GCH (Brackenbridge House) Ltd

Brackenbridge House

Inspection report

Brackenhill
Victoria Road
Ruislip
Middlesex
HA4 0JH

Tel: 02084223630
Website: www.goldcarehomes.com

Date of inspection visit:
31 January 2016
01 February 2016
03 February 2016
04 February 2016

Date of publication:
06 September 2016

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**

Summary of findings

Overall summary

We undertook an unannounced inspection of Brackenbridge House on the 31 January, 1 February, 3 February and 4 February 2016.

Brackenbridge House is a residential home and is part of Gold Care Homes. It provides accommodation for up to 36 older people in single rooms. The home is situated within a residential area of the London borough of Hillingdon. At the time of our visit there were 31 people using the service.

We previously inspected Brackenbridge House on 6 and 8 July 2015 and we identified issues in relation to staff training and supervision, staffing levels, maintain accurate records of care, the support provided not reflecting people's needs, sending notifications to the Care Quality Commission and care plans not including information on DoLS.

At this inspection we found the provider had made some made some improvement but there were still shortfalls with staffing levels, training and supervision, medicines management and activities.

The service had a new manager who started during January 2016. They were in the process of applying to be the new registered manager. 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 number of care workers on shift at night had increased to three. However, there were not enough staff deployed during the day to meet people's needs and there were delays in people receiving the support they needed. People told us they felt safe but they had concerns regarding the number of care workers available to provide support.

There were recruitment processes in place for care workers that were directly employed by the provider but records were not kept in relation to the care workers employed via an agency. Therefore the provider could not ensure these care workers had the appropriate knowledge and skills to provide safe care.

There was a procedure in place for the management of medicines but care workers were not recording the administration of medicines accurately. Stocks of prescribed medicines were not monitored appropriately which resulted in people running out of their medicines.

The care workers did not have access to appropriate hand washing facilities to support their infection control process. We observed people were being put at risk because some practices in relation to supporting people to eat were not safe.

The provider had processes and procedures in place for the recording and investigation of incidents and

accidents. Each person using the service had an evacuation plan in place in case of an emergency.

Some staff had not completed training identified as mandatory by the provider. Staff had not had annual appraisals in line with the provider's policy in relation to supporting staff.

We found the service had made appropriate applications to meet the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA) but these applications had not been monitored to ensure they were being processed.

We saw that in general people were treated with dignity and respect but on some occasions this did not happen when people were being moved using a hoist and being weighed.

The activities provided in the home were not meaningful, were not based on people's interests and did not encourage engagement with other people.

The provider did not ensure equipment was kept clean and met the needs of people using the service.

Detailed assessments and care plans were in place identifying the care and support needs of the people using the service.

The provider had limited systems in place to monitor the quality of the care provided. These did not provide appropriate information to identify issues with the quality of the service.

Records relating to care and people using the service were not completed accurately to provide a current picture of the person's needs and the support provided.

We found a number of breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking action against the provider for the breach of the Regulations in relation to person-centred care (regulation 9), safeguarding (Regulation 13), the safe care and treatment of people using the service (Regulation 12), the good governance of the service (Regulation 17) and staffing (Regulation 18). You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's

registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People using the service were put at risk as standards of cleanliness were not maintained.

There were not always enough staff to meet people's care needs appropriately and safely.

There were procedures in place for the safe management of medicines but staff did not complete records relating to medicine use as required by the provider's own systems.

Information was not available in relation to the training and skills of the care workers employed via an agency.

People were put at risk because some practices in relation to supporting people to eat were not safe.

Is the service effective?

Inadequate

The service was not effective. Staff had not received the necessary training and support they required to deliver care safely and to an appropriate standard.

We found the service had made appropriate applications to meet the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA) but these applications had not been monitored to ensure they were being processed.

People gave mixed feedback regarding the choice of food available. People did not always know what food options were available and did not receive the food they requested.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring. Care workers understood people's needs but were limited as to the time they could spend with each person due to other tasks.

We saw that in general people were treated with dignity and respect but on some occasions this did not happen when people were being moved using a hoist and being weighed.

Care plans identified the person's cultural and religious needs.

Is the service responsive?

Inadequate

Some aspects of the service were not responsive. Activities provided by the home were not meaningful and engaging.

The provider did not ensure equipment was kept clean and met the needs of people using the service.

Detailed assessments were completed before a person moved into the home. The care plans identified the person's wishes and needs in relation to the care provided.

People knew how to make a complaint and there was a complaints policy and procedures in place.

Is the service well-led?

Inadequate

Some aspects of the service were not well-led. Regular audits had not been carried out to identify aspects of the service requiring improvement. Action had not always been taken to address issues.

