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Bracknell House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

This unannounced inspection took place on 17 and 22 December 2014. Bracknell House is a large detached property providing accommodation and personal care for up to 22 older people. The home has two small lounges, a small conservatory to the front of the property and a second and larger conservatory to the rear of the home overlooking the garden. At the time of the inspection 18 people were living at Bracknell House.

The service is run by a registered manager, who was present on the days of the inspection visits. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting

Summary of findings

the requirements in the Health and Social Care Act and associated regulations about how the service is run. The registered manager and deputy manager are also the providers of the service.

People told us that they felt safe living at Bracknell House. One person said, “I think we’re safe here” and another person said, “I don’t have any concerns”. Relatives said that they never had any concerns about the safety or welfare of their relatives. They told us that they would be confident speaking to a member of staff or to the registered manager of the service if they had any concerns. The staff told us that they had completed training to support people safely, recognise and report abuse, and would report any concerns to the registered manager. However, we found that the safeguarding policy was out of date and the service did not have a copy of the safeguarding protocols from the local authority, to ensure that the service had the up to date guidance with regard to reporting safeguarding issues. There were no clear procedures in place to take account of relevant legislation and guidance for the management of alleged abuse.

Although people told us they felt safe we found that this service was not providing consistently safe care. One person was not being moved safely and the risk assessments in their care plan were not detailed enough, to show how the risks should be managed safely. The assessments also lacked guidance for staff to support people with their behaviour, so that these risks could be minimised. There were no environmental risk assessments in place to help make sure the premises were safe, and fire drills had not been carried out, to ensure that staff knew what to do in the event of a fire. Risk assessments to support people to bath safely did not contain sufficient information to show how these risks were being managed.

There were systems in place to review any accidents and incidents and make relevant improvements, to reduce the risk of further occurrence.

The management of the medication was not safe. There were no checks being made by the registered manager to ensure that medicines were being handled and recorded appropriately. We observed the medicines administration and found that medicines were not being recorded or given to people safely. There were no medicine risk assessments in place for people who were ‘self-administering’ some of their medicines, to ensure they were able to do this safely.

There was insufficient guidance for staff to manage medicines prescribed as "when required" , such as pain relief, to make sure people received their medicine when they needed it, or when staff should seek professional advice for their continued use.

People and relatives told us they felt there were sufficient numbers of staff on duty. However we could not always be assured that there was sufficient staff on duty at all times. On one occasion there was only two staff on duty to care for 17 people. There was no formal tool in place to assess the number of staff required to fully meet people’s care and support needs. The registered manager told us that together with the deputy manager they supported the staff to provide direct care to people, however there was no evidence on the rota to confirm this. People and staff told us that there were times when the registered manager and deputy manager supported them.

People were not protected by robust recruitment procedures. Staff records showed that not all checks had been completed, such as checking out people’s employment history and obtaining references relating to previous conduct in employment. Other checks, such as health, identification checks and evidence of a Disclosure and Barring Service (DBS) had been undertaken and were held on file.

Although staff completed an induction training programme, which included shadowing experienced staff, the induction was not competency based and in line with the recognised government training standards (Skills for Care). There were shortfalls in the training programme and records, as the registered manager told us that staff had received mental capacity training, but there was no evidence to confirm this. Specialist training had not been provided, such as epilepsy and diabetes training.

We could not be sure that people’s health care needs were met due to the lack of detail about their medical conditions, such as what symptoms and signs to look for if they needed medical attention. People had been weighed and this was recorded, but when there were concerns and action needed to be taken with regard to monitoring their food and fluid intake, this was not

Summary of findings

always in place. People with loss of appetite had been referred to dieticians, but there was no record in the care plan to show that staff were following any recommendations made.

There were insufficient details and information about obtaining people's consent and involvement in their care planning, including assessments of people's mental capacity and making decisions in people's best interests.

People and relatives told us that there was a lack of choice of menu for the lunch time meal. They said that the matter of choice had been brought up at a resident's meeting and they were asked to write down their choices, but nothing happened and there was still a lack of choice. People had not been asked, and did not know, what options were available for lunch on the first day of the inspection, and in addition the staff were unable to find the menu, to confirm that choices were offered. People told us the food was "OK" and one person felt it was a little bland.

Staff had received one to one meetings with their manager, and annual appraisals had taken place. Some staff felt overall they were supported, but at times felt that the management of the service could be improved. Staff had the opportunity to attend regular staff meetings.

