Britannia Care Homes (Sussex) Limited

Britannia House

Inspection report

7-11 Jameson Road
Bexhill On Sea
East Sussex
TN40 1EG
Tel:01424 217419
Website: www.britanniacarehomes.co.uk

Date of inspection visit: 11 and 15 December 2014
Date of publication: 18/03/2015

Ratings

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

Overall summary

We inspected Britannia House on the 11 and 15 December 2014. Britannia House is registered to provide accommodation and support to people, many of whom were elderly and living with dementia. The service can provide care and support for up to 21 people. There were 18 people living at the home during our inspection.

Britannia House is a service belonging to Britannia Care Homes (Sussex) Limited and is a family run business.

Accommodation is provided over three floors with communal lounge and dining areas. Britannia House is situated in the coastal town of Bexhill, which benefits from good rail and road public transport links and a wealth of local shops and amenities.

A manager was in post however they were not the registered manager, but had submitted an application for registration with us. A registered manager is a person who has registered with the Care Quality Commission to

Summary of findings

manage the service and shares the legal responsibility for meeting the requirements of the law with the provider. The previous registered manager had left the home at the end of October 2014.

People spoke positively about the service and commented they felt safe. Our own observations and the records we looked at did not always reflect the positive comments people had made.

People's safety was being compromised in a number of areas. Medication was not administered as prescribed and its management meant that required medication was not always available when needed. Care plans did not reflect the complexities of some people's needs and incident and accident information was not used proactively or always taken into account when reviewing risk assessments. Where injuries were sustained, this was not always reported to the local authority safeguarding team when needed. Inadequate infection control oversight meant that people were not protected from the risk of infection. The building was not adequately maintained and the equipment available did not suit everybody's needs. Staffing levels were stretched and did not reflect the most recent needs analysis.

The provider was not meeting the requirements of the Mental Capacity Act (MCA) 2005. Mental capacity assessments were not completed in line with legal requirements. Staff were not following the principles of the MCA. We found restrictions imposed did not consider whether people could consent to these measures or if a less restrictive practice could be used. Mandatory and needs based staff training had significantly lapsed.

Although a quality assurance framework was in place, it was ineffective. This was because it did not provide adequate oversight of the operation of the service.

There were some positive aspects of care at the service. People were very complimentary about the caring nature of the staff. Staff interactions demonstrated they had built rapports with people and people responded to this positively. People told us staff were kind and compassionate and respectful of their privacy and dignity. However, we found some interactions were task led and other practices did not promote people's dignity. It was not clear that people were actively involved in the planning of their care.

People were able to see their friends and families as they wanted. There were no restrictions on when people could visit the home. The visitor we spoke with told us they were made welcome by the staff. Everyone we spoke with was happy with the food provided. Some people enjoyed the activities provided, but other people told us they were limited and there were not enough staff to support them to go outside. Feedback was regularly sought from people, relatives and staff.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Britannia House Care Home was not safe. Medication was not suitably controlled or administered.

Care planning and risk assessments did not reflect people's changing needs or take account of incidents and accidents. Incidents and accidents were not always reported to the local safeguarding team when someone had sustained harm. There were not enough suitably experienced or qualified staff.

The service was not properly maintained and infection control measures were inadequate.

Is the service effective?

Inadequate

Britannia House Care Home was not effective. Some staff had not received training on the Mental Capacity Act 2005. Mental capacity assessments were not completed in line with legal requirements.

Training and refresher training, intended to improve the skills and knowledge of staff had lapsed significantly.

The adaptation of facilities available did not meet a significant number of people's needs.

Poor communication meant that key tasks relating to people's health were overlooked.

Is the service caring?

Requires Improvement

Britannia House was not consistently caring. People spoke positively of the care they received; however, care practices did not always respect people's dignity and were task orientated.

There provider did not involve people in planning their own care plans. Care plans did not reflect people's involvement, wishes or aspirations.

Individual staff were seen to interact positively with people throughout our inspection. It was clear staff had built rapports with people and they responded to staff well.

Is the service responsive?

Inadequate

Britannia House Care Home was not responsive. Care planning was not suitably developed to meet the complexities of some people's needs. Care plan reviews did not always recognise and respond to people's changing needs.

The delivery of care often suited staff routine, rather than people's individual preferences and choices. Activities were not meaningful to some people living at the home.

Summary of findings

The service's complaint procedure was not readily available for people or visitors.

Is the service well-led?

