Alliance Care (Trendlewood) Limited

Brockwell Court Care Home

Inspection report

9 Cobden Street
Consett
County Durham
DH8 6AH

Tel: 01207501851
Website: www.fshc.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 11, 12 and 15 January 2018 and was unannounced. Following our last inspection in October 2015 we rated the service as overall 'Good' and there were no regulatory breaches.

During this inspection we found breaches of Regulations 10, 12, 15, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff were not aware of people's needs and how to keep them safe. The provider had not done all that was reasonably practicable to mitigate risks to people including the safe administration of people's topical medicines and the cleanliness in the home. The premises in certain parts of the home were unsafe. The audits carried out to monitor the service had failed to identify these issues and records were not always up to date and accurate.

Brockwell Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home can accommodate up to 75 people. At the time of our inspection there were 70 people using the service. The home was divided into four areas – Allensford, Blanchland, Corbridge and Derwentside. Each area had a different emphasis on meeting people's care needs.. For example Allensford focussed on people with dementia whilst the Derwentside focussed on people with nursing care needs. People can transfer between the areas.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The local infection and prevention control team had visited the home and carried out an audit in August 2017. They returned in January 2018 and found not all of the actions had been carried out. We found the Allensford area of the home was odorous and lacking in cleanliness.

We found the administration of people's medicines varied in the home. There were arrangements in place for the ordering, receipt, administration and disposal in the home. However we found in Allensford some topical medicines (creams applied to the skin) in people's bedrooms which were out of date. These were removed by staff during our inspection.

Relatives told us there were not enough staff on duty. We looked at people's needs and the demands place upon staff and found more staff were required to provide the necessary support to people. The deputy manager told us new staff were being employed in the home.

Regular maintenance checks were being carried out to ensure people were protected from fire and water hazards. However we found areas of the home to be unsafe. For example we found some emergency pull cords were tied up and out of reach of people who may have fallen to the floor.

We saw that the physical environment in Allensford did not reflect best practice in dementia care. Adaptations were not in place to support people to remain independent. We also found some care practices did not always promote the dignity of people living with dementia. The regional manager brought a dementia care specialist into the home who agreed to support the home make improvements.

Checks were carried out on staff before they started working in the service to ensure they were suitable to provide care to vulnerable people. After being appointed, staff underwent an induction process and were supported through supervision and appraisal. However we found not all staff had received the four supervision meetings with their supervisor in 2017 and annual appraisals.

Other professionals had been consulted regarding people's health care needs and advice sought. We found the guidance and advice provided by other healthcare professionals was not always acted upon by the care staff.

Audits carried out in the home failed to identify the deficits we found during the inspection.

People were protected from the risk of abuse because the staff in the home understood their responsibility to keep people safe and the actions to take if they were concerned a person may be at risk of harm.

We saw some staff knocking before entering people's rooms, and closing bedroom and bathroom doors before delivering personal care. However we found not all staff knocked on people's doors before entering.

Staff recorded incidents and accidents on the provider's electronic system. The registered manager reviewed the accidents as they occurred. However, we found some accidents in people's files which had not been recorded on the system for the registered manager to review.

The registered manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted.
Staff provided support and encouragement to people to eat. Food supplements had been sourced for people who were at risk of weight loss. Menu boards were available but not in use to enable people to make meal choices.

People's care plans contained person centred information and described people's needs in detail. We found people's care plans who had been discharged from hospital for intermediate care prior to making decisions about their future care needs were documented on the NHS documentation. had familiarised themselves with their discharge plans.

Complaints had been investigated by the registered manager and appropriate responses were provided to the complainants.
Lessons had been learnt by the management team. We saw there was a 'You said, We did' board where the management team had listened to people's comments and taken action.

The provider had an electronic system in place for gathering feedback about the quality of the service. People who used the service, their relatives and professionals had given positive feedback about the home and the way it was run.

Following the inspection the registered manager sent us an action plan to tell us what actions they had taken and intended to take to improve the service.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We found actions had not been taken to ensure cleanliness throughout the home and reduce the risk of cross infection.

People's personal risks were identified. However we found this did not always result in referrals to specialist healthcare providers. Guidance was provided to staff but we found staff did not always follow the guidance.

Regular checks were in place to maintain the home and keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Adaptations had not been made to the environment to support people with dementia type conditions.

