Winnie Care (Brantwood Hall) Limited

Brantwood Hall 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?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

The inspection of Brantwood Hall took place on 11 February 2015 and was unannounced. We previously inspected the service on 18 September 2013 and, at that time; we found the provider was not meeting the regulations relating to care and welfare and records. We asked the provider to make improvements. The provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulations. On this visit we checked to see if improvements had been made.

Brantwood Hall is a care home currently providing care for up to a maximum of 60 older people. The home consists of two separate houses, numbers 12 and 14, located in the same grounds, providing care and support for people with residential needs including people who are living with dementia.

The service had a registered manager in place. 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 the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

We found that people were being put at risk because robust procedures and arrangements were not in place to keep people safe. Incidents, which had the potential to become an abuse or safeguarding issue were not investigated. There were issues with the safety of the premises including a fire door which was difficult to open, poor standards of cleanliness and infection control and a lack of equipment.

There were not enough staff available to meet people's care needs.

People did not always receive their prescribed medicines and where errors where identified, there was no evidence that appropriate action had been taken.

This demonstrates breaches of regulations 11, 12, 13, 15, 16, 21 and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 13, 12, 15,19 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had not been recruited safely and staff training was not up to date. We were unable to evidence some staff had received induction training when they commenced employment.

The registered manager told us they did not complete any assessments of peoples mental capacity and we were unable to evidence from peoples records that staff were acting in accordance with peoples likes and preferences.

The menus offered a limited choice of hot food for people. We saw people did not receive their lunchtime meal in a timely manner. Peoples food records did not evidence they were receiving adequate nutrition and hydration to meet their needs.

These examples demonstrate breaches of regulations 14, 18 and 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 14, 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence that staff had got people who were not able to manage their own care needs up and out of their beds and prepared for the day at 4am. People were not always protected against the risk of developing pressure sores.

During the inspection we observed staff rarely offered people choices or enabled them to make decisions about their everyday lives.

These examples demonstrate breaches of regulations 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Peoples care and support records were inaccurate and did not reflect the current care and support needs.

There was no system in place to record or monitor complaints.

These examples illustrate breaches of regulations 19 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 16 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

There was a lack of robust and effective monitoring in place to ensure the service provided safe, effective and responsive care. There was no evidence the registered provider or the registered manager assessed or monitored the quality of the service which was delivered to people.

These demonstrate breaches of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

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?
The service was not safe.

People were not adequately protected from the risk of abuse or harm.

People were at risk of serious injury or harm due to a failure to ensure the premises and equipment were safe, clean, suitable and well maintained.

The registered provider did not have a robust recruitment procedure in place and there were not enough staff to meet people's needs.

People who used the service were not protected against the risks associated with medicines.

Inadequate

Is the service effective?
The service was not effective.

There was no evidence that staff received appropriate or adequate training or that new staff were supported in their role.

Staff had not received any training in the Mental Capacity Act 2005. The registered manager told us they did not assess people's capacity.

People did not always receive their food and drinks in a timely manner. There was a limited choice of food available for people.

Inadequate

Is the service caring?
The service was not caring.

People who lived at the home told us staff were caring, however, we saw numerous examples where staff did not respect people's right to make choices and decisions about their everyday lives.

Staff spoke over people and did not involve them in their conversations.

Inadequate

Is the service responsive?
The service was not responsive.

People were not protected from the risks of unsafe or inappropriate care and support because accurate records were not maintained.

There was no evidence in peoples care records which indicated people received care and support to meet their individual preferences.

The registered manager told us they had not received a formal complaint since November 2011, they also told us verbal concerns were not logged.

Inadequate

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

The registered manager demonstrated little understanding of their responsibilities as registered person under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were no effective systems in place to monitor the quality of the service.

There was no effective monitoring system in place to ensure the premises and equipment were safe, clean, hygienic and well maintained.

Brantwood Hall 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11 February 2015 and was unannounced.

The inspection team consisted of three adult social care inspectors and an expert by experience.

An expert-by-experience is a person who has personal experience of using or caring for an older person who uses this type of care service.

Prior to our inspection we reviewed information from notifications, the local authority commissioners and safeguarding. We had received information of concern from the environmental health and infection prevention and control teams and from an anonymous source. The concerns were regarding the cleanliness and suitability of the premises and equipment, a lack of personal protective equipment and inadequate staffing. We had not sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the lounge and dining room areas observing the care and support people received, inspected the premises, reviewed care records for four people and examined a variety of documents which related to the management of the home. We spoke with eight people who lived at the home and four relatives who were visiting. We also spoke with the registered manager, an administrator, two senior carers, three care assistants and four ancillary staff.