Inadequate

The service was not well-led. Although there were systems to assess the quality of the service provided, these were not effective. The systems used had not ensured that people were protected against the risk of receiving inappropriate or unsafe care and support.

Incident and accidents were recorded but were not analysed for any emerging trends, themes or patterns.

Staffing levels did not reflect people's level of care needs.

Staff, visitors and people told us that the manager and owner were approachable.

Britannia House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection took place on the 11 and 15 December 2014. It was an unannounced inspection in response to receipt of information of concern. The inspection team consisted of two inspectors.

Before our inspection we reviewed the information we held about the service. We considered information which had been shared from the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection, we spoke with six people who lived at the service, a relative, the manager, deputy manager, operational manager, provider, three care staff and the cook. We looked at areas of the building, including people's bedrooms, the kitchen, bathrooms, the lounge and communal areas. Some people had complex needs and limited communication. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the records of the home, which included quality assurance audits, staff training schedules and policies and procedures. We looked at five care plans and the risk assessments included within the care plans, along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we followed the care and support a person's receives and obtained their views.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe. Comments included "I feel perfectly safe," "There is nothing that concerns me" and, "I think I am looked after well and the care I have received is good." People told us if they had any concerns they would speak with the manager or staff. They felt confident staff would support them to address any issue. Relatives spoke positively about the service. They had no concerns about the way their family members were treated and felt that they were safe. Although people told us they felt safe, we found examples of care practice which was not safe.

Skin condition and immobility require some people to use air mattresses to reduce the risk of skin damage. Air mattresses have specific pressure settings, based on a person's weight. Risk of skin breakdown is increased due to incorrect pressure mattress settings. One person's current weight was unknown, but the pressure mattress was set at double the required pressure based on their last estimated weight. An air mattress pump alarm sounded for another person. Staff did not know why the alarm was going off and cancelled it. On the second day of our inspection, we asked what action had been taken. Although the manager stated the pump was working and mattress inflated, no action was taken in the interim. The manager did not know why the alarm had sounded. This may have indicated a fault with pump or mattress pressure, placing the person at risk. Where people required repositioning in bed to help reduce the risk of skin pressure damage, it was not possible to know if this had always happened when it was supposed to because records were incomplete. The manager and provider were unable to confirm if people were repositioned when needed. This placed people at risk of skin breakdown and development of pressure areas.

Systems intended to allow an overview of incidents or accidents were ineffective. Incident and accident records showed that one person had fallen four times in November. A monthly falls risk assessment review had since been completed. The falls history was not taken into account.

Care plans contained personal emergency evacuation plans for people, however, although those looked at did describe a person's mobility and dependency, they lacked detail because they did not explain evacuation procedures to be followed.

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

Specific staff administered all medicines. Sample signatures of staff trained to administer medicine were out of date. This made it difficult to know who had signed medicine administration records (MAR) to indicate that they had administered medicines. Some people had not received medicines they were prescribed. Some medicine was not held in stock and other medicine was consecutively offered at a time of day that a person was asleep. Where consideration should have been given to increase a dose of medicine, this had not happened. Where a person refused their medicine for nine consecutive days, staff had not contacted the GP to establish any impact this may have on the person. This was contrary to the service's medication policy, which explained the GP should be contacted following three refusals. Staff inconsistently recorded the administration of prescribed drink thickeners. This made it difficult to track the amount of drink thickener held and impossible to establish if it was given to people appropriately, potentially placing people at risk of choking.

Where people were prescribed topical medicines such as creams, in some instances, records were incomplete. In one instance, staff were unable to provide any record that a cream was applied. This cream should have been applied twice a day and recorded. Staff could not demonstrate that the person's skin condition had been treated as prescribed.

There was no formal competency assessment of the ability of staff to safely administer medicine in between training events, set at three yearly intervals. People were placed at risk of not receiving their correct medication because safeguards and strategies to check the safe administration of medication were not embedded into practice.