Staff were supported to carry out their duties through induction, training, supervision and appraisal. However, we found not all staff had met with their manager for the provider's required number of supervision meetings. Annual appraisals had not always been completed.

We observed staff supported and encouraged people to eat. In one area we found staff created a pleasant atmosphere for people to eat. They played background music whilst people ate their meals.

Is the service caring?

Requires Improvement

The service was not always caring.

We found some staff did not always follow people's care plans to ensure they received the required care.

We found care practices varied across the home and observed some practices did not always promote the dignity of people living with dementia. Staff spoke to people and called them

'good girl' or 'good boy'.

Staff protected people's dignity and carried out personal care behind closed doors.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We found information provide by healthcare professionals had not always been acted upon to ensure people were appropriately supported.

Activities were provided in the home. We observed people engaged in a coffee morning and bingo. We found the activities coordinator understood people's needs and provided appropriate activities.

The service had arrangements in place to ensure people were supported towards the end of their life.

Is the service well-led?

Requires Improvement

The service was not always well led.

We found the provider and the registered manager had failed to identify deficits in the service when they carried out their audits.

The registered manager held staff meetings to exchange information and provide support and encouragement to staff.

The registered manager had notified CQC of the required incidents and accidents in the home.

Brockwell Court 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, 12 and 15 January 2018. The first day of our inspection was unannounced.

The inspection team consisted of two 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 someone who uses this type of care service. The expert by experience on this inspection had experience of working with people with dementia.

Prior to the inspection we checked the information we held about this location and the service provider, for example we looked at the inspection history, safeguarding notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service; including local authority commissioners.

Before the inspection, 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 improvements they plan to make.

During the inspection we spoke with 15 staff including the regional manager, the registered manager, a nurse, senior care staff, care staff and kitchen, domestic and maintenance staff. We spoke with eight people who used the service and 12 relatives. When we carry out an inspection we ask the registered manager to put a poster up to explain to people that we are inspecting and inviting people to make contact with us to give their views. Following the days we spent at the home two other relatives also made contact with us to tell us about the service.

We reviewed eight people's care files and other information in relation to the regulated activities. We looked

at seven staff files. We also spoke with two professionals who had contact with the service during our inspection. We observed staff practices throughout the course of all three days in the communal lounges, dining rooms and corridors.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe living at Brockwell Court. People told us, "I do feel safe in here, because there are people around if I need someone", "I feel very safe in here. What makes me feel safe is that I am not on my own and the staff are here" and "Yes I do feel safe here." Relatives also talked to us about safety. One relative said, "This is a safe place for my [family member] as they are well looked after and there are staff around if they need anything." Another relative said, "It is safe enough yes, I think it is fine." We saw relatives had access to the home using a key pad. The front door was open and closed electronically.

During our inspection we spent time in the Allensford area of the home and carried out an inspection of service users' bedrooms and en-suite toilet/shower facilities. In three bedrooms we found prescribed creams and ointments which if ingested or used incorrectly could cause potential harm to people. For example, in one en-suite toilet/shower, on an easily accessible cabinet, we found a topical medicine prescribed for the management of eczema with a warning 'avoid contact with eyes'. In the en-suite toilet of another bedroom we found a prescribed topical medicine called Daktacort with the instructions 'if accidentally swallowed you should contact a Doctor or go to your nearest hospital straight away'. One of these topical medicines had a written date on the label of 2013. Other topical medicines were past their use by date. We raised these concerns with the staff on duty who removed the topical medicines. Over the course of the inspection we observed some people walk along the corridors without the supervision of staff. We found that all bedrooms were unlocked and easily accessible. There were no other safeguards in place to minimise the risks of people accidentally or deliberately ingesting potentially dangerous creams and medications designed only to be used externally.

Prior to visiting the service we spoke with the Infection Prevention and Control Team which is funded by the Clinical Commissioning Group. They sent us a copy of their report dated 10 January 2017. The report showed actions highlighted in the previous report dated August 2017 had yet to be carried out.