Inadequate

Is the service safe?

Our findings

All the people we spoke with told us they felt safe. One person said, "I like to keep my door unlocked and open because I feel safe".

We asked four staff about their understanding of safeguarding people from harm and abuse. They were able to describe a number of different types of abuse. One member of staff said, "It can be mistreating people, being too rough". Staff told us they would report any concerns to a member of senior staff or the registered manager. One member of staff told us they were also aware they could escalate their concerns to the local authority or CQC.

We looked at the registered providers' training matrix, this indicted safeguarding training was to be updated annually. We saw that of the 63 staff listed on the training matrix, there was no record that four staff had received any safeguarding training and no record that a further 16 staff had received refresher training for over twelve months. This meant that not all staff had up to date knowledge to enable them to identify the potential for abuse or harm.

In one of the care records we looked at we saw two entries relating to bruising. One entry recorded bruising to the palms of persons' hands and the second recorded bruising to their arms. Neither of these entries were dated and there was no record of how this bruising had occurred. There was no documented evidence this unexplained bruising had been investigated or referred to the local authority safeguarding team. This meant these two incidents, which had the potential to become an abuse or safeguarding issue had not been effectively recorded and investigated. We asked the registered manager to make a referral to the local authority safeguarding team. This meant that someone external to the service will look at the concern we have raised.

This demonstrated a failure to ensure that people living at the home were protected against the risks of abuse. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this visit we made an inspection of the premises. This included looking in some people's bedrooms, communal bathrooms and toilets, lounge and dining areas, the laundry and kitchen.

In one of the houses we saw a number of concerns relating to fire safety. For example, in one house we saw a fire door at the entrance to a staircase was propped open by a fire evacuation chair. We also saw a number of bedroom doors which were wedged open with furniture. We asked the administrator to open a fire door on the top floor of one of the houses. The door could not be opened with ease. As a result of our concerns regarding fire safety, we contacted the fire authority the day after our inspection and requested they visit the home. The fire authority visited the home on 12 February 2015 and found Brantwood Hall was not fully compliant with The Regulatory Reform (Fire Safety) Order 2005. They advised that action was required relating to fire escape routes, emergency lighting and the registered provider's fire risk assessment.

We also found a number of doors marked 'out of use' were not locked. For example, the door to the boiler house and the laundry room was not locked. The laundry room led to the maintenance room where cleaning fluids and tools were stored. This was all easily accessed by anyone who was in the building. We also noted access to some stone cellar steps did not have restricted access. This meant people were at risk of serious injury and harm as access to potentially dangerous areas was not restricted. We brought this to the attention of the administrator while they were showing us around the building.

In one person's bedroom we saw the glass in the window was cracked. We spoke to the person whose room it was and they said a member of staff had cracked the window when they had closed it. The registered manager said she did not know when the damage had occurred, they said it had only been reported for repair on the day of our inspection.. Following the inspection we asked the registered manager to confirm when the damage to the window had occurred. They told us 'December 2014. This meant the person in this room and other people who had access, had been at risk of injury or harm from unsafe glass for a period of over six weeks.

We also tested the water temperature at a number of hot water outlets. Each of the outlets we tested recorded a low temperature. For example, in one bedroom the hot water temperature at the wash basin was 24 degrees C and there was no plug available. The administrator said the person who occupied this bedroom washed at their wash basin. The bath water temperature in one of the bathrooms was 37 degrees C. This showed people were washing and

bathing in water which was tepid in temperature and may have made bathing an unpleasant experience. We brought this to the attention of the registered manager on the day of our inspection.

A shower enclosure door in one of the houses was found to be broken and screws were sticking out. We also saw a washbasin in a shower room was cracked and stained. A number of carpets were showing signs of wear and tear. We saw the carpet had been taped over in two places. This showed the registered provider did not have a system in place to ensure the premises were suitably maintained.

This demonstrated that the provider had failed to ensure residents and others who had access to premises were protected against the risks associated with unsafe or unsuitable premises. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found equipment was not safe or adequately maintained. For example we saw a shower chair in shower room which was rusty and had a 'foot' missing. In one house we saw the hoist had foam and tape wrapped round part of it. Staff told us this was padded 'to prevent injury to people'.