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

The deputy manager was the service's Infection Control Lead. No additional infection control training had been provided. Their last infection control training required refreshing in May 2014. We looked around the service and all of the beds were made. Sheets, pillow cases and duvet covers remained stained after laundering, but were put on people's beds. One person's bed sheets were heavily soiled. Another person suffered from a skin condition that caused flaky skin. Their bedding was stained where their skin had wept and it contained flakes of skin. There was a lack of

proper planning and control of cleaning processes, including wet cleaning of carpets and antibacterial wiping down of commode frames. A strong smell of urine in two bedrooms, heavy staining and built up scale in some toilets indicated irregular cleaning. Adequate infection control knowledge and management oversight was not embedded into everyday practice. These concerns were raised to and acknowledged by the manager and provider.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staffing comprised of three staff on the day shift in addition to the manager. One additional member of staff attended the service for two hours at busy times of the day in the morning and in the evening. Two waking staff provided support at night. At the time of our inspection, two people were confined to bed. They were fully dependant on staff and required two staff to support them for all of their personal care and mobility needs. A further eight people required two staff to assist them with all personal hygiene and mobility needs. The most recent needs analysis dated August 2014 did not reflect that two people were confined to bed. In addition to providing care and support for people, one member of day staff administered medication three times a day, care staff carried out laundry duties, were responsible for delivery of activities and plated up food for the evening meals following the daily departure of the cook at 2.30pm.

Staff told us “Shifts can be hectic in the mornings and in the evenings, especially if any of the residents aren’t well” and, “Sometimes there is not enough time to do everything as I would like to.” During our inspection a member of staff supported a person with personal care when another person entered the bathroom. They needed to ask for the support of another member of staff, there were insufficient staff available to support them. Additionally, for the 10 people who needed the support of two members of staff, there was no staffing contingency should more than two people require support at the same time. Accident and incident reports recorded a number of unwitnessed falls of people in communal areas, this indicated that staff were not present and people were not adequately supervised.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked around the building. There were water leaks in two bedrooms at the top of the building, one was occupied. This caused areas of water staining, damp wallpaper and damage to the plaster. A water stain on the dining room wall reached from the ceiling to the floor. There were other dried water stains on ceilings and walls around the building. The cellar floor was visibly damp with some black mould on the end wall. Moisture absorbent equipment such as paper hand towels and incontinence pads were stored in the damp cellar environment on shelves. Externally, vegetation grew in some gutters and flat roof areas. Brickwork at the front of the building, particularly around windows, was weather eroded and cement pointing was missing. The poor maintenance of the exterior of the building would not help prevent water entering the building.

Some bedroom windows had been taped closed because window latches were missing or broken. Wardrobes in some people’s bedrooms leaned away from the wall into the room. The wardrobes could topple onto people with light pressure as they were not secured to the wall, presenting a risk of injury.

Maintenance reporting process were in place, however, there was no plan for proactive or remedial maintenance. The standard of decoration of some areas of the service and its exterior appearance showed maintenance efforts had not kept pace with the rate of wear. The ground floor communal toilet and staff/visitor top floor toilet had deteriorated, there were damp areas, peeling wallpaper and damaged plaster. Much of the gloss painted woodwork on doors, door frames and skirting boards was scuffed and chipped exposing bare wood. Some radiator covers were not securely fixed to the walls, others required painting or repair. Maintenance was not adequately planned or prioritised to prevent the deterioration of the property.

The periodic electrical installation test certificate could not be located. Areas around the service were dimly lit, making it difficult to see in artificial light. A current legionella risk assessment or management plan was not in place and no proactive measures, such as routine flushing of unused water outlets, were undertaken. It was not possible to know if the electrical wiring of the service complied with safety regulations or if the water was safe to use.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Safeguarding and whistleblowing policies and procedures were in place, although they had not been reviewed since

Inadequate

Is the service safe?

January 2012. Training schedules showed that safeguarding training had lapsed for five care staff and mandatory safeguarding training had not been delivered to either of the cooks or the cleaner. Staff had an understanding of the signs of abuse and told us they knew how to report concerns. However, we found some incident and accident reports showed people had sustained injuries and a cause was not always determined. In these instances, although warranted, referrals had not been made to the Local Authority Safeguarding Team as a reasonable step to identify the possibility of abuse.

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

Stairs were partitioned by gates at the top and bottom of each flight and also on half landings. The gates were secured by enclosed manual slide bolts, these would not release automatically in the event of a fire. We have referred this concern to the local Fire Safety Officer for their consideration.

People were protected, as far as possible, by a safe recruitment system. Staff told us they had an interview and before they started work and the provider obtained references and carried out criminal record checks. We checked two staff records and saw that these were in place.

Inadequate

Is the service effective?

Our findings

People and visitors spoke positively about Britannia House and the staff. People told us that they had confidence in the staff. Comments included, "The carers are very good" and, "The staff are marvellous." However, we found the service did not consistently provide care that was effective.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS).

DoLS form part of the Mental Capacity Act (MCA) 2005. It aims to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place intended to keep people safe. Where restrictions are needed to help keep people safe, the principles of DoLS ensure that the least restrictive methods are used.