Records relating to care and people using the service were not completed accurately to provide a current picture of the person's needs and the support provided.

People using the service, relatives and care workers gave mixed feedback in relation to if the service was well-led and identified there had been a lot of changes in recent months.

Brackenbridge 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 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 the 31 January, 1 February, 2 February and 3 February 2016. The first day of the inspection was unannounced with the following days being announced. The inspection was undertaken by one inspector.

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. We also reviewed the notifications we had received from the service, records of safeguarding alerts and previous inspection reports.

During the inspection we spoke with six people using the service, three relatives and five care workers. We also spoke with the manager, group operations manager, the provider's care quality officer and care quality support worker. We reviewed the support plans for seven people using the service, the daily records of care for seven people, the employment folders for four care workers, the training and support records for 30 staff and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

At the inspection of Brackenbridge House on 6 and 8 July 2015 we found that people using the service, relatives and care workers had concerns relating to the staffing levels at the home. This was a beach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider told us this breach would be addressed by 30 September 2015.

At this inspection we found that the provider had not followed their action plan in full in relation to staffing levels during the day. The manager confirmed they had increased the number of care workers overnight. At the time of the last inspection there had been two waking care workers with a senior care worker asleep (on call to provide support when required). This had increased to three waking care workers at night by the time of this inspection. The provider had agreed following our previous inspection to add an additional care worker during the morning to provide support. At the time of this inspection that had not happened.

People using the service told us "Staff don't have time to sit and chat" and "We have our emergency bells around our necks but it doesn't mean they will come quickly as they are busy".
Relatives told us "Regular carers are brilliant but are pushed from pillar to post to do things" and "There are just not enough staff to help people and the amount of help they need had increased.''

Care workers we spoke with said "It is very task focused and sometimes you feel guilty when you can't spend time with a person. The focus should be on the people at the end of the day, it's about good quality care. Mornings, you get your list of who you need to get up and you are running around like a lunatic", "It's like a conveyer belt, everything is rushed and is stressful" and "It is busy in the mornings and you don't know where to go. You bring a person into the dining room then someone else asks for help but you have people on your list that you need to get up and dressed. You dread going into the lounge or dining room when you are busy as people ask for help but you have other people to help." Another care worker told us "You can't expect four staff to do all the care, the bells keep ringing and we can't do everything."

At the time of this inspection there were 31 people were living at Brackenbridge House with eight of them requiring the support of two care workers during personal care and the help of one care worker when eating.

We saw that people were still being brought down for breakfast at around 10 am and one person had been left in the dining room in a wheelchair for more than an hour before having their breakfast at 10 am as there were no care workers available to support them. We observed another person, whose care plan stated they should be supported by a care worker to eat during meals, who had been left with a bowl of porridge in the dining room. The person tried to eat their breakfast on their own as no care workers were available to help but ended up with their hands and face covered in the food. A care worker then arrived, helped the person clean the food up and then supported them to eat the rest of the porridge which by that point had been on the table for more than 20 minutes.

During the inspection we observed care workers regularly waiting up to 10 minutes for a colleague to be

available to help them move a person using a hoist between a chair and wheelchair in the lounge. People should only be transferred by hoist when supported by two care workers. This meant the person had to wait in their wheelchair for longer before being moved to an armchair. We also observed that when a person in the lounge felt ill two care workers were required to take them to their room and help them feel comfortable. This resulted in the evening meal being delayed by 40 minutes as there was only one care worker available who could not use the hoist on their own.

One relative we spoke with described a number of occasions where their family member did not receive their care in a timely manner as care workers were busy. One incident related to their family member not being dressed and supported to access the commode until after 11am so the relative had to provide the support for their personal care. Another occasion related to their family member being left on a commode by a care worker during personal care in the morning. The care worker had left and no one else was there to provide support. The relative told us it took 30 minutes for find a care worker available to support their family member.

We saw that during the period of the inspection the care workers were receiving extra support at meal times and when moving and handling from a care quality officer and a care quality support worker who were brought into the home by the provider. These experienced staff had recently been placed at the home in a supernumerary role by the provider to help improve the quality of the care provided and ensure that relevant records had been completed correctly.

The manager told us that changes to the number of care workers in the morning were being implemented and it was planned that two senior care workers would be on duty in the morning to carry out the medicines round and then assist with personal care. There were also plans to encourage people to eat their breakfast in their rooms before receiving personal care to allow care workers more time to provide support for people with a higher level of need.

Therefore the provider had acknowledged that they did not have enough staff on duty to meet people's needs at the time of the inspection. This meant that people had to wait for the care they needed.

