St Anne's Community Services

St Anne's Community Services - The Brambles

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on the 18 and 20 January 2017. We last inspected The Brambles on 22 and 23 July 2014 and found the service was meeting the requirements of the regulations we reviewed at that time.

The Brambles is a respite unit for adults with profound learning disability, some of whom also have physical disabilities .The unit offers accommodation for up to five people, each with their own bedroom, and the service provides 24 hour nursing care. A sixth bedroom can be used for emergency placements. On the first day of our inspection there were two people using the respite service and on the second day there were three people using the respite service. It was difficult to gain the views of people who used the service due to their conditions therefore we spoke with six relatives of people who accessed the service, the registered manager and three staff members. We also observed the interactions between staff and people using the service throughout our inspection.

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

During this inspection we found five breaches in the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. You can see what action we have told the provider to take at the back of the full version of the report.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

People and their relatives gave us conflicting feedback about the service. Some people felt their relatives were safe whilst other people said that they were not treated with dignity.
Systems which were in place for the management of medicines were unsafe and did not protect people using the service or ensure they received their medicines as prescribed. On admission to the service people did not always have the required medicines for their stay. We recommend the service reviews its pre-admission process to ensure people receive safe care and treatment.

Medicines were not always administered and stored as per manufacturer's instructions. Some of the medicine records had only one signature, when they should for safety have been signed by two members of staff.
Care plans were not always up to date or accurate and risk assessments that were in place were not reviewed to ensure they were still appropriate. Care records lacked the necessary information to ensure the health and welfare of the person was protected.

The service did not always follow the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Two people who did not have the mental capacity to make their own decisions had accessed the service however no mental capacity assessment had been completed or best interest meetings had been held.

New staff had induction training which included shadowing experienced staff, until they were competent to work on their own. However other had not received the up to date training to make sure they had the competencies, skills and knowledge to do their jobs effectively and safely.
There were systems in place to prevent the spread of infection. Staff were trained in infection control however recommendations made from the local authority infection control audit had not been acted upon. For example there were no hand hygiene facilities in the launderette or the sluice area.
Gas appliances were serviced regularly, however portable electrical equipment had not been tested to ensure they were safe to use. Each person had a personal emergency evacuation plan (PEEP) and there was a business plan for any unforeseen emergencies.

During our inspection we saw there were staff in sufficient numbers to keep people safe and the use of staff was effective. Staffing was determined by people's needs. Staff and relatives we spoke with confirmed that there was enough staff on duty.

Robust recruitment processes and systems were in place to ensure staff members were safe to work with vulnerable people. Checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

We saw there was adequate equipment throughout the service to meet the physical needs of people who used the service such as specialist baths, hoists (including ceiling track hoists), moveable sinks and shower trolleys.
The service had a sensory room which provided a relaxing and therapeutic atmosphere for people who used the service.
People who complained received a satisfactory answer. However the comments people made about the service were not always logged and used to make service improvements.

There were policies and procedures available for staff to follow good practice.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.
Systems for the management of medicines were unsafe and did not protect people using the service or ensure they received their medicines as prescribed.
Risk assessments were not always accurate and up to date and did not identify specific risks and the measures which needed to be in place to keep people safe.
Staff were able to say what they would do if they thought someone was being abused and knew the correct procedures to follow.

Is the service effective?

Requires Improvement

The service was not effective.
People were not supported with adequate nutrition and hydration. Some people were not safely supported when they had specific dietary needs.
The service did not seek consent from people in line with the Mental Capacity Act 2005.
People were not protected from the risk of unsafe or inappropriate care because staff did not have the knowledge and skills to safely and effectively deliver the care people needed.

Is the service caring?

Requires Improvement

The service was not always caring.
People were not always supported in a way which promoted their dignity.
Staffs were kind, caring and compassionate towards people who lived at the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.
The provider had systems in place for people and their relatives to feed back about their experience of the service.
We found that whilst care plans were pictorial and in an easy read format, the information contained within them was not consistent or up to date, which meant people were at risk of unsafe care and treatment.
Complaints were recorded and we could see these had been

investigated and resolved. However comments from family members had not been recorded and used to improve the service.

Is the service well-led?

Inadequate

The service was not well led.
Whilst there were auditing processes in place, these were not effective in identifying concerns and ensuring these were resolved in a timely manner.
Records were not always completed in a timely manner and there were errors and omissions in key records for example risk assessments and medicine records.

