Nellsar Limited

Bromley Park Dementia Nursing Home

Inspection report

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Date of inspection visit:
07 April 2017
10 April 2017
12 April 2017

Date of publication:
30 May 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 07, 10 and 12 April 2017 and was unannounced. At the last comprehensive inspection on 07 and 08 October 2014 the home was rated good.

Bromley Park Dementia Nursing Home is registered to provide accommodation and nursing care for up to 50 people with dementia. On the day of the inspection there were 37 people using the service. Since the last inspection there had been some changes in the management team at the home. At the time of this inspection there was no registered manager or deputy manager in place. The previous registered manager had left the home in October 2016. A new manager had been appointed and had left in January 2017. Another new manager had been appointed and had just started work at the home in March 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found considerable concerns about the systems used to assess and monitor risk which had impacted negatively on people's care. Quality assurance checks were not effective at identifying the concerns we found. We identified problems that had arisen prior to the new manager's arrival which impacted on the current safe running of the home. We found a serious breaches of regulations around the governance of the home. Following our inspection we raised concerns about our findings with the local authority and CCG.

The provider's systems had not always alerted them to the concerns we found. However, during the inspection the manager and operations manager took prompt action to address the more serious risks we found. The provider and manager were open about the concerns and issues found, and demonstrated a commitment to address them promptly and effectively. The manager had identified some issues since starting work at the service, in particular about medicines management and staff competency. We saw that they had already taken some action to address the concerns; however we were unsure that these had been embedded into staff practice. Following the inspection the provider sent us an action plan which included a system of support for the manager to ensure they could start to embed good practice across the home.

We also found further breaches of regulations as people were not always protected from neglect, some areas of medicines management, such as medicines that may need to be administered covertly, were not safely managed. Other areas of risk to people were not always assessed or action taken to reduce risk. There were not always enough staff to meet people's needs and staff did not always have sufficient training to be able to meet people's need safely. Care plans had been recently reviewed; however, they were not always reflective of people's needs and staff were not always aware of what people's current needs were. People or their relatives told us they were not always involved in the planning of their care. You can see the action we have asked the provider to take in respect of these breaches at the back of the full version of this report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports

after any representations and appeals have been concluded.

There were areas for improvement as we observed that people were not always treated with sufficient dignity and respect.

The overall rating for this service is 'Inadequate' and the service is therefore 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we may take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we could take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

We also found there were some good elements to the care provided at the service. People and their relatives told us that staff were kind and caring and knew people well. We saw some warm and friendly interactions between people and staff across the home. People were observed to be clean and well presented.

People had access to a suitable range of health care professionals and two health professionals gave us positive feedback about their contact with the home. Staff sought consent from people when offering them support. The home followed the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), where people had been assessed as lacking capacity to make certain decisions about their care and treatment.

There was a complaints system readily available and responses had been made in line with the provider's policy. Annual surveys and relatives and residents meetings were held to capture people's experiences of care and views about the home and the care provided.

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 home was not safe.

People were not always protected from the risk of neglect. Risks to people were not always monitored, or guidance provided to staff to reduce risk. Medicines were not always safely managed. Some improvements were needed to the arrangements the administration of covert medicines needed and to the guidance for people's 'as required' medicines. Medicines were safely stored.

There were not always sufficient numbers of staff to meet people's needs.

People told us they felt safe at the home. There were arrangements to deal with emergencies.

Is the service effective?

Requires Improvement

The home was not always effective.

Staff received an induction and refresher training across a range of areas. However, we found a breach of regulation in respect of staff training as some new staff had not received manual handling training or dementia training to enable them to support people safely. Staff competence in other areas had also not been checked in other areas to ensure training was effective.

People were provided with arrange of food and choice of drinks. The meal time experience required improvement to ensure it as a consistently enjoyable experience for everyone.

The manager and staff understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and acted according to this legislation.

People had access to a range of health care professionals.

Is the service caring?

Requires Improvement

The home was not consistently caring.

People were not always treated with dignity and respect. People and their relatives were not always involved in day to day decision making about their care.