The above paragraphs demonstrate a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People living at the home were at risk because some of the practices care workers followed were not safe or suitable. We observed a care worker supporting a person to eat their meal in the dining room and this person had restricted movement and could not sit up straight in a wheelchair. We saw that the way the person's wheelchair had been placed at the table meant their head was bent below the edge of the table. We observed the care worker place their hand on the person's forehead, lift their head and place the spoon in their mouth and then let their head drop back into position. The person needed a puree food diet and we saw the care worker was helping them eat yoghurt which was also on the person's face, hands and clothing. We saw the person was coughing and because of the position of the person's head the care worker could not see their face to ensure they had swallowed the food or if they wanted to continue eating. The person being supported could not clearly communicate verbally so the care worker needed to be able to see the person was swallowing the food and was happy to continue. The care worker was also supporting another person across the table to eat their lunch at the same time so had to monitor two people at the same time.

The observed practices put the person at risk of choking. The care worker was unaware that their actions were inappropriate and dangerous as they confirmed that they had recently started work as a care worker and had not received any guidance or training in relation to supporting people to eat.

The above paragraphs demonstrate a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our comprehensive inspection of Brackenbridge House on 6 and 8 July 2015 we made a recommendation to the provider to review the NICE (National Institute of Clinical and Care Excellence) guidance on the management of medicines in care homes in relation to organising medicine rounds.

The provider had a policy and procedure for the administration of medicines but the care workers were not recording the administration of medicines accurately and stock levels of medicines were not monitored. Medicines were kept securely in locked trolleys which were placed in a locked storeroom. Medicines were only administered by senior care workers who had completed medicines management training and had been assessed as competent. Senior care workers were supposed to record the medicines they had administered or supported the person to take on a medicines administration record (MAR) chart. We looked at the MAR charts for 16 people using the service and saw that the MAR charts for 11 people had not been completed accurately. We also saw that the stock of a prescribed medicine for people had run out. For example, we saw the MAR chart for one person indicated they should be given half a 20mg tablet of a diuretic twice a day but the records from a recent General Practitioner (GP) visit stated dosage had increased to 40mg twice a day. The senior care workers had been administering the medicine at the level indicated on the MAR chart which had not been amended following the GP visit. We saw one person had been prescribed a transdermal patch for pain relief and the MAR chart indicated it had been administered but the chart showing the positioning of the patch had not been completed each time it was replaced.

During the last day of the inspection visit, we saw that the MAR chart for one person had not been completed for the previous evening's medicines. Later that day the administration details for the previous evening were filled in. This meant that the records had not been completed at the time of administration by the member of staff administering the medicines. Therefore, they were not an accurate and contemporaneous record.

We checked the blister packs for the person's medicines which showed they had been administered the evening before and we discussed this with one of the provider's senior managers who agreed to review what happened in relation to the medicines recording.

The MAR charts for eight people showed the stock of at least one of their medicines had run out therefore they had not received these medicines as prescribed. This included one person who did not receive their medicine for seizures for eight days as the stock had run out. Another person had not received their prescribed pain relief for seven days. Other medications which had run out included paracetamol, aspirin and various inhalers.

The MAR charts for three people indicated they had been prescribed pain relief but did not clearly identify if they were to be given as required (PRN) or the prescribed dosage at regular times during the day. We saw a senior care worker bring a person their medicines and the person queried why there was only one diuretic and one pain relief tablet in the cup as they usually had two pain relief tablets. The member of staff then asked the person if they were in any pain and if they were not they could not have the second tablet. The member of staff was not clear if the pain relief medicine was a regular dosage or to be taken as required.

This meant people were at risk because they were not receiving their medicines as prescribed and the staff did not follow safe practices for administering medicines.

The above paragraphs demonstrate a breach of Regulation 12 of The Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Care workers did not have access to separate hand washing facilities and equipment. We saw that care workers had to use the sinks located in people's bedrooms or in the communal bathrooms to wash their hands after they provided care. Other types of personal protective equipment (PPE) were available for care workers to use. There was a bathroom available for care workers to use near the staff room but this was located at one end of the building and was not quickly accessible for care workers when busy. We saw that alcohol hand gel was not provided for care workers to support an infection control process. This meant care workers could not ensure they maintained appropriate levels of hand hygiene.

The home had a cat which was looked after by the care workers and had a care plan and risk assessment in place. During the inspection we noted there was a strong malodour in the lounge area. We saw the cat litter tray was located in the corner of the lounge behind armchairs used by people using the service. It appeared the litter tray had not been emptied for a number of days which resulted in the strong malodour of ammonia. There was no system in place to ensure the litter tray was regularly emptied and the litter replaced. We raised this with the care quality support worker who replaced the existing litter tray with a covered one to control any odour.