A member of staff told us, in one of the houses there was only one hoist and one sling. They said slings were not used on an individual basis, 'just used for whoever needs it'. They added if staff need a different sized sling they would either 'go to the other house and borrow a sling or just or manage with what they'd got, whether it's the right size or not'. This demonstrated staff where not ensuring they were using the hoist sling which was most appropriate to people's assessed needs. This could put people's safety at significant risk. The member of staff said when the hoist was in use, other people who may need it had to wait. This showed the registered provider had not ensured there were adequate supplies of equipment available to meet resident's individual needs.

We also saw a person being moved in a wheelchair with no footrests. When we asked a member of staff why there were no foot rests on the wheelchair they told us the person's legs 'don't bend and they slip off the footrest'. We looked at the care plan for this person but could not see a risk assessment or recorded evidence to corroborate what the member of staff had told us.

This demonstrated a failure to ensure an adequate supply of equipment and failure to ensure that equipment provided is properly maintained and suitable for its purpose. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our inspection of the premises we found a number of serious concerns which evidenced a lack of regard to effective management of infection prevention and control procedures. We found a number of bedroom carpets were stained and malodourous. For example, the carpet in two bedrooms was heavily stained with faeces. We also found a number of toilets, sluices and commodes which were soiled and stained.

In one house we found a number of upstairs rooms which were unoccupied. They were seen to be very dirty with a build-up of dirt, debris and dead insects. In one of the bedrooms we saw the walls were stained with what appeared to be damp. There were three mattresses and two bed bases also in the room. They were all stained and one of the mattresses was torn open.

In one of the sluice rooms there was no personal protective equipment available for staff. One of the bathrooms we looked at had no toilet paper available. We saw a paper towel had been put down the toilet. We also saw there no paper hand towels in a communal toilet.

We saw a number of duvets and pillows in the laundry cupboard, however, none of these were made of impermeable material. In a bathroom we saw staff had placed clean laundry on top of a dirty linen skip. This evidenced there was a lack of effective systems in place to reduce the risk and spread of infection.

When we went in one of the bedrooms, we turned the bedding back. We saw the bed had been made with soiled sheets and the fabric mattress cover was stained. We left the bed covers turned back to enable staff to change the sheets. We checked the bed a short time later and saw the bed had been made but the sheets were still soiled. We left

the bed covers turned back again. When we checked the room approximately five hours later, we found clean sheets were on the bed but the stained mattress cover had not been replaced.

This demonstrated a failure to maintain appropriate standards of cleanliness and hygiene. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the personnel files two staff. We found the registered provider did not have a robust system in place to ensure staff had been thoroughly checked before they commenced employment. In one of the files we looked at we saw the personnel file did not contain a DBS (Disclosure and Barring) check. The second personnel file only contained one reference. This meant staff working at the home had not been properly checked to make sure they were suitable and safe to work with vulnerable people. We spoke to the administrator about these issues on the day of the inspection and they assured us they would take the appropriate action to address these issues.

This demonstrated a failure to operate effective recruitment procedures. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person we spoke with said, “I feel there are enough staff on at evenings and weekends, when I press the buzzer the carers come quick.

Two of the staff we spoke with told us they did not think there were enough staff to meet people’s needs. A member of staff in one of the houses told us, ‘There are not enough staff here to give people what they need’. They said people had to wait to be attended to and staff only had time to attend to people’s care tasks, there was no time to socialise or listen to people. We asked another member of staff from the other house how many staff were on duty during the day. They said, “Occasionally a senior carer and three care staff but it is usually a senior carer and two care staff”. We also asked the member of staff how many people needed two staff to support them in meeting their needs. They told us in one of the houses, there were six or seven people in the house who required two staff to support them. This meant that when the senior carer was administering medicines or dealing with other health care professionals and two staff were supporting a person with their needs, there were no other staff available to meet the needs of the other people.

We looked at the duty rota for the home. We saw there were two staff on duty from 10pm until 8am in each house. A member of staff said that in one of the houses, there were two or three people who, in the event of a fire, would be unable to use the stairs and would need two staff to help them in the event they needed to evacuate their rooms. This meant people may be put at risk due to a lack of adequate staff to support them in the event of an emergency.

We observed lunchtime in one of the houses. We saw the dining room was frequently unattended other than catering staff. We saw some people began to sit at the dining table for lunch from 12.15 onwards. Lunch did not begin to arrive until 12.40 and we saw some people begin to grumble about waiting too long. We saw some other people who could not verbalise became restless and agitated. For example we saw one person used a spoon to feed them self from juice glass, another person poured salt onto the table, licked their fingers and began tasting the salt. After lunch a number of people were still sat at the dining table at 13.45. This demonstrated there were not enough staff to ensure people received their lunch in a timely manner and people were not protected from the risk of harm.