People and their relatives told us staff were kind and caring.

Is the service responsive?

Requires Improvement

The home was not consistently responsive.

People's care plans did not always reflect their needs and staff were not always aware of people's needs. People and their relatives did not always feel consulted about their care plan.

There were a range of activities provided to meet people's needs for stimulation and social interaction.

There was an effective complaints process in place.

Is the service well-led?

Inadequate

The home was not well-led.

Systems to assess, monitor and mitigate risk, or to monitor and improve the quality of the service were not effective. The provider's audits and quality assurance processes had not identified the issues we found at the inspection. We heard mixed opinions about how the home was run from relatives.

The manager and operations manager took immediate action to reduce risks in a number of areas we identified. However the manager was not registered and we could not be assured of the sustainability of the changes.

The provider sought people's views about the home and the views of their relatives through a range of methods, including annual surveys. We saw from this feedback that areas of learning were identified for improvement.

Bromley Park Dementia Nursing 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 07, 10 and 12 April 2017 and was unannounced. The inspection team consisted of one inspector and an expert-by-experience on the first day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service. A single inspector returned on the remaining days to complete the inspection.

Before the inspection we looked at the information we held about the service including any notifications they had sent us. A notification is information about important events that the provider is required to send us by law. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We also asked the local authority commissioners for the service and the safeguarding team for their views of the home.

At the inspection we spoke with four people at the home and five relatives. Most of the people who used the service were unable to communicate their views about the home so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us about all aspects of their care. We also observed staff and people interacting, and tracked to check that the care provided met their needs.

We spoke with four care workers, three nurses, the two activities coordinators, the office administrator, the maintenance person, the service manager, a representative of the provider, the operations manager and the manager of the home. We looked at seven care records of people who used the service, and five staff

recruitment and training records. We spoke with two visiting health care professionals. We also looked at records related to the management of the service such as fire and maintenance checks and audits.

Inadequate

Is the service safe?

Our findings

People and their relatives told us they felt safe from abuse, bullying or harm and that their possessions were safe at Bromley Park. One person said, "I am safe here because the staff are pretty good, we talk and get along." A relative told us, "I do feel that [my family member] is safe here. The staff are pretty good, the home never smells and they are well looked after." However we were not assured that people were always safe from the risk of possible neglect.

We were aware of a recent safeguarding alert of neglect that had been made and was being investigated at the time of the inspection. During the inspection the manager raised a further safeguarding alert in respect of an issue of neglect they identified to the local authority. Following our inspection we raised our concerns about the issues we identified with the local authority and the clinical commissioning group. We were also made aware of further safeguarding alerts of possible neglect raised following the inspection by the manager.

These issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's health and safety were not always adequately identified and action not always taken to reduce the level of risk. For example, we saw at lunch time on the second day of the inspection, two people, who were assessed as at high risk of choking and in need of constant supervision with food. Their meals were left in front of them for at least 15 minutes with no staff presence in the room. There was therefore a risk of them choking if they began to eat independently. For one of these people we also observed that they had a drink with a straw when the guidance in their care planning from a health professional indicated they should avoid using a drinking straw because of the potential risk of choking.

One person with diabetes did not have blood sugar monitoring carried out as frequently as their care plan stated. Records showed where higher than normal blood sugar readings had occurred on two occasions no action had been taken in line with their diabetes care plan. There was therefore a possible risk to their health which had not been acted on. For another person there was no guidance for staff on what action to take if their blood sugar levels became high. We found one recent record of a high reading but no evidence of any action having been taken to reduce risk.

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

We discussed these issues with the manager and operations manager and they took action to address the immediate risks. They updated people's care plans and records to provide further guidance to staff. Handover meetings were used to communicate and discuss information about the risks to people that we had observed; although we were unable to monitor the effectiveness of this action at this inspection.

Systems to monitor and track risks were not always followed and accurate records not maintained. For

example, one person's wound care plan had not been updated to reflect new advice following a visit from a health professional who had recommended an increase in the frequency of dressing changes to try and aid healing. The provider's quality assurance processes had not identified this issue. There were no photographs or body maps in use, as recommended by the health professional to monitor for healing or deterioration. There was therefore a failure to operate effective systems to monitor risks and a failure to maintain accurate records of people's care or treatment.