We looked around the home and found a significant number of areas of Allensford was not suitably clean. This exposed people, staff and others to health care associated infection. In every bedroom in Allensford we found that armchairs and furniture were stained with what we assessed to be food and or bodily fluids. The plastic covering on one mattress was torn and therefore could not be cleaned effectively and on another was badly stained with an unknown white substance. We found walls and switches splattered with dirt and debris. In en-suite shower facilities the white plastic covering over the shower base was badly marked. The pull cords for lights in people's en-suites were covered in grime and dirt, we found beds that had been made yet the bedding was stained and marked. We found a pressure cushion (used to prevent people from developing pressure damage to their skin) which was heavily soiled. We found in-grained dirt around the base of one person's toilet and extensive brown staining on the net material covering another person's bed rail. Unlike other areas of the home there was an extremely unpleasant odour throughout this area which was noticeably stronger in some people's bedrooms. Following our inspection relatives contacted us about other areas of the home which they found to be lacking in cleanliness. We contacted the provider who agreed to take action to address their concerns.

On the second day of our inspection the registered manager told us staff had been working to clean the Allensford area of the home. We saw attempts had been made to make improvements, but further improvements were required. Following the inspection the registered manager sent us an action plan and told us what further steps they had taken to clean the home.

Risks assessments were in place to mitigate accidents and incidents for staff working in the building. We saw a standardised assessment and care plan document was used to identify people's needs. This included risks to people's health such as risk of falls, risk of pressure damage, and risk of malnutrition. However, the information recorded in some care plans did not reflect what happened in practice. For example, one person had been assessed as at high risk of falling. It had been identified in their care plan that they used a bed sensor whilst in bed, which would alert staff if they had got out of bed. There was no bed sensor in this person's bedroom. We asked the care staff about this. They stated this person did not use a bed sensor. We saw a standardised assessment tool was used to identify if people were at risk of choking and/or at risk of depression. Where people had been assessed as at high risk there was no evidence of referrals being made either to the person's GP, mental health team or Speech and Language Therapy Team.

We saw a risk assessment had been completed for the practice of removing a nurse pull call from one person due to "excessive use". We saw in this person's social work assessment that care staff should provide this person with re-assurance at times when they 'shouted and banged'. There were no triggers identified in this person's care plan to this behaviour or evidence that they were offered re-assurance at such times. There was no evidence of any further preventative action staff should take, the only action being to remove the nurse pull call to prevent this person from using this.

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

We looked at the maintenance of the building and found arrangements were in place for regular checks to be carried out in respect of protecting people from potential fire and water hazards. In the record sheets for 2017 we found the recorded checks were missing from January to May 2017; in their place was an explanation to say due to a new book not arriving at the home the maintenance person had continued with the 2016 records and added those for 2017. We asked the registered manager to see the 2016 records and found checks were documented as being carried out from January to March 2017. There were no records for April and May 2017. The registered manager explained there had been some confusion. The provider was not sending out new books and these were now to be downloaded from the provider's electronic systems. This issue had now been rectified. We found the updated fire checks demonstrated risks to people were reduced.

Checks on water temperatures were carried out on a regular basis to ensure people were not at risk of scalding. Thermometers were in place in bathrooms for staff to check people's bath water. Staff were able to tell us about people's preferred bath temperature. The Health and Safety Executive recommends water should not exceed 44 degrees. We checked the bathwater temperature of one bath to make sure it was within the recommended temperature. We found this to run at 46 degrees centigrade which was above the safe temperature recommended by the Health and Safety Executive for vulnerable people. Further checks were carried out by maintenance staff. The regional manager told us the water temperatures were within the recommended 44 degrees.

Twice weekly checks were in place to prevent legionella's disease. Maintenance staff were expected to run water from unused water outlets. Records showed maintenance staff had experienced difficulties in carry out these checks as the care staff had stored equipment and incontinence pads in shower trays. We spoke with the registered manager about this issue. They confirmed there had been tension between the two staff

groups but this had now been resolved.

We looked at staffing levels throughout the home. The provider used a system called CHESS to help them identify how many staff should be on duty to support people using the service. Relatives told us there was not enough staff on duty and they had to wait excessive amounts of time for staff attention for their relatives. Other relatives described finding their family members wet and attributed this to a lack of staff having the time to carry out sufficient checks on people. One relative told us they had to wait up to 45 minutes for help for their family member. Other relatives said, "The staff are very nice, and my family member is well looked after, but the staff always seem very rushed and short staffed at times", "The staff are really lovely, they do a great job, but they do seem under staffed a lot of the time", and, "I think the care here is fine and happy with the care my family member receives from the staff, they always do their best, but they are always very busy and seem to be running around a lot." One relative described their family as "isolated" as staff drop off their meals and do not have the time to support them.