St Anne's Community Services - The Brambles

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 18 and 20 January 2017 and was unannounced.

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

An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.
Before our inspection we reviewed the information we held about the service including notifications the provider had made to us. This helped to inform us what areas we would focus on as part of our inspection. We had requested the service to complete a provider information return (PIR); this is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.
We contacted the local Healthwatch organisation to obtain views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. No concerns were raised with us. We asked the local authority contracts and safeguarding teams for their views about the service. They did not have any concerns.

Due to their health conditions and complex needs not all of the people were able to share their views about the service they received with us. We spoke with three people who used the service, six relatives and healthcare professionals. We also spoke with the registered manager and three care staff members.

We looked at the care records for four people who used the service and the personnel files for four staff

members. We also looked at a range of records relating to how the service was managed. These included training records, quality assurance systems and policies and procedures.

Inadequate

Is the service safe?

Our findings

Due to some people's complex needs we were not able to gather all their views. One person said 'I like it here, they look after me.''

We received mixed views about how people felt about their safety at St Ann's The Brambles. One person said 'I can say categorically it is a safe place, he would not be there if it wasn't." Another relative told us I have an absolute confidence that he is safe and well cared for whenever he goes there." In contrast another person told us "we have had problems, I can never send my relative in with nice clothes they love, we don't get them back, I can't understand it."

Prior to the inspection the service had made several notifications to CQC about the unsafe management of medicines. However when we looked at records not all medicine errors had been reported. For example, records showed that there was a medication error in October 2016 however CQC had not received notification of this.

We reviewed the way medicines were managed. People were not always protected from unsafe practices around medicines management. We looked at the policies and procedures for the administration of medicines. The policies and procedures informed staff of all aspects of medicines administration including ordering, storage, administration and disposal. Competency checks were undertaken by the registered manager to ensure that staff remained competent to administer medicines.

There was a signature list of all staff who gave medicines for management to help audit any errors. The service had a copy of the NICE guidelines for administering medicines and the General Nursing Council policies and procedures to help the service safely administer medicines.

Facilities for the storage of medication safely and securely where provided in bedrooms by way of a lockable cabinet. Each medicine cabinet contained a controlled drug storage cabinet, which required an additional key; however this was kept in the main cabinet. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.

People using the service had their own medicine administration record (MAR). A MAR is a document showing the medicines a person has been prescribed and recording when this has been administered. People's MARs included a photograph, which helped staff to ensure they were administering medicines to the right person.

Medicines were booked into the home when each person was admitted; this was done by the qualified nurse on duty. Medicines were also booked out if there were any remaining on the day of discharge; this was again carried out by the nurse on duty. We reviewed some of the records which showed what medicines had been booked in. The forms which were used to book medicines in and out of the home clearly showed there was two staff signatures required for each process. We found that whilst there were some records where two members of staff had signed to confirm what medicines had been present, on other occasions there was only one signature and this had not been signed for each individual medicine. It is safe practice for two

members of staff to sign hand written records to help prevent errors.
We found that none of the medication administration records (MARs) that we reviewed were completed correctly. We found one instance where a medicine was prescribed to be given every other day, however the medicine had been given for two consecutive days, and other times where it had not been given less frequently than it was prescribed.

We found instances where there was either more medicine than there should have been or not enough medicine at the end of the persons stay in respite. This along with the poor recorded of medicines meant It was not possible to tell whether or not people's medicines had been given as prescribed. We spoke to the registered manager about this and they told us that care plans and medicine records were updated after a person's stay in respite. This meant the person was at risk of receiving care and support that was not accurate and up to date.

We found people had been admitted to the home without the correct supplies of medicines to ensure medicines were administered in line with the prescriber's instructions. We found one case where there were insufficient antihistamines supplied for example, a further supply had to be sourced during the person's stay in the home, however there had been a period where the medicine was not available and doses had been missed as a result. We noted from other records this medicine had run out during more than one stay. The service could have improved the pre-admission process to ensure people had access to medicines when required. We recommend the service reviews its pre-admission process to ensure people receive safe care and treatment.