At 17:45 on the day of the inspection, we saw there were no staff available on the middle floor of one of the houses. We found a person who lived at the home in the hall way in a distressed state, crying out for help. The person believed they were locked out of their home and they were frightened and confused. We noted there were also eight other people seated in the lounge with the TV on. Another person came out of their bedroom in their nightclothes and asked for a member of staff to come and help them. We found a member of staff administering medicines on the top floor at 6pm. We asked them where the other members of staff were. They said there were two other members of staff and they were attending to people, assisting them to go to bed. The staff member told us it was not unusual for the middle floor to be unattended. We asked the registered

manager what would happen if there was an emergency, for example, if a person fell, when there were no staff in the vicinity. The registered manager made no response to this question.

This demonstrated there were not enough staff on duty to safeguard the health, safety and welfare of residents. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of our inspection we looked at how the service managed people's medicines. We looked at two medicines audits which were dated 4 and 29 December 2014. We saw a number of instances had been highlighted on these two audits where medicines had been signed as administered but the records indicated the person had received the medicine. For example, one persons' medicine had not been administered on eight occasions. Another person had not received one of their medicines on three occasions and had not received their prescribed analgesia on five occasions. We asked registered manager what action had been taken as a result of these errors being identified. They told us the findings had been discussed in a staff meeting and at staff supervision. The registered manager told us no referral had been made to the local authority safeguarding team and no staff had been disciplined. We asked if further audits had been undertaken since 29 December 2014. The registered manager said another audit had been commenced the week of our inspection. This meant that despite a high number or errors having been identified six weeks prior to our inspection, no other audit check had been made by the registered manager to ensure people were receiving their prescribed medicines appropriately.

We looked at the controlled drug (CD) register which was kept by the home. We saw the CD register had been completed on 10 February 2015 at 9pm and 11 February 2015 at 9am. Both these entries had only been signed by the member of staff who administered the medicine and had not been countersigned by a second member of staff.

We looked at the registered provider medicines policy. This recorded that two staff were to sign the CD register. This evidenced staff were not complying with the registered provider's policy for administering medicines.

Three people were prescribed Alendronic Acid. These tablets must be taken before the first food or medicines of the day and given 30 to 60 minutes before food. We looked at the medicine administration record (MAR) for one person who was prescribed this medicine. We asked a senior care assistant what time this medicine was administered, they said 'it was usually about 11am' when this person received their medicine'. This meant this person may be receiving medicine which is not effective.

When we checked the MAR for another person we saw one of their medicines was prescribed once daily at night. We saw the MAR had been signed to indicate the medicine had been given every night from 30 January 2015 to 10 February 2015. The MAR recorded staff had received 28 tablets and the medicine had been signed as administered for twelve consecutive nights. This should have left a balance of 16 tablets. When we checked the stock there were 19 tablets remaining. This meant this person had not received their prescribed medicine on three occasions.

We saw a number of people had topical applications in their bedrooms. We asked a senior care assistant who applied these medicines. They said the care staff who supported the individual would apply the creams and the senior care staff who was administering the medicines would sign the MAR to confirm the cream had been applied. We asked the senior carer how they knew staff were correctly applying the medicines they were signing for. They said, "We trust they do it". This meant there was a risk a number of people were not receiving their topical medicines as prescribed.

This demonstrated a failure to protect residents against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

We spoke to people about the meals they were served at the home. Their comments included, "The food is good we get enough vegetables", "The carers bring my tea up to my room on a tray" and "The food is hot sometimes we get vegetables".

We also asked four people if they were enjoying their lunch time meal. One person told us 'it is horrible, it is corned beef, it is cold and it did not look appetising'. A member of staff asked them if they would like something else to eat, they asked the member of staff if they could have soup. The staff said they did not have any soup. They also asked for a banana but the member of staff said they did not have any bananas.

We saw a person with a plate of salad in front of them. We saw the salad comprised of tuna, limp lettuce, a couple of slices of cucumber and a few bits of yellow pepper. We asked the person if it was nice, they replied, "I don't even like tuna". This indicated staff had not ensured this person had been provided with a meal they would enjoy eating.

A member of staff told us people had a poor choice of food. They said corned beef hash was frequently on the menu and there were very few alternatives for people. We looked at the menu sheets for the home. On fifteen of the 24 days menu's there was no second 'hot' option listed for lunch. For seven of the 24 days menu there were no hot puddings listed for lunch. Corned beef hash was listed on four of the 24 menus sheets. This showed people were offered a limited choice of hot food.