The above paragraphs demonstrate a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had safe recruitment practices in place for care workers directly employed by the service but appropriate checks were not carried out in relation to care workers provided by an agency. New care workers provided the details of two referees and underwent an interview process before starting as a care worker and we saw records to confirm this. The manager explained that a number of care workers from agencies were regularly used. We asked the manager for any records relating to the agency workers including their names, a photograph, contact details, training records and if they had completed a Disclosure and Barring Service check (DBS). The manager confirmed that they did not have these records and could not confirm the previous experience, training and skills of the agency care workers. This meant that the provider could not ensure that the care workers provided from an agency had the appropriate knowledge and skills to provide safe and suitable care.

The above paragraph demonstrates a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We asked people living at the home if they felt safe when receiving care and they told us they did feel safe when cared for by the longer term care workers but they had concerns about what the new care workers knew about their care. One person told us "There are not enough staff and the new ones don't know what they are doing and we can't understand them." A relative said "They used to be really safe but not sure now." We saw the service had effective policies and procedures in place so any concerns regarding the care being provided were responded to appropriately. There was also a policy in place in relation to whistleblowing. Care workers we spoke with understood the term safeguarding and knew what to do if they had any concerns about the care being provided. However, we observed a number of practices where people were put at risk of harm and neglect.

We looked at the records for safeguarding and saw there was only information about one safeguarding concern on file since July 2015. We asked the care quality officer to check how many referrals had been made to the local authority since July 2015 and there had been four. This was discussed with the manager and they agreed to locate the information. We saw that records for referrals made by the new manager

included appropriate information about the safeguarding concern identified.

The provider had a process in place for the recording and investigation of accidents and incidents but this was not always followed by care workers. The manager explained that when an incident or accident occurred the care worker was required to complete a form recording the details of the event, who was involved and what action was taken. We looked at six forms that were completed before the new manager started and saw that the forms had not been completed in full and the events had not been investigated or signed by the deputy manager. We also looked at four forms for incidents and accidents that had occurred since the new manager had started and saw they were completed in full and the manager had reviewed the information and signed the forms. The manager confirmed care workers were being supported to complete the forms with detailed information. The manager told us they would also discuss the event with the care worker and identify any actions required to reduce the risk of the event occurring again.

Plans were in place in case of an emergency that required people using the service to be evacuated from the home. Each person using the service had an up to date personal evacuation and egress plan (PEEP) in their care folder. Each plan identified the person's support needs in relation to mobility, hearing and vision as well as their physical and mental ability. The plan also identified if the person could react to a fire alarm and how many care workers were required to help them leave the building safely.

We saw there were a range of risk assessments that had been completed for each person using the service. During the inspection we looked at the care folders for seven people using the service and we saw a general risk assessment was initially carried out when the person moved in to the home and were regularly reviewed. We saw specific risk assessments were completed and regularly reviewed for people who had been identified as being at a higher risk of pressure ulcers, falls and malnutrition. Moving and handling risk assessment was also in place for each person, identifying the level of support they required from carer workers including the use of a hoist. We saw the risk assessments linked to care plans which provided guidance for care workers on how to provide appropriate and safe care.

Inadequate

Is the service effective?

Our findings

At our comprehensive inspection of Brackenbridge House on 6 and 8 July 2015 we found the care workers had not received suitable training and support to enable them to provide appropriate and safe care for people. This was a beach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider told us this breach would be addressed by 30 October 2015.

At this inspection we found that the provider had not followed their action plan in full in relation to training and appraisals. We saw that supervision sessions had been carried out with some care workers but these had not been carried out regularly. The manager confirmed that no appraisal had been carried out since the previous inspection.

We looked at the training records for 30 staff members in relation to courses identified as mandatory by the provider and we saw some care workers and other staff had not undertaken training or had not completed the required refresher course. In relation to mandatory training which was identified as requiring to be completed annually we saw two senior care workers and two care workers had not completed moving and handling training. Also two senior care workers, six care workers and three domestic support staff had not completed safeguarding training. The fire safety training had not been completed by one senior care worker, four carer workers and five domestic support staff. In relation to infection control training two senior care workers, seven care workers and one domestic support worker. One senior care worker, seven care workers and four domestic support workers were not up to date with their health and safety training. Also one senior care worker, seven care workers and six domestic support workers had not completed the first aid awareness course.

This meant that care workers and other staff had not received suitable training and support to enable them to provide appropriate and safe care for people using the service.