We looked at five medicines administration records. We found there had been an occasion where essential medicines had not been provided, for example a thickening agent to allow a person to drink fluids safely without risking aspiration (choking) was not supplied and was not available for the first two days of the person's respite care, this meant the person was not able to drink any fluids and had to be given additional fluids via a percutaneous endoscopic gastrostomy (PEG).This meant the provider did not have suitable pre-admission arrangements in place to ensure they could meet the needs of people who were admitted to the service.

We looked at daily records and found evidence that time specific medicines and feeds had not been administered at the correct times. Daily records we looked at recorded another instance where a piece of equipment had failed and the records showed feeding had been ceased, there was no record of what action was taken and when the person received additional nutrition. This meant we were unable to tell if the person had received adequate nutrition during their stay.

We found a person who required specialist feeding via a PEG. A PEG is a tube which is passed through the stomach to provide a means of feeding when oral intake is not enough. We noted there had been a supply of their prescribed feed signed into the service, which should have meant that there would have been enough to last the planned stay with some in reserve. However we found in daily care records an entry which showed staff had given an alternate supplement (which was not of a comparable calorific content) to the person as there was not enough of the correct feed left.
We reviewed the records of when the feed had been administered and found they were incomplete, which meant it was impossible to know what feed had been given to the person during their stay. We found there were also issues with the records for the same person as there were medicines shown as being signed out at the point of discharge which had not been booked into the home we could not confirm where the items came from, when they were supplied or how much of the item had been used during the person's stay. This meant it was not possible to tell whether people's medicines had been given as prescribed. We spoke to the registered manager and they made an immediate referral to safeguarding.

We found one person's care records showed the person had asthma and required an inhaler; however this was not present with their medicines. We asked the registered manager why this was not present; the registered manager told us they thought this was due to the person not using it recently. There had been no enquiries made into why this was not present or whether the person still needed it, and there was no change to documents or care plans to show the person's needs had changed. We discussed why the medicine was still showing as being required in the care records if it was no longer needed. The registered manager told us they review and change the care records after the person has been discharged, which meant that for the duration of their stay their records were not accurate or up to date.

We noted there were body maps in the medication records for people who used the service to show what creams they required and where these should be applied. We found in one case there was a cream which needed to be applied which was not present. We found from daily care notes that an alternative cream was being applied. There was no evidence of a supply of either cream being available for use. Daily records showed the person had symptoms which meant the cream needed to be used, however the manager was unable to explain why there was no cream and where the alternative cream had come from or on what authority it had been applied. The service could have improved the pre-admission process to ensure people had access to medicines when required. We recommend the service reviews its pre-admission process to ensure people receive safe care and treatment.

We saw from daily records and summary records of visits, that there had been issues with catheters and other surgical appliances not being carefully maintained and issues with surgical sites becoming unhealthy during stays. We saw that where nurses had identified faulty equipment they had not always taken action to rectify the situation, and there were no records to show what follow up action had taken place to evidence action had been taken in a timely manner. Although there was no evidence of this impacting on anyone at the time it meant there was a risk of unsafe care and treatment.

We found medicine that should have been stored in a fridge at a temperature of between 2C to 8C. This type of medicine should be stored securely and temperature checks should be undertaken to ensure storage is as per manufacturer's guidance. This posed a risk to people who used the service. We spoke to the nurse on duty about storing medicines as per manufacturer's guidance but they did not know this medicine needed refrigerating as they had not read the label correctly.

The above demonstrates a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because medicines were not managed properly or safely and people did not receive their medicines in line with the prescriber's instructions.

We looked at the assessment of risk Each care record contained a risk assessment for falls, moving and handling, tissue viability and nutrition. We found that whilst there were risk assessments in place they were not recently completed and were not reviewed to ensure they were still accurate, assessments included nutritional risk and skin integrity risk, both of which need to be regularly reviewed to ensure people's risks are understood and their care and support meets their needs. We found concerns in relation to skin integrity within the records we reviewed and found the necessary measures were not in place to minimise the risk of harm to people who used the service.

In one person's care plan it stated that the person "requires food to be in bite size pieces." However on the day of the inspection we observed the person was eating toast that was cut into quarters. The same persons care records recorded there was a risk of dehydration. We looked at the food and fluid records within their care plan however the fluid totals were not completed and there was no required intake recorded to guide staff to know if the person was at risk of de-hydration. This meant we did not know how much fluid intake

the person had and they could be at risk of dehydration.
The service used recognised tools such as the Waterlow to assess risk. The Waterlow scale gives an estimated risk for the development of a pressure sore. However the recording in one person's care plan had not been reviewed since 17 April 2014 and another person's waterlow score had not been calculated and the record was blank. This meant the person was at risk of developing of skin integrity problems.