The system to monitor possible risks from the use of equipment and the premises was not always effectively operated. We found checks on water temperatures for March 2017 showed that in two rooms the recorded temperature was two degrees above the recommended safe water temperature limit but no action had been taken to reduce the temperature to safe levels. We pointed this out to staff and this was addressed at the inspection. However this risk had not been identified by the provider's auditing system.

Checks on equipment were not always completed in line with the provider's processes to ensure any risks were identified and addressed. There were checks on some equipment but we found other checks were not carried out in line with the provider's requirements. Monthly wheel chair checks had not been completed since December 2016. There were no records of monthly bed rail checks recorded since January 2017. There were also no recorded checks of radiator covers to ensure they were not loose which would pose a risk to people's safety.

One person nursed in bed with high risk of skin integrity breakdown had two different recorded settings for their pressure mattress. The mattress had been set at the higher of the two settings since 26 March 2017, when the person's recorded weight suggested the lower setting should be used. The nursing staff on duty were unable to advise which the correct setting was when we showed them the form. The manager advised us of the correct setting which was the lower setting and told us they had written these details on a label for each bed when they arrived at the home as there had been no guidance for staff in people's rooms. Despite this, the pressure mattress had been recorded as set at the incorrect setting and this risk had not been identified by any audits or checks.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks to people were assessed and monitored, and action taken to reduce risk levels. Risk assessments were completed and reviewed for people's individual health needs such as risk of falls, weight loss or skin integrity and we saw action was taken to reduce risk. For example, where there was a risk of malnutrition, people's weight was monitored more frequently, referrals were made to the dietician and their food was fortified. Where people were at risk of falls there was guidance for staff on how to reduce the risks. People had evacuation plans to guide staff or the emergency services in the need for an evacuation. Risks in relation to other equipment and the premises were monitored through regular maintenance checks and servicing; for example gas safety, fire safety equipment, electrical testing, checks on hoists and the lift.

We received mixed feedback about the management of medicines at the home. One relative told us, "There are no problems with medicines; the nurses give [my family member] their medication daily." Another relative told us there had been a problem with medicines and a significant delay in the home obtaining a prescription for their family member. They told us, "It has been resolved now but it needed us to raise it."

Medicines were not always safely managed. Some people were unable to make decisions about their medicines and these people had their medicines administered covertly. This was done after a mental capacity assessment and best interests' decision had been made. However, clear protocols and guidance

for three people were not available for staff to understand how this could be safely done. In addition we found some decisions had not been signed by the pharmacist or GP to record their opinions or how to safely administer the medicines covertly, or to confirm their involvement in the best interest decision. There was therefore a risk that people may not receive their medicines safely or that they could be made ineffective through the wrong method of administration.

There were no risk assessments to identify and reduce the risks associated with high risk medicines such as warfarin to guide staff on actions to take to reduce risks when needed. For medicines prescribed 'as required' we found that there were not always protocols in place to guide staff to support the consistent use of these medicines. For one person prescribed insulin their PRN protocol had not been followed on one occasion as prescribed by their GP. There was therefore a possible risk to their health as medicines were not administered when prescribed. Pain assessments were also not always completed to identify pain levels for people who may not be able to communicate their needs. This meant there was no guidance in place for staff on the signs to look for that might identify when medicines prescribed to manage pain should be administered.

There were not always body maps to guide staff on where to administer prescribed cream which meant staff unfamiliar with people's needs may have applied such creams incorrectly. We also found records of prescribed cream application had not always been completed correctly. For example, one person's records showed that a prescribed cream had only been applied once a day when their prescription stated the cream should be applied twice daily. We therefore could not be assured this person had received their medicines as prescribed.

These issues were a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had carried out medicines audits but had not identified the issues we had found. The manager had an action plan in place to address some of the issues we identified and those raised by a recent pharmacy audit. They took action to address the other issues we raised during the inspection but we were unable to assess whether the changes had been understood and maintained by staff.

