisciplinary team record sheet was completed with the outcome of the visit so any input from a healthcare professional could be monitored.

Requires Improvement

Is the service caring?

Our findings

When we asked if they were happy with the care they received, people gave us both positive and negative comments which included, "Yes, it's quite a nice home. Some of the care workers are not very caring because they don't do what you ask them", "Not really, we are restricted – within reason. It's not too bad but sometimes we are treated like children", "Oh yes, you can't beat it" and "I have no complaints at all."

People we spoke with, in general, felt the care workers were kind and caring with comments including, "Very much so, you can have a laugh with all of them", "They are always helpful" and
"They are quite kind." One person did comment, "They are on show. If you ask them to do something they don't always follow it up."

Whilst individual care workers were caring and kind to people using the service, the provider has not ensured that the service was caring enough. This was because they had not ensured there was appropriate leadership at the home and effective arrangements to provide a consistent quality of care. The service had consistently breached regulations which meant people were being subjected to sub-standard of care and support. Their quality of life was also not as good as it could have been because of the provider's failure to recognise the lack of activities for people who use the service and doing something promptly and substantial to improve this aspect of care so people led as meaningful and fulfilling lives as possible.

During the inspection we observed interactions between care workers and other staff in the lounge, dining room and other communal areas of the home with people living at the home. The interactions we saw were kind and respectful and demonstrated care workers clearly knew the people they were supporting well and the care they provided reflected the person's preferences and support needs.

People told us they felt the care workers helped them maintain their independence when they received support. Their comments included, "If they would help you, yes", "Certainly, if we need help, we can go ask them, they show us then leave us to it", "I am quite independent" and "Yes, I think they are very good."

Most people we spoke with felt the care workers treated them with dignity and respect but a couple of people said they felt it varied with the care workers. Their comments included, "I think it's the case of, they all treat you how you treat them. But they are fine, I have never had any problems", "They do and they don't. They all have their own ideas about things but you have to be ready to answer back", They are alright when there are a lot of people around", "Oh, yes, certainly you couldn't ask for anyone better." A relative told us, "Absolutely. They check on my relative regularly and care and dignity is quite high on their list of activities." Care workers demonstrated they understood the importance of respecting each person's privacy and dignity when providing care.

People's cultural and religious needs were identified in their care plan. In addition, the name they preferred care workers to call them by, was also recorded. There were regular visits to the home by local religious groups and people were supported to attend religious meetings if they wished. One person commented, "No, I don't have any [religious or cultural needs], but church meetings are there for people who want to go."

We also asked people if they had been asked their preference in relation to the gender of care worker who supported them with personal care. They said, "I have never been asked but I have a preference and I have made that clear and it has been respected" and "No, I don't think I've been asked. But I do prefer female care workers." The information regarding people's preferences were recorded in some of the care plans we looked at.

Requires Improvement

Is the service responsive?

Our findings

People told us they were not happy with the activities available at the home. Their comments included, "We had a wonderful activity leader, now she had left, but there is hardly, if at all, anything", "Yes, I like to be active, I can't sit still long but they don't do much. We sit here too long. They could do with another activity person" and "There are games sometimes, there are not many because the staff are too busy." We also asked if there were any activities they would enjoy and they told us, "Something more energetic, things that make you think, not just throwing balls", "A few things outside" and "I would like to go outside more when the weather is nice. When I first came here they used to do that more often."

During the inspection we saw there was a lack of meaningful activities provided for people in the lounge areas and in their rooms. We saw the television in the lounge was left on without people being asked their preference for what they wanted to watch and in addition music was also being played at the same time. When an activity was organised, for example a giant ten pin bowling game was set up in the lounge, the activity only lasted for under 10 minutes and not everyone could be involved. The registered manager explained the previous activities coordinator had left and they were in the process of completing the recruitment process on a new staff member for this role. The registered manager confirmed the care workers were leading on activities but these were not as structured as previously when there was a specific staff member responsible.

The above was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We asked people if they knew how to raise concerns regarding their care and they told us, "No, but I would do this through the office if I wanted to", "No, I just ignore people", "I would tell someone, but no I haven't [made a complaint]" and "I don't think so. There isn't much to complain about really." The provider had a complaints process in place and we saw a shared learning tool had been completed to review the response to recent complaints and the actions taken. The information for two complaints, which had been received earlier during 2018, did not always include information relating to the complaint, any investigation and the outcome. The complaints responded to by the new registered manager included information on any investigation, the outcome and any actions identified. The registered manager told us he planned to respond the any completed received in line with the provider's complaints policy and review what could be learned from any investigation.

During the inspection we saw that some people did not have access to appropriate equipment because they had not always been referred to relevant healthcare professionals to review their needs. We saw one person did not have a suitable armchair which provided support and enabled the care workers to position the person so they would not slip down the chair. We also saw people did not have appropriate footstalls that could be adjusted and easily cleaned to ensure the person's legs were in a comfortable position. We asked the registered manager if the people we saw had been assessed by an occupational therapist to identify any appropriate equipment required to meet their care needs. He confirmed these assessments had not been completed but by the end of the inspection referrals had been made to the appropriate service to request

assessments.