This was a breach of Regulation 9 Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We saw there were personal emergency evacuation plans in place for people and these were accessible to staff should an emergency situation arise. There was a business contingency plan in place which set out what actions would be taken in the event of various emergencies.

We reviewed the way in which accidents and incidents were recorded. We found these were recorded on an electronic system. The records were then reviewed by the organisations head office who then made a decision as to whether any further action was required.

The registered manager showed us records of handover meetings were they discussed people who were visiting the service. The handover included nursing and personal care needs as well as an overview of the activities they had taken part in that day.

We looked at the systems in place to ensure staff were safely recruited. We reviewed four staff personnel files. We saw that all of the files contained an application form, two references, and confirmation of the person's identity. Recruitment procedures minimised the risk of unsuitable staff being employed. Applicants were required to complete an application form setting out their employment history, and we saw in recruitment records that any gaps were explored at interview. Two written references were sought (including, where possible, from a previous employer) and proof of address and identify obtained. Disclosure and Barring Service (DBS) checks were carried out before staff were employed. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults.

All relatives stated that they thought there were enough staff on duty. Relatives said that managers endeavoured to ensure that staffing was consistent, so that people could get used to the same staff at each visit. One person told us this has a real benefit for their relative.
We asked the registered manager how many staff members were on duty throughout the day and night. The registered manager told us they had two nurse vacancies which they were in the process of recruiting to. Due to the fact that the service was running with two nurse vacancies we were told that regular agency nurses were being used to cover the rota.

The registered manager told us that due to the nature of the service being for respite staffing levels varied on a day to day basis and was dependent upon the amount of people using the service. We observed that there was sufficient staff on duty to meet the needs of people who used the service. However on the second day of the inspection we observed people in communal areas were left unsupervised as staff were busy elsewhere in the home. This meant people had to wait for assistance, if needed, as staff were not available. We spoke to the registered manager about this and they said that staffing levels would increase depending on how many people were using the service.

The service had infection control policies in place which included COSHH, clinical waste, personal protective equipment and cleaning. COSHH substances were stored correctly and there were up to date risk

assessments for all substances stored.

During the inspection we looked around the environment including communal areas, bathrooms and toilets, bedrooms and laundry areas and the Kitchen. We looked at the cleanliness of the home and the measures which were in place to reduce the risk of infections being contracted or spread within the home. We found there had been an infection control audit carried out by the local authority in in February 2016. Our findings did not demonstrate that the areas of concern identified in the local authority audit had been acted upon by the provider to address the issues. For example there were no hand hygiene facilities in the launderette or the sluice area.
Moving and handling equipment was available throughout the service to assist people with physical disabilities, such as ceiling track hoists. Records we looked at showed these had been serviced regularly. Records also showed that all the gas equipment had been serviced and checked. Hot water outlet temperatures were checked to ensure they did not scald people. The service had a contingency plan in place in case of emergency, including electrical failure and gas failure. Control measures were in place for staff to follow. However the registered manager told us that PAT tests had never been carried out on portable electrical appliances in the service. This meant the provider could not be sure of the safety or efficiency of electrical equipment.

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

There was a fire file in place. The fire file was up to date and contained a clear plan showing exits, fire extinguishers, and smoke alarms .We saw that fire equipment, fire extinguishers, fire blankets and emergency lighting was checked on a monthly basis. Weekly inspections were undertaken of means of escape and the fire alarm. There was also a record of fire drills that had been undertaken which detailed how many staff had been involved, how long it took to evacuate the building and any action taken.

We saw from the training matrix and staff files that staff had received safeguarding training. Staff had policies and procedures to report safeguarding issues. This procedure provided staff with the contact details they could report any suspected abuse to. The policies and procedures we looked at told staff about the types of abuse, how to report abuse and what to do to keep people safe. Staff members we spoke with confirmed they had received safeguarding training.

The service provided a whistle blowing policy. This policy made a commitment by the organisation to protect staff who reported safeguarding incidents in good faith. Staff members told us they understood the whistleblowing policy.