DoLS authorisations were in place for two people, but applications had not been submitted for the remaining people unable to consent to their care and treatment at Britannia House. Restrictive practices such as stair gates and some bed rails were used, but assessments did not consider if people were able to consent to these measures or whether a less restrictive practice could be used, for example pressure mats or door monitoring alarms. This did not meet with the principles of DoLS.

Staff we spoke with had some knowledge of mental capacity and deprivation of liberty issues. Staff told us that most of the people supported would be unable to consent to care and treatment. The MCA requires that assessment of capacity must be decision specific and must also record how the decision of capacity was reached. We found mental capacity assessments did not always record the steps taken to reach a decision about a person's capacity. This did not meet with the principles of the Mental Capacity Act 2005 (MCA).

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

The staff training plan showed most training had lapsed for the 18 staff the service employed. This included MCA and DoLS, First Aid and Infection Control training. The training plan was in places contradictory, for example, it showed that some staff required Moving and Handling and Health and Safety refresher training after one year and other staff after three years. Training appropriate to the client group, for example, Behaviour that Challenges, Falls Prevention and Pressure Area awareness had lapsed or had not been delivered for all staff identified as requiring it. Training and refresher training, intended to improve the skills and knowledge of staff had lapsed significantly. People could not be assured that staff had acquired or maintained the skills and knowledge required to appropriately support them. Appropriate arrangements were not in place to support staff development in their responsibilities to deliver effective, safe care.

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

Britannia House specialises in the provision of support for elderly people, many of whom are frail. However, the facilities and adaptation of the premises did not meet each persons need. For example, eight people were unable to use the bath because the bath chair was not suitable for them due to their frailty. There was no alternative, more suitable bath chair, or provision of a specialist bath, seated shower or wet room. The limited facilities did not compliment the specialism of the service and directly impacted on the way personal care was delivered.

This is a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Communication within the service was not always effective. Although we saw a thorough and informative staff handover process, some basic communication systems within the service were not effective. For example, records for one person showed they had recently had a blood test. A District Nurse had left instructions with the service to contact the surgery for the test results the following week. This had not happened and only took place when pointed out by us. We discussed our concern with the manager and found that staff had not transferred the follow up request into the home's system. This meant that the person was potentially placed at risk because of staff inaction.

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

Staff supervision and appraisal processes were in place. Staff confirmed they had occurred when planned and they found them useful. Most care staff had achieved a level of National Vocational Qualification in care. Staff told us that the management and owner of the service were approachable.

Inadequate

Is the service effective?

We observed lunch on both days of our inspection. The service catered for a variety of diets, determined by individual choice and medical requirement. Where specialist healthcare professionals, such as speech and language therapists, had recommended that some people required softened food, this was provided. People told us, “The food is very good” and, “There is always plenty to eat.” The food served was well presented, looked appetising and was plentiful. People were encouraged to eat independently and supported to eat when needed. Drinks were provided during meals together with choices of refreshments and snacks at other times of the day.

Staff monitored people's food and fluid intake and watched for any signs of weight loss and malnourishment. Records of people refusing to eat or only eating small amounts were recorded in daily notes and formed a basis for GP or dietician referrals. Where possible people were weighed each month which helped to ensure weight loss was recognised and addressed.

Requires Improvement

Is the service caring?

Our findings

People told us staff were kind in their approach. People commented their privacy and dignity was respected and that staff at Britannia House were caring. Some people with more complex needs we were not always able to share their view on the care and support they received, so we spent time observing staff and people interacting together. Staff interactions were compassionate and well-intended; however, we identified some aspects of care that impacted on people's dignity and independence which required improvement.

Elements of care delivery were task orientated, suited to the availability of staff. For example, following lunch, there was a clear 'toileting' routine where staff took people in turn to the toilet. This did not consider choice or promote people's dignity, independence or individuality. A notice pinned to the back of some people's bedroom doors and displayed in the dining area set out a daily schedule, which included meal times. People were encouraged to eat in the dining areas and breakfast was served at 8am. The routine reflected the needs of the service rather than the individuality of people living there, as it impacted on when people had to get up. Bedding was crumpled and worn, often with some tears and staining. This did not contribute to people's feeling of self-worth, individuality or dignity. Two bedrooms smelled strongly of urine. This indicated that these people's continence needs were not well managed which degraded their standard of living.