Medicines were stored safely and appropriately including controlled drugs which require additional security and medicines that needed refrigeration. Nurses administered medicines and permanent nursing staff told us they had undergone a competency assessment to ensure they understood how to administer medicines at the home; we confirmed this from records.

We found that there were not always enough staff to meet people's needs at all times. People and their relatives gave us mixed views about the staffing levels at the home. Three relatives told us there were not always enough staff. One relative said, "Sometimes they are late getting [my family member] up in the morning and it is almost lunchtime and they are not up when I come in. They tell me they are short of staff." Another relative said, "There are not enough staff especially at weekends." Staff told us that there were occasions when the right levels of staff were not always on duty because of staff sickness.

The operations manager told us, and we observed that, there was a high level of agency use due to staff turnover. The operations manager explained they had recruited to the vacant posts but were waiting for staff to be able to start work. The manager told us, and records confirmed that they tried to use the same agency staff wherever possible. This meant they were more familiar with the support people required.

We looked at the staff rotas for the weeks of 20 March and 03 April 2017. We saw from the staff rota that there

were occasions when the right numbers of care staff were not always allocated on the rota. We were shown email correspondence to verify that agency staff had been requested. It was clear from the email correspondence that the agency was not always able to supply the planned or short notice requirements for staffing. However no alternative arrangements had been considered by the provider to reduce the likelihood of there not being enough staff. Records showed that planned staffing levels were not always met. For example, on two days of each week seven rather than eight care staff had covered the shifts."

On the first day and third day of the inspection the home was one staff member short of expected levels. On 09 April there were only seven staff planned on the rota in the morning and six in the afternoon. The agency had been unable to supply additional staff. We learned that in the afternoon that day two people had been seen by relatives in the garden unescorted and the relatives had needed to alert staff to this issue. This meant low staffing levels posed a potential risk to people's safety.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment checks were in place to reduce the risk from unsuitable staff. Full background checks were carried out on staff before they started work. These checks included details about applicants' employment history and reasons for any gaps in employment, references, a criminal records check, right to work and proof of identification. This helped to ensure people received care from staff that had been vetted appropriately.

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Requires Improvement

Is the service effective?

Our findings

People's relatives told us they thought the permanent staff were competent in their roles. A relative told us, "The regular staff know what to do but the agency staff are less reliable." Not everyone we spoke with could express a view about staff training. However we found staff were not always knowledgeable about how to meet people's needs.

New staff told us they received an induction which included training and a period of shadowing more experienced staff members. The induction followed the Care Certificate, a recognised programme for staff new to health and social care. We saw there were checklists to confirm when new staff were ready to complete tasks on their own. There was a separate induction for nurses and care workers to cover their different roles. However we found that five new care workers had not received some training the provider considered essential prior to commencing work on their own. This included manual handling training and health and safety.

We observed the handover on two days of the inspection and found that the manager was providing guidance about issues identified to the staff group, for example about the use and storage of prescribed thickener, the different dietary consistencies, risks around choking and guidance from a speech and language therapist (SALT). It was evident that staff had not understood these areas and while training had been provided about people's dietary needs, no competency checks were completed to ensure that staff understood their roles to enable them to provide safe and effective care.

There was a programme of refresher training to ensure staff remained up to date and their skills and had their knowledge refreshed. However, we found safeguarding training was out of date for eight care staff and nurses and two non-care staff, and manual handling training was out of date for four staff in total.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received regular individual supervision and felt well supported. We confirmed this from records.

There were good elements to the training provided. The manager told us about some individual training for staff to help develop their roles as champions for example Namaste training. Namaste is a recognised sensory person centred programme for people living with advanced dementia.

Most people and their relatives told us they had plenty to eat and that they enjoyed the food. One person told us, "I really do enjoy the meals." A relative said, "The lunches were good as far as I was concerned." However we found improvements were needed to the meal time experience.