Requires Improvement

Is the service effective?

Our findings

Staff told us and records confirmed they had undertaken an induction prior to commencing their roles. This is an essential part of a six-month probationary period which must be completed before confirmation in post can be given.

New employees are issued with a staff handbook containing summaries of St. Anne's mission and values, main policies and procedures. The handbook was also available to staff via the Intranet.

During the induction phase managers took new staff members through an Induction Checklist that ensured new workers are familiar with key organisational policies, procedures and working practices. All new staff members had to complete the care certificate when commencing employment at The Brambles. The care certificate is considered best practice for staff members new to the caring role.

We looked at the training matrix and saw other courses available to staff members included safeguarding adults, health and safety, first aid, fire safety, infection control and moving and handling The training matrix showed that nine people needed refresher training in moving and handling. Fifteen people were in need of emergency first aid refresher training and five people needed training in positive behaviour support.

We found that there was specialist training the nurses were required to complete in accordance with the providers own policy. The provider's policy stated that "a record of training specifically around PEG feeding and medication administration must be kept." We spoke to the registered manager about this and although they said the training had been completed they could not provide any evidence of this.

Care staff we spoke with said training was "really good." One person told us they had completed intensive interaction. Intensive Interaction is a practical approach to interacting with people with learning disabilities who do not find it easy communicating or being social. Another staff member said they had done dementia training and positive behaviour support training.
Care records showed that a number of people who used the service communicated using Makaton, which is form of sign language. We did not see any staff using this method of communication despite people in the service requiring this support, which was confirmed when inspectors used signs and these were responded to positively. We looked at people's communication plans and they did not contain sufficient detail to enable staff to communicate with people effectively. For example in one persons care plan it stated" [the person] has no problem with communication, however in other parts of the plan it said the person may struggle with communication because of their dementia. On the day we observed that staff members' approach was calm, sensitive, respectful and valued people. They explained options and offered choices using appropriate communication skills. People appeared comfortable and confident around the staff. We saw people laughing and smiling with staff members.

This meant that the staff providing support to people who used the service were not appropriately trained to meet their needs. The lack of appropriate training was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18.

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and the least restrictive course of action 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. Most members of staff had been trained in the Mental Capacity Act 2005 (MCA 2005) so should be aware of how to protect people's rights.

However we found there were no mental capacity assessments in place in any of the care files we reviewed. There was no facility within the care needs assessment, support plans or risk assessments where mental capacity was assessed or considered. We found there was no evidence that people had been asked for or had given their consent to the care and support they were receiving or that where possible people had been given the opportunity to make their own decisions or be involved in decision making processes.

We found there was no information in the care files we reviewed to show in cases where people were not able to express their views or make their own decisions which showed where there was an advocate or power or attorney who could support the person to ensure their thoughts and preferences were considered. We found there was no evidence that people or their advocates had been asked for or had given consent for the care and support which people received.

This was a breach of Regulation 11 need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as consent had not been gained and documented from the relevant person. Every staff member had received regular supervision and an annual appraisal. As part of that appraisal every member of staff had completed and signed up to an individual action plan.

The building was set out on one floor, the rooms were spacious to allow the use of specialist equipment and corridors were wide enough to allow people to be moved easily in wheelchairs. There was tracking in all the rooms for the use of hoists to move people from the bed to their wheelchair and to allow them access to the bathrooms. There was a specialist bath which was available to everyone who accessed the service.

The home had a sensory room, which allowed people who may usually need to be in a wheelchair to spend time in a safe comfortable environment without being constrained in any chair as there were large padded mats and bean bags to allow them to spend time on the floor.

We looked in a number of bedrooms and found they were personalised with pictures on the doors showing current occupants. Respite may only be for a short period and therefore it is difficult to make each room personal to its occupant, however the service did offer the facility to leave some personal effects in a box at the service which could be place in the room before the person arrived for each visit following consultation with people who used the service and their families.