Each person had a care plan, intended to give guidance about the care and support being provided and how they wanted to receive it. Care plans should be designed and agreed with the person through the process of care planning and review. However, there was no evidence people were actively involved in their care planning. Care plans did not reflect the how people's interests, aspirations or goals should be met. Information was not available on how the person wished to receive their care, or what aspect of their care delivery was important to them. Care plans were reviewed monthly, but we could not see any confirmation people had been involved in care plan reviews.

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

People were supported to wear their glasses and hearing aids as needed and wore clothes of their choice. A hairdresser called at the service weekly. Gentlemen had been supported to shave, however, one member of staff commented, "Shaving doesn't always happen, it depends who is on duty".

Although we identified some areas that required improvement, we did see staff interacting with people in a kind and compassionate way. Staff understood the basis of dignity in care and we observed some positive interactions. For example, a member of staff engaged a person in conversation which enabled them to orientate to their surroundings and reminisce about music and pets. We saw staff sensitively supporting a person who had become upset. Staff were able to speak knowledgably about people's characteristics and personalities. Most people appeared comfortable with staff. When supporting people and if asking their preferences, staff did so at an appropriate pace, giving people time to form their decisions and express their views. Screens were placed around people to afford some privacy if receiving care or medical consultation in a communal area.

Staff were considerate and accommodating of people's evident cultural and religious needs and beliefs.

Relatives told us that they were made to feel welcome when they visited and that visiting times were open and flexible. They did not raise any concerns with us about the service or care delivery.

Inadequate

Is the service responsive?

Our findings

People said they were well looked after by care staff, but some people commented they felt they needed to fit in with how and when staff wanted to do things; giving examples of bath days, group activities and only going outside if staff were available. Care plans we looked at did not consistently respond to people's needs.

Each person had a care plan. Their physical health, mental health and social care needs were assessed and care plans developed to meet those needs. Care plans included information about people's next of kin, medical background, dietary needs and health care needs. However, we found that some aspects of care planning was not sufficiently developed to adequately address the complexities of some needs. For example, a continence care plan did not address the person's need. Although their plan had been reviewed, no specialist advice was sought or alternative strategies developed. Another person regularly became upset, wanting to go home to see a relative who was now deceased. There was no plan in place to support their upset, or strategy to help staff consistently orientate their confusion.

Another care plan did not contain sufficient guidance for staff, because of generalised statements. For example, a risk assessment about a person's mobility and how they should be moved told staff to ensure that they used the correct lifting sling. It did not however tell staff which was the correct sling to be used. This placed the person at risk of injury if the incorrect sling was used. A further care plan contained contradictory information about a person's seizure history. This was because different information about it was recorded in different places in the care plan. This meant that staff may be misinformed about the person's condition. Forms intended to record information about the support and personal care provided in areas such as oral hygiene, application of creams, fluid intake, hourly checks and pressure mattress setting checks were often incomplete. This made it difficult for staff to track or respond to changes in people's condition and know if tasks were completed.

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

Activities were delivered by two care staff, allocated one hour a day each in addition to their other duties. Activities included sing along events, music for health, hand massages and nail care as well as quizzes, magazines and talking book events. A PAT dog, owned by the provider, regularly visited the service and was popular. A Christmas party was also planned. People told us while they welcomed these activities, in the absence of anything else, some people found them impersonal and communal by their nature. This was because they did not necessarily represent their interests. When observing interaction between people and staff we saw that some people sat for long periods of time, dozing or disengaged with the environment around them. On both days of our inspection a number of people asked to go outside. Staff told them it was not safe for them to go outside on their own and, because staff were engaged in their various duties, people remained within the service. People told us they would have enjoyed going outside.

The four main rooms of the communal area were all painted the same colour and, although decorated for Christmas, did not provide visual stimulation or help people to easily distinguish them from the other rooms. Rooms with different uses should have a variety of colours to help people, particularly with dementia, easily distinguish them from other rooms. Most of the service, including people's bedrooms, was painted the same colour and did not promote individual choice or contrast.

We recommend that the service considers implementing aspects of the East Sussex County Council Continuous Improvements in Dementia Care Homes Good Practice Guide, together with soliciting the support of organisations such as the local Care Home In-Reach Team.

People and visitors we spoke with told us that they did not have any concerns about the care and support received. They told us they were confident staff or the provider would satisfactorily address any complaint or concern should the need arise. The manager confirmed that they were not dealing with any complaints at the time of our inspection. Although the service had a complaints policy, the complaints procedure was not readily displayed for people and visitors. We have identified this as an area that requires improvement.

Inadequate

Is the service well-led?