People and relatives told us the staff were kind and maintained their privacy and dignity. However, staff supporting one person with their mobility did not uphold their dignity. This practice had been recorded in the care plan and had been going on since July 2014. There was no indication or evidence that this procedure had been agreed with the person and health care professionals. Staff had not raised issue that this was unacceptable practice as this person's privacy and dignity was being compromised.

Staff were familiar with people's likes and dislikes and supported people with their daily routines.

People were chatting to each other and staff in a relaxed and friendly manner. Different members of staff were supporting people to be involved in conversations and they took time to listen and respond to their requests. People's independence was promoted, however this was not always recorded in the care plan. Staff supported people to go where they wished within the service. People and relatives told us that they were able to visit at any time and they had their privacy respected.

People's needs were assessed before they came to live at the service; however there was no evidence to show how people were involved in their care planning. Some people told us that the service had been recommended to them and another person told us that they had had relatives who had used the service before and had liked what they saw when they had visited.

The format of the care plans was varied and they did not always contain details of people's preferred daily routines, such as a step by step guide to supporting the person with their personal care. In one case the information recorded was contradictory, with inconsistent guidance for staff to follow, to make sure people's needs were fully met. People's assessed needs, such as information from a falls risk assessment, was not always crossed referenced with their mobility needs. Although one health care professional told us that staff acted on their guidance, this detail was not recorded in the care plans. Care plans had been reviewed, but it was not always clear how effective the reviews were as some plans just noted 'no changes', which would indicate that people's needs had remained the same since the previous review, which in some cases was over a year.

People and relatives told us that they had the opportunity to voice their concerns. There were

monthly residents meetings, which also gave people the opportunity to give feedback. There were no dedicated staff hours for activities; however, people told us that some activities were provided by the staff. The local church visited the service regularly and recently school children had visited the service to sing carols.

There was a complaints procedure in place and people and their relatives were confident how to raise issues and felt that their concerns would be addressed fully.

The management of the service was not effective. The quality of care was not being checked to make sure people were safe and protected from inappropriate care and treatment. The systems in place to ensure the service was protected from the risk of fire were not adequate. Staff training was not being monitored to make sure staff had the competencies to fulfil their role. The staff were not aware of the visions and values of the organisation or involved in the continuous development of the service.

The providers were not able to produce all of the documents needed for the inspection and records were

Summary of findings

not easily accessible. Records were not robust, policies and procedures had not been reviewed, some records were not up to date, care plans were not accurate and medicine records had been changed. There were no systems in place to measure and review the delivery of care against current guidance. Due to the concerns raised in this report there was a clear indication that the management did not have an understanding of the key challenges of the service.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were shortfalls in the management and storage of medicines to make sure people were receiving medicines safely.

Risk assessments did not give staff enough detailed guidance to make sure people received the right support to meet their needs.

Staff records did not show that the service had investigated gaps in prospective staff employment history, to help make sure they were suitable to work in the service.

There had not been regular fire drills to make sure staff knew emergency procedures. There were no environmental risk assessments in place.

There was no maintenance plan in place to continually improve the building, and some equipment checks had not been completed.

Is the service effective?

Inadequate

The service was not effective. The staff competency was not assessed and some training was not up to date. Specialist training had not been provided.

Care plans did not show how people's health care needs were being fully met. People were not involved or supported to make decisions about their care.

People were not receiving their choice of meals and their nutritional needs were not always recorded in their care plans.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity. Staff were kind, patient and respectful to people.

The atmosphere within the service was relaxed and people were listened to by staff who were attentive to their needs.

Staff supported people to maintain and develop their independence; however this was not always recorded in their care plans.

Is the service responsive?

Requires Improvement

The service was not always responsive. People were not involved in planning their care. People were not supported to follow their interests and there was a lack of meaningful activities for people to be involved in.

Summary of findings

Care plans varied in detail with some detail of people's preferred routines, likes and dislikes, however this was not consistent. Although the care plans had been reviewed they did not always show the most up to date information, to make sure people were receiving the care they needed.

Complaints had been logged and responded to appropriately and people and their relatives told us they would raise any issues with the registered manager or staff.

Is the service well-led?

Inadequate 

The service was not well led.

People were at risk because systems for monitoring the quality of care provided were not effective. Records were not suitably detailed, or accurately maintained.