We saw each person had a care plan folder which included a range of care plans, risk assessments and other information in relation to the person's support needs. The care plans included nutrition, personal care, mobility and falls, pressure relief and a night plan. The registered manager told us the format used for care plan was being reviewed. A separate care plan had been developed to identify the person's wishes in relation to how they wanted their care provided at the end of their life. We saw the care plan included information if the person wished to stay at the home at the end of their life and when they wanted their family to be contacted. We saw records indicated the care plans were reviewed monthly.

Requires Improvement

Is the service well-led?

Our findings

During the previous inspection we found the provider had a range of audits in place but these were not effective and comprehensive enough to identify areas of concern and where improvements could be made. During this inspection we found that audits were still not providing appropriate information for the provider to identify areas for improvement so these could be addressed.

The registered manager had completed care plan audits but we found these were focused on whether a document was in the person's care plan folder and if it had been reviewed instead of if the information was accurate relating to the person's care needs. We saw a care plan audit had been completed in relation to one person which had been placed in their care plan folder. The audit identified a number of sections of the care plan and risk assessments that had not been completed in full but the actions section of the audit did not have any information in relation to what was required and by when. The audit had been completed and signed by the registered manager.

Checks carried out in relation to medicines storage and administration of people's medicines did not identify the issued noted in this report.

During the previous inspection we found records relating to the care people received were not accurate and providing up to date information for care workers. At this inspection we found improvements had not been made to the recording of information.

The end of life wishes document completed in November 2017 for one person identified their wishes but the end of life care plan which had been written in February 2018 stated no decisions had been made in relation to their preferences.

The records for the same person identified they had lost weight over a period of time and the registered manager confirmed a referral had been made to the dietician but this had not been recorded in the nutrition care plan or as part of the monthly review.

The care plan for another person stated they could move themselves in bed without the support of care workers but there was a pressure relief chart which indicated the person needed to be regularly repositioned.

This meant care workers were not provided with accurate and up to date information regarding people's care needs.

During the inspection we identified the provider did not have effective arrangements to assess, monitor and mitigate risks associated with the provision of care. They did not demonstrate that they were providing care and treatment to people which was safe and appropriate. These risks included those associated with risk assessment and care plans not being updated following a change in support needs, incident and accident records not being reviewed and medicines not being managed in a safe way.

The above was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

A monthly audit was completed by the registered manager which was based on the outcomes of other checks that were done. The audits reviewed included dining room observations, complaints, safeguarding referrals and environment checks.

The home has not had a stable management structure and leadership since April 2015 to help provide a stable service for people to live in and a supporting work place for staff to work in. One care worker told us they felt that as most of the managers in recent years had only been in post for a short period of time there had not been a consistent message for staff, people using the service and relatives in relation to expectations as to how the care should be provided and the expected quality of that care. Other comments from care workers we spoke with included, "Paperwork is always to be done so you don't get to spend time with people and to care for them", "We need to give the new manager some time to get to know us. He appears to have his feet on the ground but you can't judge too early", "It is a bit better, the main problem is that residents are bored. Why don't they have a physiotherapist to help, people are not active enough and there is a lack of staff" and "The registered manager appears to know what needs to be done and is working through it."

We asked people if they thought the home was well-led and they told us, "I get on with [the registered manager] quite well. I'll give him a chance. We have had quite a few come and go. I would like them to involve us more in what goes on in the office", "I don't know who that [the registered manager] is", "The staff I have met are really nice and friendly" and "The manager is very nice and very respectful." A relative commented, "I don't really know the new manager and haven't really had the time to speak to him. But I am familiar with the general staff. There could be more support from the owners of the care home."

The registered manager had joined the home at the end of April 2018 and had been registered with the CQC shortly before the inspection.

The registered manager explained a questionnaire had been sent to relative of people living at the home and a meeting had been arranged for later in July 2018. They also confirmed regular meetings had been held with people living at the home to discuss anyd issues and ideas for activities.

We saw monthly senior team meetings were held where topics for discussion included care plans, medicines, confidentiality and complaints. We saw minutes were taken for each meeting.

The registered manager told us they worked closely with the local authority in relation to improving the quality of the care provided. They also were in contact with the Clinical Commissioning Group and local authority to be involved in schemes to implement good practice and training.

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 The registered person did not ensure the care and treatment of service users was appropriate, met with their needs and reflected their preferences. Regulation 9 (1) (a) (b) (c)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care and treatment was provided in a safe way for service users. The risks to health and safety of service users of receiving care and treatment were not assessed and the provider did not do all that was reasonably practicable to mitigate any such risks. The registered person did not ensure the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) (g)

The enforcement action we took:

We issued a Warning Notice requiring the provider to comply with the Regulation by 13 November 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have an effective system to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity The registered person did not have an effective process to assess the specific risks to the health and safety of services users and do all that was reasonably practicable to mitigate any such risks. The registered person did not have a system in place to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of

decisions taken in relation to the care and treatment provided.

Regulation 17 (1) (2) (a) (b) (c)

The enforcement action we took:

We issued a Warning Notice requiring the provider to comply with the Regulation by 13 November 2018.