In one of the houses we saw someone still in bed at 13.30, they appeared to be asleep and there was no indication they had been served any lunch. We asked a member of staff about this person. They said they 'served people in the dining room first and then we see to the others'. This meant this person had not received their lunchtime meal in a timely manner.

We heard another person shouting out, asking for a drink. When we entered their bedroom, they said they were very thirsty. We saw half a cup of cold tea was in the bedroom. We checked the food record for them and saw that no fluid had been recorded since the previous day. This meant we were unable to evidence they had been offered or had received regular drinks.

This demonstrated a failure to protected people from the risks of inadequate nutrition and dehydration. This also demonstrated a failure to ensure people are provided with an adequate choice of nutritious food which meets their individual needs and preferences. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us they had received supervision. One member of staff we spoke with told us they had recently received supervision with the deputy manager. This showed there was a system in place to ensure staff received regular management supervision.

We looked to see how new members of staff were supported in their role. One member of staff told us they had recently commenced employment at the home. They said they had shadowed a more experienced member of staff when they had begun to work at the home. We looked at the personnel file for this staff member and saw a document 'staff induction and training programme'. We saw the only section which had been completed was 'admin day one'. We also looked to see what training they had completed. The only evidence was a completed test sheet for fire training and infection control training. This meant we were unable to evidence this person had been adequately supported and trained when they commenced employment.

Staff we spoke with told us they had completed training in a variety of topics. This included, moving and handling, fire and safeguarding. When we looked at the individual training records for two staff we found their refresher training was not up to date. The registered provider's records indicated that moving and handling, fire and safeguarding required an annual refresher. However, the training record for one staff member evidenced they last completed safeguarding training in April 2012 and fire safety in June 2013. We also looked at the training records for another member of staff and saw they last updated their moving and handling in September 2013.

We also noted from the training matrix that many of the 63 staff listed on the matrix were not up to date with their training. For example, 18 staff had not updated their moving and handling training for over twelve months. The matrix did not detail the frequency staff should update their infection prevention and control training, however,

Is the service effective?

there was no record that nine staff had received any training in this subject and 11 staff had not refreshed this training for over two years. This evidenced staff had not received appropriate training to enable them to fulfil their job role and keep people safe.

We asked the administrator if the senior care staff who administered medicines had their competency assessed. They said some staff had been assessed but they were unable to provide evidence of this. We saw from the duty rota that eight staff were listed as senior care staff. The training matrix did not indicate how often staff should update their training in medicines management, however, the matrix recorded that five of these staff, including the registered manager had not updated training for over two years and there was no evidence one of the senior staff had completed any medicines training.

This demonstrated a failure to have suitable arrangements in place to ensure that staff were appropriately supported. This also demonstrated a failure to ensure staff received effective training in relation to their responsibilities, to enable them to deliver effective care and support to people. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

When we asked the registered manager about this subject they were unable to demonstrate an understanding and knowledge of the requirements of the legislation. One of the staff we spoke with told us they had not received any training in MCA and DoLS. We asked this staff member if they could describe how the mental capacity act impacted upon their role and they could not. We saw from the training matrix that MCA and DoLS were not listed on the matrix as a training course which was provided for staff.

We looked at the care records for four people. We found there was no process or documentation evident to address issues in relation to obtaining consent from people for the care and support they received or to evidence staff were acting in accordance with people's wishes. We asked the registered manager if care was provided to any person who lacked capacity. They said some of the people who lived at the home did have dementia but no mental capacity assessments had been completed for any one at the home.

This demonstrated a failure to comply with the requirements of the Mental Capacity Act 2005.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

A member of staff we spoke with told us how they accessed the district nursing service and the GP. This showed this member of staff was aware of how to access external healthcare support for people who lived at the home. We saw from people's records they had received input from the GP and district nursing service. This evidenced people using the service received additional support from external healthcare professionals.

Inadequate

Is the service caring?

Our findings

Our inspection on 18 September 2013 found the provider was not meeting the regulations relating to the care and welfare of people who use services. On this visit we checked and found improvements had not been made.

All the people we spoke to said the staff were caring and compassionate. One person said, "The carers are very kind and compassionate. I had to go for an appointment at the hospital and one of the carers took me, my (relative) was in the same hospital and the carer suggested we go and see them, it made me very happy". Another person said, "If I want something the carers will get it for me".