We noted staff in one area going out two at a time for cigarette breaks leaving one member of staff on duty. The registered manager told us some staff preferred not to take a long break and took shorter smoking breaks but leaving one member of staff on duty should not be happening. In another area we saw two staff taking their lunch break in a dining area leaving one member of staff on duty. Irrespective of this pattern of staff breaks we found on the first day of our inspection there was a senior carer or a nurse working with in each area of the home. On Allensford two people required support and/or supervision to eat to avoid choking. This left one member of staff on duty to support the remaining amount of people.

Blanchland area had seven intermediate care beds for people who are discharged from hospital to a care home to continue their recovery before decisions are made about their future care needs. Staff told us people were being continually admitted and discharged. Admissions and discharges to the home were managed by the senior carer on duty. At the time of our inspection if a senior carer was required to admit a person this would have left two care staff providing care for 16 people, three of who required two staff to support them transfer. Staff told us if there was a senior care staff member on duty who did not know people they were likely to be worried about meeting people's needs during the shift.

On the first day of our inspection we found one nurse and two care staff members on duty to care for up to 21 people. We asked the staff how many people required two staff to support them; staff told us 16 people required the higher level of care. The deputy manager told us new staff had been employed and they were waiting for them to start. We found one new member of staff had recently started and had been required to work in the kitchen to cover a member of staff who was off sick. We found there were insufficient staff on duty to support people's needs.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We found bottles of alcoholic drinks in an insecure cupboard in one dining room and discussed with the registered manager the risks associated with this practice. The registered manager explained they did not want to prevent people from having an alcoholic drink with their meal and offered to put in place a risk assessment. They provided us with a suitable risk assessment during the inspection.

Accidents and incidents were electronically recorded by staff. These were then checked by the manager for trends. We reviewed the accidents between October and December 2017. We compared the accidents on the electronic system with people's personal records and found there were more accidents in people's records that there were recorded on the electronic system. This meant the registered manager was not in possession of all the accidents and incidents on which they could base their analysis. Following the

inspection the registered manager provided us with an action plan to address this area of concern.

Some of the people we spoke to advised they were aware of their medicine needs and were generally happy with what they were taking and when it was administered. Others advised they did not really know what medication they were on but were happy and had no complaints with it. One person said, "I get my medication twice a day, and have no issues." Another person said, "I get medication usually in the morning and at night. I have no problems with it." Relatives were confident their family members received their medicines in a safe manner. One relatives said, "My [family member] receives their medication morning and evening and everything seems to be working - no complaints." Another relative said, "My [family member's] medication is fine, I don't get too involved with it as they seem fine."

We looked at the arrangements for the ordering, delivery, storage and disposal of people's medicines. We found arrangements were in place to ensure the safe management of people's medicines. Controlled drugs are drugs which are liable to misuse. We carried out checks on the controlled drugs and found the records matched the stock. However on one area we found there was a lack of disposal facilities. Staff told us they were cutting up pain patches which were removed from people before disposing themselves in a non-clinical waste bin. The registered manager agreed to ensure an appropriate disposal bin was provided.

We discussed with the regional manager and the registered manager lessons which had been learnt in the service. They showed us the 'You Said, We Did" board where there was a list of concerns for example laundry not being returned to its rightful owner and actions the staff had taken to improve the service.

We also saw safeguarding incidents had been reviewed and actions put in place to demonstrate the learning form the incidents. Safeguarding issues had been raised by staff. This showed staff understood how to protect people.

We looked at staff recruitment records and saw that appropriate checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates.

Requires Improvement

Is the service effective?

Our findings

As we walked around the home we found in the Allensford area of the home the floor including communal areas and people's bedrooms to be 'spongey'. We found the floor undulated, dipped, and in some areas had sunk creating a pothole effect, all of which presented a potential hazard to people with dementia at high risk of falling. The registered manager explained work had been undertaken to look at the causes and as yet a decision had yet to be made as to the exact cause before work could commence to repair the floor. The regional manager told us when the cause of the problem is identified a plan will be required to move people out of this area until the work is carried out.

Where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). We carried out safety checks throughout the building and found arrangements were in place to support people's safety. However, we found the toilet seat in the accessible toilet on Allensford was loose and could be a potential hazard for frail elderly people at risk of falling. We found a number of cords to the nurse call alarms in people's en-suite facilities had been tied up out of reach and therefore could not be used should a person need to call assistance. Poor maintenance of the Allensford area did not promote the dignity or safety of people with dementia living there.