The above paragraphs demonstrate a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

During the inspection the care quality officer provided a chart which showed when Deprivation of Liberty

Safeguards (DoLS) had been applied for, when they were approved by the local authority and the date they ran until. We saw that the DoLS for three people had ended at the beginning of November 2015 and a new application had been made to the local authority but no update on the process had been recorded. We asked the care quality officer to check with the local authority about these applications. They informed us that the applications for all three people had been returned by the local authority shortly after they had been made as there were errors on the forms. This had not been recorded and the applications had not been resubmitted. This meant the processes the provider had in place in relation to DoLS applications had not been followed for these three people and this increased the risk of their rights not being protected.

The above paragraphs demonstrate a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When asked about the food people we spoke with said "I get a choice but the food could be hotter. They don't cover the food from the kitchen so it gets cold" and "My relatives bring me food which is kept in the fridge as there are days when I don't like the food on offer." Another person told us "They get us into the dining room and then we can wait for an hour for food. They won't give us anything to eat until every seat in the dining room is filled. You wouldn't get treated like that in a restaurant but really we are paying like it is a restaurant."

During the inspection we saw four people asking the care workers in the lounge what was for lunch. The care workers told the people they did not know what was for lunch. We asked three people if they knew what choices they had from the menu each day and they confirmed they did not know until they were taken into the dining room. We noted that during meal times the dining room was very quiet and people were not provided with menus in a suitable format to help them choose their meal. We discussed this with the care quality support worker who started to introduce picture based menus by the end of the inspection.

We observed a care worker asking a person in the lounge what they wanted for lunch. The person did not want any of the options on that day's menu and indicated to the care worker they wanted some of the food provided by their relatives that was kept in the fridge. They asked the care worker for boiled potatoes to be served with their meal option. When a different care worker brought the person's lunch to them in the lounge there were no potatoes. When the person asked why these were missing the care worker told them "It's mashed potatoes or nothing as that is what is on the menu." The person told the care worker they did not like mashed potatoes and the care worker told them "Then it's nothing as there are no other options." This meant the person did not receive the meal they wanted.

The above paragraphs demonstrate a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our previous inspection of Brackenbridge House we made a recommendation for the provider to review guidance on developing a suitable menu that met the nutritional needs of the people using the service. During the recent inspection the manager informed us that a new menu had been introduced at the home three weeks before the inspection. We saw a record of each person's food requirements was kept in the kitchen. This information included if the person required a soft or pureed food and if they had any food allergies. Some of the care folders we looked at included a form indicating the person's food preferences.

At our comprehensive inspection of Brackenbridge House on 6 and 8 July 2015 we found the care plans for people with DoLS in place did not identify any impact on the way that care should be provided. This meant that care workers were not given sufficient information for them to provide appropriate care and support in line with the DoLS. This was a beach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2010.

During our recent inspection we saw that the people with DoLS in place had a specific care plan in place which described how the care workers should provide care and support and how decisions should be made in the person's best interest. These care plans had been regularly reviewed and related to each person's specific needs. This meant that the care workers were now provided with a suitable level of information to provide appropriate care and support.

There were regular visits to people using the service from a General Practitioner (GP) and other health care professionals. The care plans we looked at provided the contact details for each person's General Practitioner (GP) and other health professional involved in the persons care.

Requires Improvement

Is the service caring?

Our findings

During the inspection we saw that, in general, people were treated with dignity and respect but on some occasions this did not happen. We saw care workers knocked on bedroom and bathroom doors before entering but we saw that sometimes when people were being hoisted their clothing would become caught in the sling and their skin would be exposed. We saw that some care workers were not aware when this happened and it had to be pointed out to them by the care quality support worker. We also observed two care workers who were weighing people in the main lounge in front of other people using the service. When asked why this was done in the lounge the care workers explained that there was no other area with enough room to use the hoist to place the person on the scales. We raised this with the care quality support worker who asked the care workers to take people to their bedrooms to be weighed.

We received mixed comments from people when asked about the care workers. People we spoke with told us "The senior care workers know what they are doing but are busy" and "The care workers are all good sorts but many of them are new so don't know us." Another person told us "I am happy to see the care workers and if I want anything I can just ask."

People were generally supported by kind and gentle staff. We saw care workers understood people's individual needs and limitations and communicated with them in an empathetic and appropriate manner. However the amount of time that care workers spent with individuals to help promote their independence and support their emotional and social rather than just physical needs was limited as care workers were often busy with other tasks, including replacing people's bedding when required when providing personal care in the morning. During the inspection we observed people who were in the lounge and saw that they had no interaction with the care workers who came into the room for over 45 minutes. The care workers were busy completing tasks and appeared no to have the time to speak with people. During the inspection we saw that one person in the lounge was upset and a care worker was holding their hand. The care worker told us "I really want to sit with the person and reassure them but I have to go and get things ready for tea. This really upsets me then I can't spend time with someone." Another care worker told us "That's what caring is all about, spending time with people and not vacuuming a room or making a bed."