We saw there was a weekly menu with one main meal which offered a variety of options. However, on two days of the inspection we observed the main meal on the menu was delivered to people and no choice of

meal offered to them. There was no discussion about what other choices might be available. On one day of the inspection we observed five people had their food delivered to them by kitchen staff and there was no one to support them to eat. There were no care workers or nurses in the lounge areas where some people were eating. Three people waited fifteen minutes before staff arrived to support them to eat and two people waited twenty five minutes. During this time the food temperature was decreasing meaning it could no longer be appetising.

We discussed these issues with the manager who confirmed they had identified these issues. They showed us a pictorial breakfast menu they had developed since they had started work at the home. People were positive about the new menu. One person told us, "I did not realise you could have egg until I saw this." The manager told us they were working to improve the meal time experience and we observed improvements under discussion at the heads of department meeting. However, these improvements had yet to be established and embedded into staff practice.

People's weight was monitored more regularly where any issues had been identified to identify any concerns about nutrition. We observed that people in the communal areas had access to a choice of regular fluids throughout the day.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff understood the importance of assessing people's ability, to decide on each decision separately, and to involve relatives and professionals as necessary in making best interests decisions. Decision specific best interests decisions such as the use of bed rails we recorded in people's care files. The manager knew how to submit a request for DoLS authorisations and had a system to monitor them to ensure any conditions made in the authorisations would be met, and to ensure renewal applications were made in a timely way.

People had access to support from health professionals when needed, for example a chiropodist, and optician. One person told us, "The doctor visits me here when needed but I'm quite healthy." There were also regular support visits from the pharmacist. We saw advice was recorded in people's records to enable all staff to see it. We had positive feedback from one health professional who told us, "The staff are approachable, the care plans were up to date and people looked well cared for. I have no concerns."

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us staff were kind and caring. On person told us, "The staff here are caring, kind and gentle with me." Another person remarked; "The home is pretty good on the whole; I have quite a lot of needs so need quite a lot of support and on the whole carers do very well with me. They meet my needs; they help me quite a lot to dress, undress and shower." A relative told us, "Staff here are very caring and kind." Another relative commented; "They really do care and to me that is everything." We spoke with a visitor to the home whose relative had been cared for there recently. They were presenting the home with a picture of thanks for the care provided. They told us, "I still visit the home; the staff here were truly excellent to[my family member].

Most people could not express a view on the support they received so we observed the care provided. We found positive and caring interactions between the staff and the people living at the home. Care staff and nurses interacted with people as they delivered care in a sociable and calm way. There was a calm atmosphere in the communal areas throughout the inspection. Other staff involved in the running of the home, such as the maintenance person and office administrator, struck up conversations with people as they passed or went about their work, we observed they knew people well and the interactions were relaxed and friendly.

People and their relatives told us they felt staff treated them with respect and dignity. A relative told us, "Staff are very gentle and knock before they come into [my family member's] bedroom." Staff told us how they knocked on people's bedroom doors before they entered and tried to protect people's privacy while they provided personal care.

However, there were some areas for improvement. In the communal areas on occasions on one afternoon we observed two staff sitting in the lounge watching, but not engaged in any interactions with the people around them. At lunchtime on the second day of the inspection we saw two staff members supported two people to eat. They did not interact with them at all but sat silently with them. They did not consult them about when or if they needed a drink, about the temperature and taste of the food or engage in any mealtime pleasantries to try and ensure an enjoyable experience. We also observed that despite the home having a dignity screen to use when people were being repositioned using equipment, it was not used throughout the inspection when people were supported to mobilise to protect their dignity. A relative told us, "There is good care when the right carers are on duty."

People were not always consulted about their involvement in their care and this required improvement. Two people told us they felt they were consulted and made decisions about their care. For example, one person said, "I am able to make decisions; I choose what I want to wear and eat." However whilst we observed staff mostly asking people for their permission before care was provided, on at least four occasions during the inspection we noted that staff provided care without first explaining what they were doing or consulting people for their views. For example, on one occasion we saw a staff member put slippers on someone's feet without asking their permission or explaining what they were doing. We also observed examples of staff repositioning people without explaining what they were doing. They were therefore failing to reassure

people who may be disorientated.

Requires Improvement

Is the service responsive?