We saw that the physical environment in Allensford did not reflect best practice in dementia care. Other than the pictures of toilets and bedrooms, there was no evidence of adaptations to the environment to show good practice guidelines had been put into practice. For example, the use of contrasting colours on light switches, grab rails and toilet seats in en-suite toilets. There was no evidence of any methods being used, such as memory boxes or past photographs, to help people to find their personal room, other than in some cases, not all, the name of the person on their door. There were no themed areas to help people orientate themselves and corridors ended in locked doors. There was no use of technology, such as sensor lights in en-suites to further aid people's independence. Staff described Allensford as "Too bare and lacking stimulation." One person living in Allensford told us, "We're bored." The registered manager told us there were some pictures due to go up on the walls which reflected the local area including the Consett steel works. We spoke with one staff member who worked in the resident experience team. They discussed with us ideas to improve people's experience and what actions they were able to take to provide people with a stimulating environment.

During the inspection we carried out checks to ensure people lived in a safe environment. We found in most of the home there were no environmental hazards. In Allensford we saw a number of hazards in the environment which posed additional risks to people with dementia. In one person's bedroom two screws were exposed on the en-suite toilet door which could cause potential harm. In another person's en-suite toilet we found cardboard boxes and slings stored on top of the shower base, which meant this area could not be used safely. We also found panels of wood, which had been attached under people's sink units for aesthetic purposes, were not secured, had sharp edges, and in one case an exposed nail, a potential risk to frail elderly people should they catch their skin against it.

One relative spoke to us about their family remember being constantly in bed. They told us they had asked staff to support the person get out of bed and had been told by staff that they were unable to do that as the hoist had not been charged. The Health and Safety executive recommends battery powered hoists are left on charge when not in use. We noted staff stored the hoists in areas of the home where there were no plugs.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We spoke with the 'residents experience care specialist 'who was responsible for providing staff with training in dementia care. We saw the provider had a dementia care training programme which had been completed in this care home. Staff confirmed they had received this training and said "The training was very interesting; it put you in mind of what was going on (for the person with dementia." Although staff had completed this training we saw very little evidence of this being put into practice by staff. We discussed this with the manager and 'residents experience care specialist' at the time of the inspection who agreed to provide further training in this area.

The provider had arrangements in place to support staff through induction, training, supervision and appraisal. We saw induction documents for staff who had recently starting working in the home. The service had electronic records to demonstrate staff had received training relevant to their role. We saw that all staff had completed other training described as mandatory by the provider such as moving and handling, safeguarding adults, infection control and food hygiene.

In a staff meeting in August we saw the registered manager had complimented staff on achieving the staff supervision required up to that date and reminded staff of the supervisory requirements for the remainder of the year. The regional manager confirmed staff were required to have four staff supervision meetings with their line manager in a year. A supervision meeting takes place between a staff member and their line manager to discuss for example the progress a staff member may have made and any concerns they may have. We reviewed the staff supervision matrix and supervision records and found staff had not met with their manager four times in 2017 for supervision purposes. There were also gaps in staff appraisals. This meant not all staff had received the required level of support.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We carried observations of meal times in the home. We observed a lunchtime meal in Allensford. We saw there was a choice of fish or sausage and chips as the main meal. We saw in one person's care plan that they did not like fish of any kind, however, this was offered to them as the choice of main meal. Dining tables were set with table cloths; we found that place mats were dirty with food debris from previous meals. Staff were attentive to those people who were having their meals in the dining room, however, support was not always provided to other people who were given their meals in their bedrooms, with, on one occasion, one person assessed as at high risk of choking, being left slouched on their bed to eat their meal. On the second day of our inspection we found the same person leaning to one side to eat their meal. The registered manager checked their care records and confirmed they should be sitting up and observations taking place to ensure the person did not choke.

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

Notice boards were available in each dining area to give people menu information. These menu boards were not used to assist people in their choices. There were no pictorial menus displayed to help those with dementia needs. We saw special equipment, such as deep plates (which prevented food from falling from them), were provided, thereby aiding people's independence.

We saw that those people at risk of losing weight were closely monitored using food and fluid charts. Staff weighed people on a regular basis. We saw that no-one had lost a significant amount of weight. The advice of dieticians had been sought and food supplements had been prescribed for people who were at risk of losing weight. Staff documented when these had been given. In the dining rooms we found kettles and toasters which were dirty. The registered manager made arrangements for these to be replaced.