The registered manager was unaware of the challenges of the service as the shortfalls in this report had not been identified. There were no systems in place to monitor the continuous improvement of the service.

Bracknell House Residential Care Home

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 was 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 17 and 22 December 2014, was unannounced and was carried out by two inspectors who had experience of older people's services.

The unannounced inspection was carried out as a response to concerns raised by relatives of a person using the service and the local safeguarding team, therefore a Provider Information Return (PIR) was not requested. 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 looked at previous inspection reports and notifications received by the Care Quality Commission (CQC) and information from the local authority and safeguarding team. A notification is information about important events, which the provider is required to tell us about by law.

We were able to speak with one health and social care professional who was providing support and treatment on the day of the inspection and one other by telephone, to obtain their views about how the service was running.

We viewed some areas of the service, talked with six people who were receiving care and treatment and six relatives.

During the inspection visit, we reviewed a variety of documents. These included seven people's care plans. We viewed three staff recruitment files; the staff induction and training programmes; staffing rotas over two weeks; medicine administration records; risk assessments; minutes for staff meetings and residents' meetings; and some of the service's policies and procedures.

Inadequate

Is the service safe?

Our findings

Although people told us they felt safe living at Bracknell House and relatives said they did not have any concerns about the safety or welfare of their family members, we found the service was not safe.

The staff told us that they had completed training to support people safely, recognise and report abuse, and knew the actions to take, such as reporting issues to their manager. However there were no clear procedures in place to take account of relevant up to date legislation and guidance for the management of alleged abuse. The safeguarding policy was out of date, the telephone numbers to report concerns to the local authority were incorrect and the policy referred to out of date legislation. In the absence of the registered manager staff did not have up to date guidance or contact numbers to raise and process a safeguarding alert. The service also did not have a copy of the local authority safeguarding protocols, to ensure that they had the up to date guidance on safeguarding people.

This is a breach of Regulation 11(1)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed two staff moving a person in the lounge from their chair to a wheel chair. The staff put a handling belt on the person to support them to weight bear, however when they moved the person, neither members of staff used the belt and put their arms under the person's arm to assist them to their feet. This was inappropriate care and unsafe practice. The moving and handling risk assessment in the care plan, dated July 2014, did not mention the use of the handling belt or give staff guidance of how to move the person safely. The care plan stated "tried (the person) with belt, but became distressed", there was no further information after this statement. In January 2014 the plan stated that the person was non weight bearing indicating that a hoist was required to move this person safely. . However, staff told us that they did not use the hoist as (the person) did not like it and used the handling belt instead. In the daily contact notes, dated 11/12/14, staff had recorded "hoisted up and put in a chair". This information was inconsistent with their care plan to make sure this person was being moved safely. Other risk assessments did not have guidance for staff to follow, to ensure people were being moved as safely as possible. There were no assessments to say when people may or may not need to use a hoist, due to the fluctuation in their mobility. Risks associated with people having a bath had been assessed, but measures to reduce any risks were not detailed in the assessments, to ensure staff did this safely.

Risk assessments for people who needed support as their behaviour may challenge others, varied in detail. One risk assessment stated "can be aggressive/rude at times", and the management measures stated "staff need to explain to the person that this is not appropriate", however the person was living with dementia and would not be able to respond to this information. There was no guidance to say how staff could reduce this behaviour, to make sure this person received consistent care and support. One person's behaviour was not always positive and there was a risk of self harm, the action recorded to reduce the risk was for staff to be aware, be calm and to ease the person's anxiety, but there were no guidelines for staff to show how to do this.

The lack of detailed risk assessments and care plans left people at risk of receiving unsafe or inappropriate care and if new staff were on duty they would not have current guidelines or procedures to ensure that people received the correct care and support safely.

This is a breach of Regulation 9 (1)(b)(ii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were limited environmental risk assessments in place to ensure that risks were being identified and managed to ensure people were living in Bracknell House as safely as possible. We asked the deputy manager for the environmental risk assessments but these were not provided, therefore we could not see that risk assessments had not been completed in relation to the building and grounds of the service. Service users' bedrooms had not been risk assessed or checked on a regular basis to make sure people were safe.

Accidents and incidents were reported and recorded, however these were not being summarised to identify any patterns or trends, to help ensure appropriate action was taken to reduce the risk of further similar occurrences.

This is a breach of Regulation 10 (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and their relatives felt medicines were handled safely. However there were shortfalls in the medicine management.