During our inspection we saw a person sitting in a communal lounge. They were sat under an open window and had a blanket wrapped around them. We could feel a cold draught coming through the window. We asked a member of staff if this person was able to walk, they said they could not. This meant staff had not ensured this person's comfort or protected them from the risk of hypothermia. We brought our concerns to the attention of a member of staff on duty.

When we looked in one bedroom we saw an airwave mattress on the bed and an airwave cushion on the easy chair. We checked to see if the person whose room it was, had been provided with a pressure reducing cushion when they were in the dining room. We saw they were not. This meant staff had failed to protect this person against the risk of developing pressure ulcers.

At 11.05am we looked at the care chart for one person who was being nursed in bed. The chart recorded 'full wash and change', this was dated 11 February 2015 at 5am. No further entry had been made on the chart to indicate this person had received any further care from staff. We also noted from another care charts that staff had given the individual their daily wash at 4am on 8 February 2015. Another person's 'turning' chart recorded 'up washed and dressed' at 04.40am on 31 January 2015. We asked two members of staff if this person was able to make a choice about the time they got out of bed. Both staff said staff would make that choice for them. In one person's daily records we saw evidence they had refused a bath on 28 January 2015 and 1 February 2015. However, from 1 January 2015 to 11 February 2015 we could not see any recorded evidence they had received a bath or a shower within this time frame. This evidenced people were not receiving care and support which was appropriate, safe and met their individuals need.

This evidenced a failure to ensure that care and support was planned and delivered to meet the individuals need. This demonstrated a continual breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care and support records we looked at did not evidence that people who lived at the home were involved in the development or review of the care plan. This meant we were unable to evidence that people had been consulted about the care and support provided for them.

We asked staff how they maintained people's privacy and dignity. Staff told us they closed curtains and bedroom doors. One member of staff told us, "We knock before we go in their rooms". A person who lived at the home told us, "When I am having a bath they (staff) treat me with dignity and respect". Another person said, "There is no restriction on anything I do, and I make my own choices". However, during the course of our inspection we saw numerous examples of staff failing to maintain people's dignity and not enabling them to making simple life style choices.

A member of staff was observed supporting a person to walk along the hall way. The persons' trousers were not pulled up properly and their jumper had 'ridden' up their back. This meant parts of their back and bottom were exposed. This meant staff had not ensured this person's dignity was maintained.

While staff were supporting people to the dining table for lunch, we observed people being moved in wheelchairs without consultation. Staff positioned people's wheelchairs at the dining tables with no discussion about where they may wish to sit. We observed one member of staff place a person in a wheelchair on an area of the floor and then walk away. The member of staff did not provide any explanation to the person or say when they would return. After a period of 15 minutes a member of kitchen staff moved the person in their wheelchair and placed them at a dining table. We did not hear the member of kitchen staff consult the person about where they may prefer to sit.

Inadequate

Is the service caring?

We also saw a member of staff place a glass of blackcurrant juice in front of a person without offering them a choice. We heard the person ask, “What is it?”. The member of staff replied, “Juice” and walked away. We saw some people were not given a choice about the food and drink presented to them. This showed staff were not actively supporting people to make choices and decisions about their preferences.

We heard staff consistently talking over people's heads. For example, 'put her on that table' 'I'll do him next' 'she needs toileting so I’ll go get her'. Staff did not speak with people discreetly, for example, one member of staff said to another member of staff, very loudly 'she's off to the toilet'. While staff were supporting people to the dining table for lunch and serving the lunch, they were observed to be interacting with each other and not with the people they were supporting, talking about their plans for the weekend for example, ‘so are you off out on Friday then?’ ‘no, I’m working’.

This evidenced people’s dignity and independence was not respected by staff. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Our inspection on 18 September 2013 found the provider was not meeting the regulations relating to records. On this visit we checked and found improvements had not been made.

In each of the care and support records we looked at we found they lacked adequate detail about the person's individual care and support needs. For example, we found the mobility care plan for one person recorded they needed to be transferred with a hoist however, there was no detail recorded about which sling staff should use. The care records also recorded that they needed staff to help to change their position while in bed. We found conflicting information as to how often they needed this support. One entry stated they needed support to change position every hour, however a further entry recorded they were to be turned four hourly at night. We also saw entries in their daily records which referred to them being turned every two hours at night. This meant the care records did not provide staff with clear directions for this persons care and support needs.