On the ground floor in Blanchland the atmosphere was very relaxed with the radio playing softly in the background. The mealtime ran smoothly. Lunch was also observed on the top floor in the Derwentside over lunchtime and was also relaxed. There were four people sat at the dining room to eat for lunch and we were advised by staff the other 12 people preferred to eat in their rooms by choice. Juice was offered with people's lunch; there was a choice of orange juice or black currant juice. People did not wait long at all for their lunch and were able to eat at their own pace. Staff knew people's individual dietary requirements. Food provided by the kitchen staff enabled the care staff to meet people's dietary needs.

We saw that people were encouraged by staff to eat in the dining rooms to promote social inclusion across both floors. Staff advised that there was no set seating for those who sat in the dining room; however most people sat in the same place.

We observed positive encouragement for people to eat and drink. We heard staff say to people "Would you like some juice? - orange or blackcurrant", "Would you like to try dessert?" and "You haven't eaten that much today; do you think you might like to try to eat a little more?"
Most of the people we spoke to were happy about the quality of food they received and that there was always a choice for their meals. One person said, "I like the food here, there is always plenty to eat and drink." Another person said, "We are well fed and watered here, I have no complaints with the food or drink we are served." A third person said, "The food is ok – it's too heavy sometimes would prefer more light bite meals."

During the inspection we saw people had access to other healthcare professionals. For example, we saw district nurses visiting and also rehabilitation professionals to support those people in receipt of intermediate care. We saw advice had been sought from other health care professionals, such as occupational therapists, dieticians, GP's, community nurses and the Speech and Language Therapy Team (SALT). One professional described to us a senior care worker as being 'very good' at knowing people and understanding when they needed to call other professionals into the home.

Before people were admitted to the home the provider had a pre-admission assessment in place. People's needs were assessed to ensure they could be met by the service.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 20015 (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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this in their best interests and legally authorised under the Mental Capacity Act (MCA) 2005. The procedures for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS) authorisations.

We saw staff considered people's capacity to make decisions and they knew what they needed to do to make sure decisions were taken in people's best interests and where necessary involved the right

professionals. Where people did not have the capacity to make decisions, their friends and family were also involved. This process helped and supported people to make informed decisions where they were unable to do this by themselves. The manager told us external independent advocates were also available if required.

Requires Improvement

Is the service caring?

Our findings

Although we observed care staff demonstrating a very caring approach to people we found some staff whose approach was less than caring. This included staff not carrying out actions which were described in people's care plans to ensure people were kept safe.

We found some care practices did not always promote the dignity of people living with dementia. For example one person was removed in their wheelchair away from watching their TV programme to be told they were being taken to the toilet. The person asked the staff where they were going. We heard one person ask to leave a unit. In response to this we heard staff say to them "No [name of person] you can't get out you live here now." This did not demonstrate an understanding of the nature of dementia, memory loss or the anxiety this person might be feeling as a result of this. In another instance we heard a member of staff say to a service user who was banging on the side of their wheelchair "Please don't do that I have important people in here today." Staff did not take the time to ask this person what they wanted. We often heard staff refer to people as 'good lad and 'good girl'. Such practices did not promote the dignity of people living with dementia. We found the care practices to be task orientated with care staff focused on meeting the basic care needs of people living with dementia with little focus on meeting people's emotional needs. We brought our observations to the attention of the regional manager and the registered manager. On the third day of our inspection they brought into the home the residents experience care specialist and put a plan together to address our concerns including further observations and further staff training.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All people we spoke to told us they felt their privacy and dignity was always respected. All people we spoke to advised if they need any help with personal care, bathing, or other assistance they felt much respected and advised any curtains were always pulled across, or doors closed for privacy and dignity.

Whilst we found some staff were not adhering to people's care plans staff in other parts of the home were able to give us personalised information about people. They spoke with us about people's likes and dislikes and provided explanations about people's personal preferences. For example we saw one person's bed had been raised to a high level. Staff told us it was because the person liked to be able to see their relative arriving in the car park.

During our inspection we observed staff at times being respectful when interacting with people who used the service and were able to describe how they promoted people's privacy when supporting them with personal care. Throughout the home we saw staff knocked on people's doors before entering, or if their door was open, they looked into the room and announced their arrival as they sought permission from the person to enter. However we also observed in the presence of the regional manager staff walking into people's rooms unannounced with their meals. We discussed with the regional manager the need to improve practice in this area.