Inadequate

Is the service safe?

There was a medicines policies and procedures in place and although these contained clear instructions in relation to the obtaining, recording, handling, safe keeping, safe administration and disposal of medicines, they were not always followed in practice. The documents also contained information relating to medicine regulations that were out of date.

Medicines, including controlled drugs were not stored safely in suitable cupboards. Stock records of medicines were not kept up to date and therefore there was no audit trail of medicines that had been administered and by whom.

Medicines were administered during the inspection. However procedures did not always follow a safe practice and was not in line with the written procedure. Medicines were administered without checking the medicine administration records first to ensure the right medicines were given to the right person, at the right time, before being given.

Medicine administration records did not always show that people received their medicines according to the prescriber's instructions. There were gaps in medicine administration recording with no code or signature entered on the records, so we were unable to ascertain exactly what medicine had been administered. Handwritten entries on the administration records were not dated, signed or witnessed, which is recommended as good practice by the Royal Pharmaceutical Society.

Medication records stated that some people 'self-administer' some of their medicines. However there were no risk assessments in place to ensure people were able to do this safely. Medicine administration records showed that at times the service did not have the right medicines in stock, so people were left without their medicine until a new supply was obtained.

Where people were prescribed medicines or creams on a "when required" basis, for example, to manage pain or conditions, there was insufficient guidance for staff on the circumstances in which these medicines were to be used and when staff should seek professional advice for their continued use. This could result in people not receiving the medicine consistently or safely.

This is a breach of Regulation 13 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and relatives told us they felt there were sufficient numbers of staff on duty. A health care professional confirmed that when they visited Bracknell House they felt there was sufficient staff on duty. During the inspection staff responded when people approached them and were not rushed in their responses. There was a staffing rota in place and the registered manager told us that the minimum staffing for the service was three on the morning shift, three on the late shift and two waking night staff. This was based on their calculations rather than using a formal staffing tool based on people's needs. Records showed that from 8/12/2014 to 17/12/2014, five morning shifts had run short and seven late shifts had run short (sometimes by a complete shift and sometimes by reducing the time of the shift). On one of these days the afternoon shift had run with two staff as neither the registered manager nor the deputy manager was on rota. Care staff were also covering the cook as there was a vacancy; there were only cleaners for three days of the week and no dedicated laundry person. Therefore staff had other duties to complete as well as meeting people's personal care needs.

There was an on-call system covered by the registered manager and deputy manager. The registered manager told us they used existing staff to fill any gaps in the rota and did not use agency staff. They were in the process of recruiting a cook and the permanent deputy manager would be back from annual leave in January 2015.

People were not protected by robust recruitment procedures. Recruitment files did not contain all the required information to show a robust recruitment process had been followed. One application form did not show a full employment history and there was no explanation relating to the gaps. Only one reference relating to previous conduct in employment was contained on a file. Other checks, such as health, identification checks and evidence of a Disclosure and Barring Service (DBS) check had been undertaken and were held on file. A Disclosure and Barring Service (DBS) check, checks if prospective staff had a criminal record or were barred from working with children or vulnerable people.

This is a breach of Regulation 21 (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

People told us they were happy living at Bracknell House. Relatives were satisfied with the care and support their family member received. People and relatives said they would recommend the service.

People smiled and chatted to staff positively when they were helping them with their daily routines. Staff were heard offering choices to people throughout the inspection. For example, if they preferred to stay in their room or where they wanted to sit. One person told us how they liked to stay in their room and others told us they did not wish to join in the activities, and their decisions were respected.

Staff had completed an induction programme, which included reading relevant documents, shadowing experienced staff and training courses. However the induction did not reflect the recognised government training standards (Skills for Care). There was an on-going training programme in place and although we were told that some staff had completed Mental Capacity Act 2005 training there were no records to confirm this. Specialist training to meet people's individual needs, such as epilepsy and diabetes, had not been provided; therefore we could not be confident that staff had the necessary skills and experience in order to meet people's needs. We also observed the staff using unsafe procedures when moving a person, which demonstrated that although staff may have been trained, but they were not necessarily competent following training.

This is a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us they attended appraisals and had one to one meetings with their manager, where their learning and development was discussed. Staff said they felt overall they were supported, but at times felt that the management of the service could be improved. Staff had the opportunity to attend regular staff meetings.