The above paragraphs demonstrate a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the care workers we spoke with how they maintained each person's dignity and privacy when supporting a person with personal care. The care workers told us "I always knock on the door and make sure doors are shut when personal care is happening. Wherever possible I give people a choice even if they are confused. They have an opinion; I put myself in their place" and "I always cover the person when helping them wash. When speaking to people in the lounge I speak to them appropriately so not to embarrass them."

The care workers showed a good understanding of the importance of supporting a person to maintain their independence. A care worker said "If the person has issues with mobility, for example, I know what they are

capable of doing. I could just put them in a wheelchair but if they can walk I encourage them to walk a bit to do them good. Have achievable targets." The care plans identified what activities the person required support from the care workers with.

We saw that the care plans we looked at identified the person's cultural and religious needs. Some of the care plans also included information on the person's personal history and family.

Inadequate

Is the service responsive?

Our findings

At our comprehensive inspection of Brackenbridge House on 6 and 8 July 2015 we found the provider did not ensure appropriate and meaningful activities were provided for people using the service. This was a beach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider told us this breach would be addressed by 30 September 2015.

At our recent comprehensive inspection we found that the provider had not followed their action plan in full in relation to providing appropriate activities. When asked about activities organised at the home people we spoke with told us "There is nothing to do here since the activities people left, we just sit here. I go up to my room and sit on my own. I might as well be back sitting in my own flat on my own." Another person said "This is where we will sit all day with nothing to do. It is very depressing to live here." Relatives told us "There are no activities organised and people are stagnating in the lounge" and "It is not usually like this, the staff are just in here because the inspection is going on."

During the inspection we saw that a religious service had been organised on the Sunday morning in the lounge and people could choose to attend. One person said "Oh the church service is on, I had better go back to my room as there is nothing else to do." We observed two care workers attempting to run quizzes in the lounge but these activities were not inclusive as people could not hear or understand the questions. We saw that this caused some of the people in the lounge to become frustrated and no longer wish to engage with the activity. There was no clear programme in place for the activities and they were arranged at short notice depending on if there was a care worker available to organise it. We observed throughout the inspection that people were often in the lounge for over an hour without any organised activity and were left watching the television. People we spoke with confirmed they were often not given a choice of what programme was on as the television was left on by the care workers and they did not know where the remote control was located.

The manager explained that one activities coordinator had left and another care worker who had taken on the role had decided to return to the care worker role. They had advertised for two part-time activities coordinators and the recruitment process was underway.

The above paragraphs demonstrate a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not ensure that equipment used by the service was suitable for the purpose for which it was used and kept clean. We saw that four people did not have appropriate seating and wheelchairs to meet their needs. During the inspection we observed that one person was regularly placed in a standard armchair that did not provide the appropriate support and positioning the person required. A care worker raised concerns that the armchair was inappropriate as it was very low and they relied on cushions to try and support the person in a comfortable position. We discussed this with the care quality support worker and the person was moved from the armchair and it was removed from the lounge. We observed two people in the dining room who were being helped by care workers to eat their meal. Both people were sat in their

wheelchairs in a position that made it difficult for the care workers to support them and did not enable the person to maintain their dignity when eating as food was spilled on their clothes and skin. This also increased the risk of the person choking when eating.

People using the service did not have specific wheelchairs and care workers would use any available standard wheelchair for a person when moving them. Two people required additional support to enable them to sit safely in a wheelchair and we saw care workers used cushions to provide this support. We also saw two people who were unable to keep their feet on the footplate of the wheelchair due to their position which resulted in their feet often dragging on the floor when being moved. We saw this happen on a number of occasions during the inspection.

During the inspection we also saw that when people chose to eat their meal in the lounge there were no tables of appropriate height for people to use. Meals were placed on coffee tables in front of the person which meant that they had to lean forward to eat their meal.

We also saw that wheelchairs, hoists and seated weighing scales had not been cleaned. We saw five wheelchairs had dried food on the cushions and frames. Three hoists and the seated weighing scales were visibly dirty and had not been recently cleaned.

This meant that people were not using suitable equipment to meet their support needs and the equipment that was used was not kept clean.