We talked to people about staff respecting their person choices. We were told by several people that they could go to bed when they wanted and were not told when to go.

We asked the manager and 'residents experience care specialist' how they supported people living with dementia to express their views, for example by using observations to understand and assess people's well-being and experience of care. They told us at present they did not have such a process in place but agreed such a method would be beneficial to people.

During our inspection we spoke with the registered manager about the provision of advocacy in the home. An advocate is an independent person who helps represent people's views or assists them to represent their own views. The registered manager told us they had an independent advocate who they could call upon if an advocate was needed.

We found the service protected people from the risks of social isolation and loneliness and recognised the importance of social contact and friendships. We saw how relatives and friends were encouraged and supported to visit the home. Staff described how some relatives came in each day and supported their family member at mealtimes. Throughout our inspection relatives arrived to visit their family members. Relatives told us they felt involved in people's care.

Independence was encouraged for those who were able. For example, it was observed that people who had walking frames and could use them independently were encouraged by staff to use them to reach the dining room. Staff offered help when they got to the table and to transfer them to the chair and walkers were the put outside the dining room.

Information about the provider and the home was available in the reception area of the home. People and their relatives were given the opportunity to engage with the service and give their comments. However we found the electronic feedback system was behind a pillar in the entrance way of the home and was not within sight of visitors entering the premises.

People's care records were stored confidentially behind locked doors and within lockable cupboards. We observed staff returning files and documents to the cupboards to maintain people's confidentiality.

Requires Improvement

Is the service responsive?

Our findings

We looked at people's care records and found, as a result of their dementia, some people could become agitated. Two people had been prescribed 'as and when required' sedative medication to be administered at such times. There was no indication in the care records of the threshold of behaviour(s) which would indicate to staff at which point medication needed to be administered or step by step guidance to inform staff about what they should do to support people in a positive way at such times other than to administer medication. We asked a senior member of staff when they would administer 'as and when required' medication for agitation for one person and they told us 'It all depends on how the shouting is going. "This placed people at risk of unsafe inconsistent care as they may receive this inappropriately.

We found the guidance and advice provided by other healthcare professionals were not always acted upon by the care staff. For example, we saw that one service user had been provided with a detailed plan form the occupational therapist suggesting ways of improving this person's quality of life. We saw no evidence of this plan being implemented.

We found examples of where information recorded in peoples' care plans had not been acted upon by staff. For example, it had been recorded in one person's care plan they had fallen on seven occasions since their admission to the care home. There was no evidence of any action being taken by staff, such as a referral to the falls team to reduce the risk of this happening again.

There was information in the care plans to describe the type of dementia people had been assessed as having, however, there was no further information as to how this may affect them and the support they may require as a result of this. This meant people were at risk of inappropriate care and treatment.

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

Staff spoke to us about managing records. Staff were required to use NHS documentation for people admitted to the home for intermediate care. If a person continued to live in the home staff transferred the information to the provider's documentation. We found staff had included person centred information. Staff told us about people's care needs and we found the information was contained in the records. Nursing staff demonstrated to us they knew and understood people's medical histories.

Care records were regularly reviewed. Staff were aware of updated information, for example when people were returned from hospital. We saw the deputy manager who was also the nurse on duty respond promptly to ensure medicine plans and records were immediately updated when one person was discharged from hospital to Brockwell Court.

We saw there were two designated activities co-ordinators whose role it was to plan a range of daily activities for people to take part in. We spoke to one of the activities co-ordinators who demonstrated a good understanding of each individual's likes, choices and current care needs. They described how they

provided people with activities both in the care home as well as trips further afield in the local community. The activities co-ordinator kept a record of activities, who had taken part and their responses. They used this information to review and develop the activities programme. The activities co-ordinator described how they used a sensory trolley with some people living with dementia. For other people living with dementia they described the importance of one to one time and also the need to provide outdoor activities, such as trips to the beach for fish and chips so people could experience the sensory stimulation such an outing provided. We observed that on one of inspection days at 10.30am there was a coffee morning and chat on the ground floor in the conservatory followed by a game of bingo. Staff brought people into conservatory to participate in the activity. There were 17 people who attended along with both the activity coordinators.