We could not be sure that people's health care needs were met due to the lack of recording in care plans to show appropriate action had been taken. People who had medical conditions, such as a history of epilepsy, had information in their care plan from Epilepsy Research UK, but there was nothing about the signs or symptoms or types of seizures, or what action staff should take if a seizure occurred, in order to manage this safely. Another care plan stated 'experiences constipation at times' and action was recorded as 'laxatives to be offered', but no medicines for this condition had been prescribed by the person's doctors. A care plan for a person who had diabetes stated 'control blood sugar - staff to monitor her dietary intake to control blood sugar', however there was no information about how this should be done and the person's diet and fluid intake had not been recorded.

This is a breach of Regulation 9(b)(i)(ii)(iii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. Although the registered manager told us that some staff had received this training, there were no records to confirm this and staff spoken with did not understand their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We saw that some people had a mental capacity assessment on file, but this just stated that the person lacked capacity and that their relative dealt with finances, whilst the doctor, family and senior staff dealt with medical conditions. This had not been signed and there was no evidence of any legal documents to confirm that this had been agreed.

This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and relatives told us that there was a lack of choice of menu for the lunch time meal. They said that the matter of choice had been brought up at a residents' meeting and they were asked to write down choices they would like, but nothing happened.. There was never a cooked breakfast, only cereal and toast. People said: "Sometimes there are two choices at lunch time, but tea is usually the same, lots of sandwiches" and "The food could be better".

On the first day of the inspection staff could not produce a menu. There was also no evidence that people had been offered a choice and staff told us people had not been asked or told what was for lunch that day. At lunch time we observed the meal being served, only one person had something different and this was because they did not like sausages and was therefore given an alternative. Some of the care plans recorded people's likes and dislikes and staff were aware of these choices.

Records showed that some people had lost weight and their food and fluid intake had been monitored, but there

Inadequate

Is the service effective?

was no explanation as to why the weight loss continued. One person had refused to be weighed and the staff had not discussed this issue with health care professionals to assess the person's weight differently. People with loss of appetite had been referred to dieticians, but there was no record in the care plans to show that staff were following the recommendations made. There was a nutritionist report in one care plan recommending that the person was offered two to three snacks a day and one pint of full cream milk, and milky drinks and puddings. There was no evidence that these recommendations were being followed. On the second day of the inspection we found that an additional food chart was in place for one person identified as at risk, dated a day after the first inspection date.

This is a breach of Regulation 14 (1)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Relatives told us that the registered manager or staff contacted them when their family member was unwell. There were records in place to show when people received support from health care professionals. Records of health care appointments were in place and people were supported to see the doctors, dentist and chiropodist.

One health professional told us that any advice and guidance they provided was adopted by staff, however this detail was not incorporated into the care plans.

Requires Improvement

Is the service caring?

Our findings

The staff were caring and attended to people's needs promptly, however, when one person returned from the bathroom we observed that staff were using continence aids inappropriately, which did not uphold the person's privacy and dignity. This person's care plan showed that this practice had been clearly recorded and had been in place since July 2014. There was no indication or evidence that this procedure had been agreed with the person and health care professionals. The staff had not raised issue that this was unacceptable practice as it compromised the person's privacy and dignity.

One care plan also contained inappropriate language when describing a person's behaviour, which was not being respectful or dignified.

This is a breach of Regulation 17 (1)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that their dignity was maintained and staff always knocked on doors before entering, and were very polite and respectful. One person said, "There is a family atmosphere in the home".

People and relatives told us that staff were kind and caring. We observed that staff took the time to listen and chat with people so that they received the care they needed. People were relaxed in the company of the staff, and the atmosphere in the service was calm. Relatives were complimentary about the staff. Their comments included: "They uphold privacy and dignity to the best of their abilities; I have never seen any poor practice". "There are no problems with privacy and dignity; they treat my relative like a member of their family". "The staff are all very caring, there has been quite a turnover of staff, but you can't fault the staff, they go beyond the realm of duty". "The staff team pull together and are never failing in their patience and kindness shown to residents and visitors".

People freely went to their own rooms, and choose to watch their own television or remain in the peace and quiet of their rooms. One person told us how the registered manager had given them a small radiator as they felt their room was cold in the night. Another relative told us that their family member liked staying in their room and staff would 'pop in' regularly to make sure there were not socially isolated..