Our findings

An assessment of people's care needs was completed before they moved in to ensure the home could meet their needs safely. Care plans were written to guide staff on how to address people's individual needs and preferences.

However we found that while most care plans were up to date and had been recently reviewed, they were not always reflective of people's needs, and staff were not always aware of what people's current needs were. For example, for two people we found their care plans and guidance from a speech and language therapist (SALT) stated they should be assisted to eat independently using a particular technique. We observed that both these people were fully assisted to eat by staff without any attempt to use the recommended technique to encourage them to eat independently. For one person their care plan had been updated to reflect their needs but staff were not aware of this. We also observed a handover on day three of the inspection where one person's needs in respect of the right way for staff to support them with drinking were discussed. It was clear that one of the nursing staff had no knowledge of the guidance from a health care professional that was in their care plan. There was therefore a risk of inappropriate care and the person's individual needs not being met.

One care plan was handwritten and we were unable to read the contents of the care plan and neither was a staff member we asked. This meant that staff had no guidance on how to meet this person's needs or to know if the care plan reflected their needs. For two people there was no care plan to guide staff about their specific health devices. Their hospital transfer forms did not record they had these in place which meant hospital staff may not be alert to their needs. People's current needs were not identified in their care planning and may therefore not be safely met.

Most people were unable to express their view and people's relatives had mixed views about whether they were consulted and involved in the care planning for their family member's support needs. One relative told us they had not been consulted about their [family member's] care plan. Of the care plans we looked at three did not evidence that relatives had always been consulted about their family member's care.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people's relatives did feel involved in their care. For example two relatives told us they felt they were involved and consulted. Another relative told us they felt new management had been more active in trying to ensure they were involved

Other care plans detailed people's needs across all aspects of their care and support. For example their needs at night, communication needs, personal care needs, mobility and eating and drinking. They explained, for example, what people felt able to manage independently and which aspects of care they needed support with. There was information about people's life history for staff to understand important facts about them and the significant people in their lives. Staff also recorded daily notes and observations

where relevant, to show that people were supported in line with their individual wishes and their care plan.

There was a range of activities to meet people's need for socialisation and stimulation. We received positive feedback about the activities provided at the home. One person told us, "There are plenty of things to do here." A relative said, "There are a lot of things going on and people are not forced to join in but are left to decide for themselves." Most people could not express their views about the activities and so we observed some activities at the inspection.

There were two activities organisers employed at the home; they told us they ran activities across seven days of the week. There was an activities timetable so people and their families would know which activities were being provided. The activities environment was dementia friendly. There was a dedicated activities room and the garden area was designed to support people with dementia and used in the warmer months. Activities included crafts and singing, outside entertainers such as pat dogs and outings. We spoke with an activities organiser who told us the provider had supported them to attend training on Namaste and that they also attended regular support meetings for activity coordinators from other homes. They provided regular individual activities for people nursed in bed or in their rooms. People's preferences were discussed with them and their relatives where appropriate to try and ensure there were activities they would enjoy. The coordinator recorded notes about the group and individual sessions held and people's responses to the different activities in order to provide learning and a record of their care.

We observed different groups of people engaged in the activities provided. The sessions were skilfully led to draw each person into the activity at the level they wished and encouraged interaction. People were absorbed in what they were doing and enjoying it. The manager had an activities action plan they had sent us prior to the inspection with a range of ideas on how to develop the activities further. This included creating and strengthening links within the community and to include visit from local schools to strengthen the range of provision.

There was information displayed about the home on how to make a complaint. Some people told us they knew how to complain but had not needed to. One person told us, "I have been here a number of years now and have not had reason to complain." Other people were not able to express a view about this aspect of the home. Relatives said they knew how to complain if they needed to and would speak to the manager. One relative said, "On the whole I'm happy with the care my [family member] is receiving, there have been little issues but nothing major." Two relatives told us they had raised concerns in the past but they had not been promptly dealt with. However, they were happy with the response they received from the manager. One relative said, "I have complained and it was not dealt with properly but things have improved now." We checked the records and found complaints had mostly been responded to in line with the policy, with one delayed response in 2016. Complaints logged had been resolved.