Following the inspection we spoke to two relatives who told us they felt when they had raised concerns with the registered manager they had not received a satisfactory response. During the inspection people we spoke with advised they did not have reason for any complaints but if they needed to make a complaint they would have no problem addressing this with staff or management. One relative told us, "We have never really had any complaints." Another relative said "I have never raised a complaint, but I would if I needed to no problem." We checked the complaints records on the day of the inspection. We found procedures had been followed when complaints had been made. The staff we spoke with told us they knew how important it was to act upon people's concerns and complaints and would report any issues raised to the registered manager or deputy provider. We saw how people's complaints had been fully investigated and the outcome reported to them.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people. This was to ensure up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met. Arrangements were in place in the home for people who were in receipt of end of life care.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection we saw little evidence of good governance or leadership. For example we found staff were not deployed in the home to avoid one member of staff caring for people on their own whilst other staff had a cigarette break. We did not see evidence that staff time was organised effectively to meet people's needs, for example, some people did not receive the support they needed at mealtimes. Staff were not always caring providing people living with dementia with the support they needed; there were no audits or observations of care practices to help identify and address these issues.

Each day the registered manager of their delegated representative carried out an audit. The daily audit included checks on the home and speaking to a member of staff and a person who uses the services. We found these audits had failed to address the deficits we found in the service. The lack of cleanliness and general poor state of repair of Allensford demonstrated a clear lack of regular auditing of standards of care.

Dining audits had been carried out in December 2017. The audits demonstrated improvements were required. However we found no remedial action plan was put in place as required by the audit document. We spoke to the registered manager about this omission. They apologised for not completing the audit thoroughly.

During our inspection the regional manager was carrying out an audit of the service. We reviewed the regional manager's audits for August, October and December 2017. The audits were fully completed and for the most part we found them to be accurate. There was however a tick in the box which indicated staff supervisions were in line with the supervision matrix. We found staff supervision notes and the matrix to be incomplete.

We found in April and May 2017 there were no checks documented in respect of water and fire hazards. The registered manager was unable to provide us with the documentation to indicate checks had been carried out. We asked to see the health and safety audits covering the same period. The registered manager sent us health and safety audits for April and July and confirmed these are carried out every three months. There was no audit evidence to indicate issues we found during the inspection. Instead the registered manager had ticked the boxes to say all checks had been carried out.

We found the provider had failed to act on feedback from the Infection Prevention and Control team to improve the cleanliness of the home and reduce the risk of cross infection.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Almost all family members and relatives knew who the registered manager was in the service. Relative told us, "I know who they is yes – they are very nice", "They are nice if I have any problem I would speak to her" and "They seems ok, don't see much of her to be honest." Staff told us they felt the registered manager was approachable.

We found the culture of the was home varied from area to area with differing staff practices on each unit. The senior on duty in each of the areas was pivotal to how the area functioned. It was evident that the areas of the home where we found the most significant breaches lacked the leadership required to run the shifts. Staff commented to us they were dependent on having a senior in post who knew people well.

The provider had an electronic system in place for people, their relatives and visitors and other professionals to provide feedback. Feedback was reviewed on an on-going basis by the registered manager. We reviewed samples of feedback. People who used the service described the home as a happy place to live. Positive feedback had also been provided by other professionals who said they were 'extremely likely' to recommend the home to others. They also reported staff were very welcoming.

The provider had carried out a staff survey. The results had been aggregated and the data for Brockwell Court had been extrapolated. We saw staff responses had been rated as red, amber or green to show the different levels of staff response. The staff survey had resulted in an action plan being developed to improve the service.

The registered manager chaired meetings for staff where they provided information, listened to staff comments and provided praise, support and encouragement to staff to carry out their duties.

Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. The registered manager had made the required notifications to CQC.

The service worked in partnership with other agencies, for example we saw partnership agreements were in place with the local Clinical Commissioning Group (CCG) to provide intermediate care arrangements for people discharged from hospital. Partnership arrangements were also in place with local GP surgeries.

At the conclusion of our inspection we gave feedback to the regional manager, the registered manager and resident's experience dementia care specialist. They agreed to send us an action plan to address our areas of concern. We received the action plan and found actions were in place to make improvements with target dates for improvements identified.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People with dementia type conditions were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to do doing all that was reasonably practicable to mitigate risks. The provider failed to ensure the safe use of topical medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises used by the provider were not always properly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate systems effectively to assess, monitor, and improve the quality of the service provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was insufficient staff on duty to meet

Diagnostic and screening procedures

Treatment of disease, disorder or injury

people's needs.

Staff had not received appropriate levels of supervision and appraisal to carry out their duties.