People's family and friends were able to visit at any time. People had their privacy respected, although one relative felt that privacy could be restricted if the large conservatory was not in use. However the cool temperatures in the porch and conservatory may impact on people using these rooms for privacy.

People's independence was promoted, however this was not always recorded in the care plan. For example, one person was laying the table for lunch and was able to make their own coffee. Staff were supporting people to go where they wished within the service.

Requires Improvement

Is the service responsive?

Our findings

People needs were assessed before they came to live at the service. This assessment was part of the care planning process. There was no evidence to show how people were involved in planning their care. However one relative told us how the registered manager had visited their family member in their previous care home to assess their needs and they choose Bracknell House as it was a family orientated home. Some people told us that they had been recommended the service and another person told us that they had had relatives who had used the service before.

There were two different formats of the care plan and the detail of information varied. The care plans did not always contain details of people preferred daily routines, such as a step by step guide to supporting the person with their personal care, what people could do for themselves and what support they required from staff. There were assessments on files in relation to people's physical health, their dependency, nutritional needs and risk of falls, however this information was not cross referenced to other parts of the care plans, such as the moving and handling risk assessments and nutritional requirements. Therefore care plans had not been developed from the assessments detailing how individual needs would be fully met.

Care plans had been reviewed, but it was not always clear what information had been updated as review dates on different parts of the care plans were different, therefore staff may not have accurate information to ensure people's changing needs were identified and met Staff told us that they kept up to date at the handovers and daily notes, however this information was not reflected in the care plan.

This is a breach of Regulation 9(b)(i)(ii)(iii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care plans had details of their life history and family life. This helped enable staff to understand people and what was important to them.

People participated in a monthly residents meeting where they had the opportunity to voice any concerns that they might have with regard to their care and support, however there was no evidence to confirm that their views had been acted upon. Relatives told us that they had also attended some of these meetings.

There were no additional staffing hours to provide activities for people. At the time of the inspection the local church were visiting and encouraging people to sing carols. The previous week children from the local school had also visited to sing carols. Some people were briefly entertained with a ball game during the afternoon. We saw comments had been made during a survey in April 2014 that more shopping trips had been requested in warmer weather. One relative told us that these trips did not happen very often and they felt activities could be improved. Concerns had also been raised that, at times, people's laundry was missing, but there was no evidence that the service had responded to improve the laundry service.

People and relatives told us they would speak to the registered manager or a staff member if they were unhappy. They felt staff would sort out any problems they had. There had been four complaints received by the service in the last 12 months, which had been responded to appropriately. Some of the people were partially sighted, but the complaints procedure had not been printed in large print to make sure it was in a format they would be able to read and understand.

The providers were visible throughout the inspection. Staff told us that any concerns or complaints would be raised with the providers to take the appropriate action. Relatives told us they did not have any complaints, but felt comfortable in raising any concerns that might arise. One relative said, "I have raised little things in the past, which have always been resolved."

Inadequate

Is the service well-led?

Our findings

People and relatives told us the registered manager was approachable and usually available if they needed to speak with them. Although they said the management of the service could be improved as it was not managed as well as it could be, they said they would still recommend the service.

The systems in place to ensure the service was protected from the risk of fire were not adequate. The fire drills had not been completed since 2013, to ensure that staff were aware of emergency procedures.

This is a breach of Regulation 9 (2) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The systems to assess the quality of the service were not in place, for example, audits of the medicine management, care plans, and maintenance of the premises, including health and safety checks.

The provider told us that the boilers had been serviced, but there was no evidence to confirm that this had been done. We asked the provider to send us the required documentation on 17 and 22 December 2014, but this had not been provided. Therefore we could not tell when the boiler was last checked to make sure it was safe. After the inspection, on 2 January 2015 the provider sent CQC documentation to confirm the boilers had been serviced and were safe to use.

The service had carried out a quality assurance survey to people on 14 April 2014 this did not include health care professionals or staff. There was no system in place to make sure people were aware of the outcome of the survey and what action had been taken to improve the service. There was no evidence to show how people had been actively involved in developing the service.

People were not involved in running the service, and although residents meetings are held, there are no records, to show how people's suggestions or views had been acted upon.