The above paragraphs demonstrate a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care workers we spoke with told us they did not have time to read the care plans regularly and were dependant on guidance from the senior care worker on duty about the care people required. During the inspection we saw examples of when people's needs were not being met. The care quality officer explained that the current care plans were being reviewed and they were in the process of introducing a new care plan format. Each person had a care folder which contained a range of care plans, risk assessments and other personal information. The care plans included plans relating to mobility, personal care, mental capacity, continence and nutrition. The care plans identified how the person wished their care to be provided and provided guidance for the care workers as to how to provide appropriate support for specific issues. The care quality officer explained that care plans were reviewed in full every six months with the person and their family as well as being reviewed monthly to ensure the person's care need had not changed. We saw that where people's care plans had been transferred to the new format they had been reviewed within the previous month. Some of the care plans in the previous format had not been reviewed for up to four months. In addition there was no record of the person or their relatives being involved in the review. The care quality officer confirmed that as part of the implementation of the new care plan format people would be involved in the reviews and this would be recorded.

Detailed assessments were carried out before a person moved into the home to identify if appropriate care and support could be provided. The manager explained the assessments were completed during discussions with the person and their family during a visit and they identified if the person's care needs were suitable for the type of care provided by the home. Information about the person's medical history was also obtained from their GP. We saw the completed assessments reviewed the person's individual support needs including mobility, social and health issues and were used to develop the care plans and risk assessments.

During the inspection the manager held a 'residents meeting' to discuss planned changes at the home

relating to how care was provided. We saw the minutes of previous meetings which included discussion relating to the complaints procedure and changes to the menu. Relatives we spoke with told us that they had been invited to attend meeting on a number of occasions but these had been cancelled at short notice. There were dates for future relatives meetings displayed in the reception area.

People using the service and relatives we spoke with told us they knew how to raise concerns and make complaints. The provider had a policy and procedure in place in relation to the responding to complaints. We looked at the records for nine complaints that had been received since July 2015 and saw these were recorded on a complaints register form. Each complaint record included copies of the investigation and response.

Inadequate

Is the service well-led?

Our findings

The provider's quality monitoring systems were not effective in identifying issues. Regular audits had not been carried out since the previous inspection to monitor the quality of the care provided.

The manager confirmed that regular audits and monitoring had not been carried out before they started at the home three weeks before the inspection. The daily health and safety audit had been completed for three weeks during January 2016 but had previously not been completed since the first week of November 2015. We found some serious breaches of health and safety because of poor practice and badly used/wrong equipment therefore the audits were not doing what they should.

A catering audit had been completed in November 2015 with actions identified to resolve issues but this had not been completed since then. The provider had not acted on the feedback from people about the food so this audit was not of use to improve the quality. We saw a dining experience audit had also been completed in November 2015 and there was no record of any actions being completed or the audit being repeated. We had identified during the inspection that the meal time experience of people using the service remained very poor.

The manager confirmed that questionnaires had not been sent to people using the service, relatives or healthcare professionals to gain their feedback on the quality of the service provided. This meant that people had not received a questionnaire to provide feedback on the care provided since the end of 2014.

We saw the manager had carried out a medicines audit on the 31 January 2016 but during the inspection we identified occasions when the MAR charts had not been completed in full and people had run out of prescribed medicines.

The provider had not identified, managed and mitigated risks to people. During the inspection we identified a range of issues including the management of medicines, use of appropriate equipment and infection control. These had not been identified by the provider using their existing processes.

The above paragraphs demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records relating to care and people did not provide an accurate, complete and contemporaneous record for each person using the service.

Care workers recorded a record of the care provided to each person and general information about their day. We looked at the completed daily record forms for eight people which were stored in a main folder kept in a secure office. We saw that the information recorded by the care workers did not provide an accurate picture of the care provided and what the person did during the day. The manager confirmed that care workers should record if the person had a body wash, bath or shower in the daily record. We saw that care workers only recorded that personal care was provided but did not describe what type of care it was. We

saw people's care plans indicated that they wished to have a regular bath or shower but this was not reflected in the daily records we looked at.

We saw care workers completed a 'Global Patient Chart' for people in relation to fluid and food intake, personal hygiene and continence. These charts were only completed for people who had been identified as being at an increased risk in relation to the areas monitored. We saw that the records were not completed in full and did not accurately record the person's actual fluid intake. The records relating to food intake only described the type of food eaten and not the actual amount. We also saw that the charts were being completed by a care worker who had not supported the person. They would ask other care workers to provide general information about the care provided and complete the chart on their behalf. This meant that accurate information was not being recorded.

Care workers were also required to complete bowel record charts for people identified as being at an increased risk. We looked at bowel record charts that had been completed by care workers and we saw that some charts indicated that a person had not had a bowel movement for more than two weeks. There was no indication on the bowel record chart that the person had developed constipation or if any action was taken.