Our findings

The previous manager had left the service in October 2014. There was no registered manager in post, however, we have received an application for the position of registered manager which is in progress.

There was not an effective quality assurance framework in place. The manager and provider regularly completed quality monitoring checks, however, these were not effective because they had not recognised or addressed many of the concerns identified during this inspection. These included improper administration of medicines and ineffective assessment and review of people's needs. Infection control processes were not embedded into everyday practice, resulting in a lack of hygiene and odours in areas of the service. People were not protected against the risks of an unsafe or unsuitable premises because it was not adequately maintained. There was also a lack of equipment required to support some of the people living at the service. Insufficient staff were deployed resulting in task led and impersonal care. The majority of staff training had lapsed. Quality monitoring systems had not ensured that people were protected against risks relating to inappropriate or unsafe care and support or that it was delivered within the principles of the MCA 2005.

Accidents and incidents were recorded, but lacked management oversight to ensure that they formed part of the quality assurance systems in place. The manager had not recognised the need to inform appropriate agencies of some incidents when they were required to.

Management checks undertaken intended to ensure the safe operation of the fire bell, automatic fire door closers, fire alarm and nurse call alarm system were sporadic and incomplete.

The provider had a vision and values statement. It explained 'Britannia Care Homes operates four high quality care homes in Bexhill-on-Sea, East Sussex, specialising in dementia care for the elderly. We pride ourselves in offering outstanding levels of care in a homely environment. We treat every resident as an individual.' The statement did not correctly reflect the number of homes operated and our inspection found Britannia House did not meet its published vision. Staff were unaware of the vision and values statement, no management strategy was evident to develop the statement into working practice. Although Britannia House specialised in the provision of dementia care, there were no established working links with specialist organisations or an active management plan to drive forward or improve the quality of the service provided.

Staff meetings were held regularly, we looked at a sample of minutes which confirmed this. Staff commented that they found these meetings useful and could raise concerns. However, we found concerns expressed to us by staff about staffing numbers and training had not been addressed. Staff told us that they enjoyed working at Britannia House, but they did not always feel listened to.

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

Records did not meet their intended use. Care plans and associated records were complex, at times confusing and contradictory; staff recorded the same things in different ways for different people. This indicated that all staff were not familiar with care planning and the systems intended to support it. Records intended to monitor the care and support delivered to people were incomplete. These included air pressure mattress checks, repositioning charts for people at risk of skin damage, application of topical cream records, oral hygiene and fluid charts. People were not protected against the risk of inappropriate or unsafe care because proper records were not kept.

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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person did not protect service users against the risks associated with the unsafe use and management of medicines. Regulation 13**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered person did not have effective systems in place to protect people from the risks of acquiring a health care associated infection as appropriate standards of cleanliness and hygiene were not maintained. Regulation 12 (1)(a)(b)(c) (2)(c)(i)(ii)(iii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The registered person did not have suitable systems in place to ensure that at all times there were sufficient numbers of suitably qualified, skilled and experiences persons employed to meet the needs of the service users. Regulation 22**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

This section is primarily information for the provider

Action we have told the provider to take

	The registered person had not ensured that people and others having access to the premises were protected against the risks associated with unsafe or unsuitable premises by means of adequate maintenance. Regulation 15 (1) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person did not make suitable arrangements to ensure that service users are safeguarded against the risk of abuse. Regulation (11) (1) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person had not ensured that staff had received appropriate training. Regulation 23 (1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment

This section is primarily information for the provider

Action we have told the provider to take

	The registered person had not made suitable arrangements to ensure the availability of equipment provided promoted the independence and comfort of service users. Regulation 16 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person had not ensured people's independence and dignity was promoted or that they were enabled to make or participate in making decisions relating to their care and treatment. Regulation 17 (1) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered provider had not taken steps to ensure that each service user was protected against the risks of receiving care that was inappropriate or unsafe arising from a lack of proper information by means of an accurate record in respect of each service user and other records in relation to the management of the regulated activity. Regulation 20 (1) (a) (b) (ii)

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered provider had not taken steps to ensure that each service user was protected against the risks of receiving care that was inappropriate or unsafe by means of carrying out of an assessment of needs of each service user and the planning and delivery of individual needs. Regulation 9(1)(a)(b)(i)(ii)(iii)

The enforcement action we took:
A warning notice has been issued. The service is to be complaint by 31 March 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of service users and others. Regulation 10 (1) (a)(b) (2)(c)(i)

The enforcement action we took:
A warning notice has been issued. The service is to be complaint by 31 March 2015