We checked four peoples care records to look at information about people's dietary needs and food preferences. Records included people's likes and dislikes. A staff member we spoke with exhibited a good understanding of the nutritional needs and dietary preferences of people using the service. The member of staff we spoke with told us if a person was at risk of weight loss they were put on a food and fluid chart. We

looked at the food and fluid charts of a person who was staying at the service on the day of the inspection. The persons care records stated that the person was at risk of dehydration however when we checked daily records they were incomplete.
We found in some instances that there were detailed schedules included for the administration of nursing tasks that were not recorded. For example one person required a jevity feed administered via a PEG once a day. Jevity is a tube feed for people who are at risk of developing malnutrition. However records were not signed for two days whilst the person was in respite. This meant we would be unable to determine if the person had sufficient nutritional intake which puts people at risk of malnutrition.

We asked people about the food in the service and one person told us "I like it in here, I can cook food" another person was smiling and laughing as we talked about the meal planned for the evening and they told us "'The food is good". Relatives told us "My son enjoys cooking, they help and support him to cook his own meals", another person told us "I have seen them have guest meetings, they choose favourite foods to eat." Other comments included "'The food is great- he eats everything" and "My brother puts on weight every time he stays".

We asked two staff about the arrangements for ensuring people were involved in mealtimes and meal planning. They told us that each day people were supported to contribute ideas and suggestions for meals, and that people were supported to eat out or have take-away food if they wanted to. However on the first day of the inspection there was very little fresh food available in the home's kitchen, there were some vegetables however these had exceeded their best by dates. We spoke to care staff about this and they said they did daily shops depending on what people wanted.

On the second day of inspection the "best by" food was still in the vegetable rack. We saw people were provided with basic meals with limited nutritional value, for example beans on toast, and baked beans and potato waffles. On the first day of the inspection support staff purchased jacket potatoes during an outing which were brought back to the home to be consumed

They returned with a takeaway of their choosing and were seen to be enjoying the food they brought home. All staff we spoke with were very knowledgeable on the dietary needs of people who used the service. One person who was using the service at the time of our inspection told us, "I go to the supermarket with staff and choose food I like." The registered manager told us, "We have a menu plan but this is not always followed as it depends who is receiving respite; we know what people like and cater for this. Food can be purchased daily to accommodate people's choices and preferences."

We spent time in the kitchen observing the lunchtime period. We saw people who required assistance with their meals were supported on a one to one basis. Staff were seen to be patient and mealtimes were unhurried. Where necessary specialist equipment was available for instance we saw some people used a plate guard to promote their independence.
There was a laundry situated away from any food preparation areas. There were two washing machines and a dryer to keep linen clean and other equipment such as irons to keep laundry presentable. However there were no hand washing facilities in the laundry area and this was one of the areas of concern picked up in the local authority infection control audit. This demonstrated that the areas of concern identified by the local authority had not been acted upon by the provider.

Staff had access to personal protective equipment such as gloves and aprons and we saw that there were plenty of supplies situated around the home. We observed staff used the equipment appropriately.

Requires Improvement

Is the service caring?

Our findings

People staying at St Ann's The Brambles had varying needs and abilities. For those people not able to tell us about their experiences, we spent some time observing lunch and how people were supported by care staff. From our observations we saw staff speak with people in a pleasant and friendly manner. One person told us "Staff are good, they are great." Another person gave a thumbs-up sign when asked if they liked the staff.

Not all relatives spoke positively about the service. One relative told us "I am fed up of the way he is discharged. [Relative] had not had a shave for the three weeks they were there" another told us "[Relative] looks like a homeless person when they come home, they are so dishevelled." Other comments included "I can never send [relative] in with any of the nice clothes that they love, we don't get them back. I can't understand it". Other relatives told us 'My [relative] has a lovely time there you can tell by their smiles" and "It's so nice to hear my [relative] laughing when they are in respite".

People were treated with care and kindness. Staff showed great care when working with people and it was obvious they knew them well. We observed staff speaking with people in a very gentle and delicate manner when supporting with personal care. When asked if the staff were kind, one person gave the thumbs up sign and laughed.

We observed that staff members' approach was calm, sensitive and respectful. People appeared comfortable and confident around the staff. We saw people laughing and smiling with staff members.

The service had a dignity champion. The dignity champion displayed a dignity board with information for both staff and people using the service.
We observed that staff respected people's privacy and dignity; staff knocked on people's door before entering and doors were closed when people were being supported with their personal care needs. Staff members we spoke with told us they always closed doors to maintain people's dignity when providing personal care.

Support plans were written in a respectful manner and in a way that ensured dignity is maintained at all times.
The service had a confidentiality policy in place which was accessible to staff members. We observed that all personal and confidential information was appropriately stored and only those people who were permitted to access it could.