The manager told us they would be reviewing the complaints going forward to identify any common themes. They had an open approach to identifying any concerns and we saw they shared any learning with staff for example complaints were discussed at staff meetings and meetings with nurses.

Inadequate

Is the service well-led?

Our findings

At this inspection we found serious concerns about the way the home had been managed and the extent and level of these problems had not been identified by the provider's own quality monitoring processes.

We found concerns across a number of key areas. Systems to monitor risks to the changing health needs of people at the home were not effectively operated. We found a series of incidents over the last 12 months where nurses had not always acted promptly to respond to changes in people's conditions, or had not recorded monitoring of people's vital signs appropriately to check for signs of deterioration. This pattern of concerns had not been identified by the provider despite a response to a complaint in December 2016 that stated learning would be put in place to reduce the risk of delayed responses. We raised our concerns about the issues we identified with the local authority and the clinical commissioning group.

Audits to monitor risk, and to monitor and improve the quality and safety of the service failed to identify the lack of a robust system to keep catering staff informed about some people's dietary needs. We found information from a speech and language therapist (SALT) about a change in the consistency of one person's diet had not been provided to the kitchen. While the chef was familiar with people's needs there was a risk that unfamiliar staff would not be. Immediate action was taken to address these issues and new dietary notification records were completed. The chef was provided with a display board to ensure this information was to hand to reduce risk. However, we found for two people there was no warning to the chef that due to their prescribed medicines there were certain foods to be avoided.

Audits had failed to establish that there was no system to provide staff with guidance on the correct consistency where people required different consistencies of fluids to reduce risk of choking. One staff member was observed to be trying to add thickener using a desert spoon rather than an accurate measure. When they were asked how they knew how much to add they were unable to respond. The relevant information was not available in the dining area. A second staff member intervened to assist them. For a person nursed in bed the guidance was not readily available in their room to assist staff in ensuring the right consistency so as to avoid the risk of choking.

The provider's systems failed to identify that charts to monitor the care of service users nursed in bed were not always completed or monitored by nursing staff to assess and mitigate risks to service users. The charts for people nursed in bed did not provide staff with guidance on how often to check or reposition people to reduce the risk of pressure areas developing, in line with the provider's protocol. For two of the three people nursed in bed on two days of the inspection we found some significant gaps in checks recorded. For example one chart showed no record of a check or repositioning from 2pm until 8pm that day. Another chart had no record of any check or repositioning from 4pm until 8am the following day.

There was no system to check that night staff had the appropriate knowledge to respond in the event of a fire. Fire drills had been carried out in 2016 but these were all completed during the day and there was no system to ensure that night staff attended fire drills. There was therefore a risk they would not know what to do in a fire emergency. The quality monitoring system had failed to identify shortfalls in the recruitment

process. We found for one staff member there was only one reference on file.

There was no system to ensure that agency staff had a recorded induction when they started work at Bromley Park which would include training about how to respond to emergencies. The operations manager told us there was a form that staff should complete; however no completed forms were found. Agency profiles were requested by the home but there was no request for evidence of any specific nursing training which might be required to meet service user's specific needs and no record that medicines competencies were carried out to ensure agency nurses had the necessary skills to administer medicines at the home. These issues had not been identified by the providers own auditing systems.

Checks on accident and incident records had not been tracked to ensure that recommended actions were completed. We tracked three accident records and found no information to demonstrate that the monitoring actions needed had been completed. Medicine errors were not separately recorded to evidence appropriate actions taken to ensure people were safe and to identify any patterns or learning from errors.

The system for assessing monitoring and mitigating risks with regard to staff disciplinary issues was not effective. We found for one staff member where the home had been advised by their professional body of an investigation in progress against them, no review of possible risks in relation to the investigation was recorded. Where informal disciplinary action had been taken there was no record of what the issue had involved so that new management would not be aware if there was a repeat of the incident by the same staff member.

None of these issues had been identified by the provider's system of quality assurance visits or checks. There had been an action plan in place prior to the inspection to address issues the provider had found; however this had not identified the concerns we raised.