Every organisation registered with the Care Quality Commission (CQC) must provide a Statement of Purpose, which includes the stated aims and objectives of the service. This enables people to have detailed information of what to expect from the service. The Statement of Purpose for Bracknell House had been reviewed in November 2014, however this contained out of date information, such as referring to Care Home Regulations 2001, and National Minimum Standards. The aims and objectives outlined in this document by the providers were not being implemented and staff were not aware of what these were. For example the Statement of Purpose stated on page 9, (5) 'Ensure the safety of the service users in relation to medication provisions, both complementary and conventional'. However the provider had not ensured that the people's medicines were being managed or administered safely as identified in this report.

There was no system in place to monitor the training staff received to make sure staff were competent, and to ensure they had up to date knowledge and guidance, or when their training required updating.

There was a lack of leadership in the service to make sure staff had a clear understanding of their responsibilities. The registered manager had not recognised the key challenges ahead for the service, until the shortfalls were highlighted as a result of the inspection.

This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

On 17 December 2014, there were shortfalls in the recording of the medicines, such as eight medicine administration records (MAR) charts had gaps where staff should have signed to confirm people had received their medicines. When we returned to the service on 22 December 2014 we found that all of the identified records, which had gaps in the information recorded, had been completed. Staff had used inappropriate ticks on the MAR charts with no explanation of a code to explain what this meant. The MAR charts did not identify who was self-administrating their own medicines and hand written entries had not been dated, signed or witnessed.

The providers were not able to produce all of the documents needed for the inspection and records were not easily accessible. There was out of date guidance, such as information in the complaints procedure for the local authority on file, the provider had not made sure that the service had the up to date local safeguarding authority guidance and their own policies and procedures had not been reviewed and updated.

One care plan was contradictory and did not contain consistent information about their medical condition to reduce the risk of deterioration in their health care needs.

Inadequate

Is the service well-led?

This is a breach of Regulation 20(1)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff meetings had been held and minutes taken to make sure staff who were unable to attend were aware of the details discussed. Some staff felt the management of the service could be more organised. Staff told us they used the daily handover sessions to keep up to date with people's changing needs.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person had not made suitable arrangements to ensure that service users were safeguarded against the risk of abuse as current guidance was not available for staff to ensure that any safeguarding concerns were acted on.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The register provider was not operating an effective recruitment process. Recruitment files did not contain all the required information as specified in Schedule 3 of the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered provider did not have suitable arrangements in place to ensure that staff had received appropriate training, including specialist and induction training.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person had not made suitable arrangements in obtaining and acting in accordance with

This section is primarily information for the provider

Action we have told the provider to take

the consent of the person in relation to their care. There was no evidence to show how people had consented to their care and staff were not aware of their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered provider had not ensured that people were protected from the risks of inadequate nutrition. There was a lack of menu choice and people's individual nutritional needs were not being monitored to ensure they received the dietary needs effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered provider had not made suitable arrangements to make sure that at all times people's dignity was maintained.

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
	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure that each person was protected against the risks of receiving care or treatment that was inappropriate or unsafe. Risks assessments lacked guidance for staff to manage risks effective and safely. People's health care needs were not being monitored or detailed in the care plans effectively to ensure they received the care they needed.

The enforcement action we took:
A warning notice was issued to the provider requiring that they take action to ensure that people were protected against the risks of receiving care or treatment that was inappropriate or unsafe by 30 January 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person had not protected people against the risks associated with unsafe use and management of medicines. There were shortfalls in the management of the medicines with regard to storage, administration, recording and disposal of medicines.

The enforcement action we took:
A warning notice was issued to the provider requiring that they take action to ensure that people were protected against the risks associated with unsafe use and management of medicines by 30 January 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered provider had not protected people and others against the risks of inappropriate or unsafe care and treatment. The service had not been regularly

This section is primarily information for the provider

Enforcement actions

assessed and monitored. There was a lack of audits to check the quality of care being provided and manage the risks relating to the health, welfare and safety of people and others using the service. The fire procedures had not been followed and there was a lack of maintenance to show how the premises were being maintained safely.

The enforcement action we took:
A warning notice was issued to the provider requiring that they take action to ensure that effective systems were developed to assess and monitor the quality of the service provided and to identify, assess and manage risks relating to the health, welfare and safety of people by 30 January 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered providers had not protected people against the risk of unsafe and inappropriate care arising from the lack of proper records. Records were not accurate, were not easily accessible or up to date and in good order.

The enforcement action we took:
A warning notice was issued to the provider requiring that they take action to ensure that people were protected against the risk of unsafe and inappropriate care arising from the lack of proper, up to date and accurate records by 30 January 2015.