We saw a record which detailed a person was 'medium risk for mobility' however, the registered manager told us this person was confined to bed and needed two staff for all moving and handling. In another person's care record we saw their personal hygiene care plan recorded 'can become agitated and hit out at staff'. We could not see any detail about how staff should manage this situation to enable the persons' needs to be met. This evidenced people were at risk of unsafe or inappropriate care because care records lacked accurate and consistent details for staff to follow.

In another record we looked at, we saw the person's eating and drinking care plan recorded, 'requires carer to support eating and drinking' however, there was no detail recorded as to what support the person needed. There was also an entry in the care plan which documented they had attended for an x-ray on 10 November 2014 and that further investigation was needed. The records did not evidence what the x-ray was for or what further investigation was required. This meant we were unable to evidence this person had received the care and treatment they needed.

We also saw a 'falls record' had been commenced 1 January 2015 for one person. This document was blank, despite the daily records evidencing they had fallen on 9 January 2015, 17 January 2015 and 20 January 2015. This showed staff were not ensuring peoples' records were an accurate reflection of their on-going needs.

We noted in each of the care records we looked at that not all the records had been reviewed monthly. We also noted that staff had recorded 'no change to care plan' on the majority of the records we looked at. This demonstrated staff were not using the monthly review as an opportunity to review and update the records to ensure they were current and reflective of the person's current care and support needs.

This demonstrated a failure to protect people against the risks of unsafe or inappropriate care because up to date and accurate records had not been maintained. This demonstrated a continual breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they knew how to make a complaint. A relative we spoke with told us "We visit my (relative) every day we can come any time, my (relative) has been here for 17 years and we have never had to make a complaint". A person who lived at the home said "If I had a complaint I would go to the manager".

We asked the registered manager if the service had received any complaints. They said no complaints had been received since 24 November 2011. We asked registered manager if verbal concerns were logged, they said they were not. The registered manager told us the person would have to say they 'wanted to make an official complaint' in order for it to be logged and recorded. This meant we were unable to evidence that where a person raised a concern they would be listened to and their concerns acted on.

This demonstrated the registered provider had no effective system in place to identify, receive, handle and investigate complaints. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection, in one of the houses, there was a clothes party being held. This enabled people to choose

Inadequate

Is the service responsive?

items of clothing to purchase from a selection which had been brought into the home. We asked one member of staff about the activities offered at the home. They told us the activity programme included quizzes, bingo and dominoes. When we spoke with people who lived at the home, one person told us, “There is nothing going on and nothing to do”. Another person said, “The priest comes in every week to give me holy communion”. Having a varied and person centred programme of meaningful activity for people can enhance wellbeing and feelings of self-worth.

Inadequate

Is the service well-led?

Our findings

All the people we spoke to knew who the manager was and spoke positively about her. They all felt she was very approachable. People told us they thought the home was well led. One relative told us, "The home is well run". One member of staff told us they felt the manager was supportive and approachable. Another member of staff said, "The managers do not know what is going on and don't take the time to find out".

The home's registered manager had been in post for over ten years, however, when we spoke with them they demonstrated little understanding of their responsibilities as the registered person under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found there were no effective systems in place to monitor the quality of the service. We found the home was poorly organised. The staff team had not been monitored to ensure they displayed appropriate values and behaviours towards people who lived at the home.

Prior to the inspection we received information from the local environmental health officer of three accidents to people who lived at the home for which referrals to RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) had been made. Due to the nature of the injuries sustained by these three people, the registered manager had a duty, to notify the Commission (CQC) without delay, of any serious injury to people who lived at the home. We were not provided with any evidence to suggest the registered manager had notified CQC of these accidents. This demonstrated the registered manager had failed to comply with their legal responsibilities.

We asked the registered manager how they analysed people's accidents and incidents. They told us they did not. This meant the registered manager had failed to conduct an analysis of incidents that resulted in, or had the potential to result in, harm to people who lived at the home.

When we looked at the management systems we were unable to see evidence that effective, robust systems where in place to monitor and assess the quality of the service provided to people. The registered manager told us the registered provider had visited the home the 'previous month', but they said no audits had been completed by the registered provider 'within the last twelve months'. When we asked the registered manager if they completed a 'daily walk around' of the home to enable them to monitor the premises, staff and service provision, they told us they did not.

We looked at a document which detailed the night staff cleaning tasks. This included laundry duties, cleaning the toilets and bathrooms, cleaning the kitchen the communal lounges and dining room. The registered manager confirmed this list detailed the cleaning the night staff should complete each night. The issues we had seen when we inspected the premises evidenced this cleaning was not being completed.