These issues were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager in place. The previous registered manager had deregistered in October 2016. Another manager had been employed but they and the deputy manager were dismissed in January 2017. The home had been run by the operations manager and other senior staff until the appointment of the new manager in March 2017. There was no deputy manager at the time of the inspection.

These concerns we found were discussed with the manager and operations manager who took immediate action to address the risks found during the inspection. The head of operations attended the inspection to discuss the concerns found and took action to provide additional support to the manager. They increased the level of clinical staff support to address the systems and processes in place, and reduce the likelihood of further incidents and concerns. They told us in response to our findings they would not allow any further admissions for at least four weeks and then, only after consultation with CQC. They agreed to send us an action plan to show us how they were addressing the concerns and to evidence how the manager was being supported with additional experienced staff. They also told us they were taking steps to try and understand how these problems had arisen and not been detected as they wanted to learn from the experience to avoid it occurring again. We will be closely monitoring this progress with the action plan.

Most people were not able to express their views about the management of the home. However one person commented; "I would say the home is managed well, I think I would recognise the manager." Relatives we spoke with had mixed views; two relatives were complimentary about how the home was run. One relative remarked, "As far as I can tell this home is well managed." Another relative said; "I would recommend the

home and have, it was my first choice of home and my siblings agreed." Two other relatives were less happy with their experiences. One relative commented, "It has been very up and down over the last six to eight months. We have had problems. The last manager as not very good but I think we are making progress now."

The manager was an experienced registered manager.They had ideas about aspects of the home they wanted to develop and improve. They were aware of the duties and responsibilities of a registered manager. We found they had already taken some action to address concerns that they found. For example they were in the process of completing an audit of all hoist slings and ensuring that people had their own individual slings to reduce risk of infection. They had reviewed the pressure mattress settings across the home and they had conducted medicines audits that had identified some of the issues we found. However, we were not assured that changes were yet embedded into staff practice.

We observed they were working hard to address the shortcomings found and they demonstrated good leadership skills at the meetings we observed in trying to develop team work and tackle the issues in a constructive way. For example, they were working to increase staff understanding of people's needs and had established a new resident of the day system which included a review of all areas of their care. This also involved different staff in contributing their knowledge and understanding about the people they cared for. They had begun to hold regular heads of department, nurses meetings and staff meetings to start to develop good communication and team work. Topics at nurses meetings included skin care and weight monitoring as well as a discussion about a complaint to ensure learning was identified and shared. Staff meeting topics included staffing levels and the rotas and team work. A visiting health professional gave positive feedback about the manager they told us, "The new manager is really on the ball. She has lots of good ideas to improve things and is enthusiastic."

The provider had sought people's views through relatives and residents meetings although the minutes of several meetings from 2016 were not available at the inspection. An annual questionnaire was sent out to people and their relatives to complete. We saw there was a display board that summarised issues raised and the action taken by the provider in response. Issues raised included staffing, the use of agency staff levels, the mealtime experience and oral care and the provider was in the process of taking action to address these concerns.

The provider had acted promptly to address concerns that we identified. However, there had been significant shortfalls in the leadership of the home, the new manager was proactive but we could not be assured of the effectiveness and sustainability of the changes they were trying to make. This key question has therefore been rated Inadequate in line with our characteristics.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not always reflective of people's needs and staff were not always aware of what people's current needs were. People and their relatives had not always been involved in planning for their care. Regulation 9(1)(3)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way. Risks to people were not always assessed or action taken to mitigate them. Medicines were not always safely managed. Regulation 12 (1)(2)(a)(b)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from abuse or neglect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons

must be deployed

Staff did not always receive appropriate training and professional development, as is necessary to enable them to carry out the duties they are employed to perform,

Regulation 18(1)(2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess and monitor risk and to monitor the quality and safety of the service were not effectively operated. Records of people's care were not always up to date. Regulation 17 (1)(2)(a)(b)(c)(e)

The enforcement action we took:

A Warning Notice was served which required the provider to meet the regulations by 05 June 2017.