We saw some care folders had a care plan summary document which described the person's care and support needs as well as how care workers should provide that support. We saw the care plan summary documents we looked at had not been amended for more than two years so did not provide accurate information for care workers on the person's support needs and how they wanted their care provided.

The MAR charts were not completed at the time that medicines were administered therefore they did not provide a contemporaneous record of which medicines were administered and when.

The above paragraphs demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and relatives if they felt the service was well-led and effective and we received a mixed response. People told us "It's worse under the new manager than the old management, we don't know what is going on" and "This is not a happy place to be." Other people told us "There is no organisation here" and "What do I think of the home? Well I have stayed so I would say average I suppose." One person said "I am well looked after and I don't stand for any nonsense as after all we pay our way to stay here and they don't dictate to us. I am quite happy here." Relatives we spoke with said "The new management is trying. It was and still is falling apart", "It's going downhill here. It was unbearable how long it took them to get a new manager", "We would not place our family member here if we were looking. They are here for the money and not the care. The number of staff that have left shows what's wrong. It used to be a happy place."

We asked the care workers if they felt the service was well-led and if they felt supported by management. We received a range of mixed comments. Care workers told us "The lack of communication is unbelievable. It is really bad between management and staff", "Things started to go wrong when the old manager left. We had different people in charge each telling us to do things in different ways. We don't know if we are going here, there or elsewhere. Now we have a new manager and new staff we are building up to what it used to be like. It used to be very very good" and "It should never have got to this level with staff leaving and lots of agency staff." Other care workers said "It is a bit frustrating. There is very little support for staff", "It does need to change", "New systems are coming in so we will have to see how things work", "The new manager wants to spend quality time with the residents and she also wants us to spend time with them to" and "I am hoping it will be better in the future."

At our comprehensive inspection of Brackenbridge House on 6 and 8 July 2015 we found the provider was not informing us when DoLS authorisations had been received. This was a beach of the Regulation 18 (2) (d) of the Care Quality Commission (Registration) Regulations 2009. The provider told us this breach would be addressed by 30 October 2015. Since the inspection we have received notifications from the provider when DoLS authorisations were made.

At the time of the inspection the manager had been in post for three weeks and was starting the process to apply for registration with the Care Quality Commission. The group operations manager explained that two staff from outside the home had been brought in by the provider to improve the quality of care. The care quality officer and a care quality support worker were brought into the home by the provider to support the new manager. They were focusing on reviewing how the care was provided and implement new ways of providing the support that met the needs of people using the service.

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	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure people were treated with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered person did not ensure the nutritional and hydration needs of service users were met. Regulation 14 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not ensure that people employed for the purpose of carrying on a regulated activity had the qualifications, competence, skills and experience which are necessary for the work to be performed by them. Regulation 19 (1) (b)

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 RA Regulations 2014 Person-centred care The care and treatment of service users did not meet their needs or reflect their preferences. Regulation 9

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care was provided in a safe way for service users. Regulation 12 (1) The registered person did not ensure the equipment used for providing care to the service user is safe to use and is used in a safe way. Regulation 12 (2) (e) The registered person did not ensure the proper and safe management of medicines Regulation 12 (2) (g) The registered person did not have processes in place to prevent and control the spread of infection. Regulation 12 (2) (h

The enforcement action we took:

The registered provider must undertake weekly audits of medicine administration record charts, service user needs and care plans. The registered provider must send the Care Quality Commission a monthly report which states the action taken or to be taken as a result of those audits.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not ensure service users were not deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13 (5)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not assessed, monitored and improved the quality of the service provided. Regulation 17 (2)(a) The registered person did not have a process in place to assess the specific risks to the health and safety of services users and do all that is reasonably practicable to mitigate any risks. Regulation 17 (2)(b) The registered person did not have a system in place to maintain an accurate, complete and contemporaneous record for each service user. Regulation 17 (2)(c)

The enforcement action we took:

The registered provider must undertake weekly audits of medicine administration record charts, service user needs and care plans. The registered provider must send the Care Quality Commission a monthly report which states the action taken or to be taken as a result of those audits.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not deploy sufficient numbers of suitably qualified, competent, skilled and experiences persons. Regulation 18 (1)

The provider did not ensure that persons employed by the service provider in the provision of a regulated activity had received such appropriate training and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Regulation 18 (2) (a)

The enforcement action we took:

The registered provider must not admit any new service user to Brackenbridge House, Brackenhill, Victoria Road, Ruislip, Middlesex HA4 0JH without the prior written agreement of the Care Quality Commission.