We had been informed by the local authority's infection prevention and control nurse that a recent inspection conducted by them had raised significant concerns. The administrator told us they were Brantwood Hall's infection prevention and control (IPC) link with the local authority and went to the IPC meetings. They said they had not completed an infection control audit since 'approximately June 2014'. The registered manager showed us a 'general maintenance and IPC audit' that had been completed by two staff on 2 February 2015, however, this audit failed to identify the serious concerns we had raised during our inspection. This demonstrated there was no effective monitoring system in place to ensure the premises and equipment were safe, clean, hygienic and well maintained.

We looked at the audits which had been completed by a member of staff on the air wave mattresses that were in use within the home. There was no criteria detailed to advise staff what they were checking for or what may indicate a 'concern' or a 'fail'. The record was just marked 'F', 'P' or 'n/a'. We saw an audit had been completed for the pressure cushions but this did not record the detail as to which house it was in relation to. The registered manager told us no one was responsible for checking that the other mattresses used within the home were of a satisfactory standard. This evidenced there was no system in place to ensure that all the mattresses within the home were safe, clean and fit for purpose.

We saw the registered manager did not have a system in place for gaining the views of people who used the service and people involved in the service. The registered manager told us the last quality survey had been issued 'the Christmas before last'. We asked to see the minutes of resident and/or relatives meetings. The registered manager told us the most recent meeting had been held in

Inadequate

Is the service well-led?

December 2014. We asked to look at the meeting minutes but the only minutes were from a meeting held over the summer months. Therefore we were unable to see what issues were discussed and if, where applicable, appropriate action had been taken to address any issues raised.

These examples demonstrated a failure to identify, assess and manage risks relating to the health, welfare and safety of people who live at the home and others who may be at risk from the carrying on of the regulated activity. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Inadequate assessment, planning and delivery of care which does not meet the individual service user's needs and ensure the safety and welfare of the service users.

The enforcement action we took:
Notification of Proposal to cancel the registration to be issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services were not protected from unsafe or inappropriate care as the registered person did not regularly assess and monitor the quality of services provided. Risks were not identified, assessed or managed.

The enforcement action we took:
Notification of Proposal to cancel the registration to be issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Lack of effective processes to ensure that people are protected from risk of abuse by means of taking reasonable steps to identify the possibility of abuse before it arises and responding effectively to any allegations of abuse.

The enforcement action we took:
Notification of Proposal to cancel the registration to be issued.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used the service were at risk from living in a home where appropriate standards of cleanliness and hygiene were not being maintained.

The enforcement action we took:
Notification of Proposal to cancel the registration to be issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Lack of systems and processes in place to ensure that residents are protected from the risks associated with the unsafe use and management of medicines.

The enforcement action we took:
Notification of Proposal to cancel the registration to be issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People were not protected from the risks of inadequate nutrition and dehydration.

The enforcement action we took:
Notification of Proposal to cancel the registration to be issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Lack of assurance that appropriate measures were taken to maintain the premises to ensure people's safety.

The enforcement action we took:
Notification of Proposal to cancel the registration to be issued.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person had not made suitable arrangements to ensure the dignity, privacy and independence of service users; and that service users were enabled to make, or participate in making, decisions relating to their care or treatment.

The enforcement action we took:
Notification of Proposal to cancel the registration to be issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

The enforcement action we took:
Notification of Proposal to cancel the registration to be issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Lack of effective systems in place for receiving, handling and responding to complaints.

The enforcement action we took:
Lack of effective systems in place for receiving, handling and responding to complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People were not protected against the risks of unsafe or inappropriate care and treatment because accurate and proper records were not maintained.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
Notification of Proposal to cancel the registration to be issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Lack of effective recruitment procedures in place to ensure the safe recruitment of staff .

The enforcement action we took:
Notification of Proposal to cancel the registration to be issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Insufficient numbers of staff to safeguard the health safety and welfare of service users in the home.

The enforcement action we took:
Notification of Proposal to cancel the registration to be issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Lack of suitable arrangements in place to ensure that staff employed at the home are adequately supported in relation to their responsibilities to enable them to deliver effective care to service users safely and to an appropriate standard.

The enforcement action we took:
Notification of Proposal to cancel the registration to be issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Suitable arrangements were not in place to ensure that equipment was properly maintained and fit for purpose.

This section is primarily information for the provider

Enforcement actions

Equipment was not available in sufficient quantities.

The enforcement action we took:
Notification of Proposal to cancel the registration to be issued.