Staffs were knowledgeable about people and their wider family networks. We overheard staff talking to people about their family and what happened in their life since they last stayed there.

The service was not currently providing end of life care to anyone but the registered manager told us they would be able to do so if necessary by following the St Ann's end of life pathway.

Requires Improvement

Is the service responsive?

Our findings

We reviewed the care records for four people who used the service regularly. We found there had been an assessment carried out prior to people being accepted by the service, and this included aspects of their care needs. However records we looked at during the inspection were often incomplete or out of date which meant people were at risk of receiving unsafe care and treatment.

Care plans were not person centred as they did not contain details of people's histories or families. We found that whilst care plans were pictorial and in an easy read format, the information contained within them was not consistent or up to date, for example we found there were sections which should have detailed each person's medical conditions and history; we found these had a basic sentence which did not include critical medical information. We found some care plans had been updated. There was some evidence of reviews taking place. However the records did not consistently provide an up to date record of how a person required support. Where undertaken reviews did not detail who had been involved in the review.
The care plans contained inconsistent information about medicines and health conditions which meant staff would have difficulty establishing what information was current and accurate and in the event of an emergency they would have to navigate through a lot of information to get an understanding of the person's needs.

One person had not attended the service for a long period of time. Their condition had deteriorated due to health complications. We checked their care plan. The information available to staff was conflicting. For example, in the person's health action plan it stated the person took medicine for epilepsy whereas on the persons night time routine it said the person did not have epilepsy. Another person's care plan contained an allergies sheet that was blank. Further on in the file it was stated that the person was allergic to penicillin. Other conflicting information included the fact people required medicine administered via a peg. However the administration route was not recorded on other records. This meant that staff were at risk of not being aware of critical information needed to meet people's needs during their stays, or to pass onto medical professionals should the need arise. The care records lacked the necessary information to ensure the health and welfare of the person was protected.

We looked at four plans of care during the inspection. We found little evidence of care plans being reviewed, as there were no review forms or reference to previous versions of care plans. We noted the care plans and risk assessments which were in place were not recent with dates of 2014 and 2015 in all the files we reviewed. For example, we looked at a person's care record that was using the service on the day of the inspection. The most recent moving and handling risk assessment had been completed in 23 March 2015 and their care records stated that their health needs had changed. Changes in the person's health had not been reflected in the persons care plan advising staff of the persons changing needs and action being taken to address this.

This was a breach of Regulation 9 Person centred care of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014.

We asked one person what activities they liked to do while staying at The Brambles and they told us "I love the dancing and the singing - and the drama." On the first day of inspection we observed people go out into the community shopping. On the second day we observed that when one person arrived at the service staff immediately got out activities which they kept at the home for when they visited. We saw that another person had been sat in the lounge to watch television.

We saw that there was a sensory room with sensory equipment, where people could have some quiet time. Relatives told us "[My relative] loves all the activities on offer - even I join in when I visit" and another relative told us "[My relative] would not even be there if I was not happy with the service.'

We saw evidence of other activities such as trips out, parties and barbecues.
The service sought feedback from people and their relatives in the form of an 'End of Stay' feedback form. The service also published a newsletter each quarter, listing information about the home, up-to-date news and planned changes. The newsletter highlighted the request for relatives to complete 'End of Stay' feedback forms. Relatives confirmed that they were given the opportunity to spend time with the manager every two weeks if they wish to discuss things .The wider organisation also held coffee mornings around the community for service users, relatives and carers to interact.

Procedures were in place to investigate complaints. A complaints policy covering both verbal and written complaints set out how issues would be investigated and the timeframes for doing so. The policy was contained in the 'resident guide' that was given to people when they joined the service. Relatives told us "I see the manager if there are any problems" and "[My relative] would not even be there if I was not happy with the service'" and another person told us "The registered manager sets time aside so that you can go to see her about anything."

There had been no formal complaints received within the last twelve months however staff meeting minutes recorded various comments that had been made by family members. Although these was not made as a formal complaint the policy states that even a comment should be noted as not all complaints had to be formal to be acted on. We discussed this with the registered manager as a way enabling the service to learn and develop from people's experience of the service.

All of the people spoken with knew how to complain. Some gave examples of leaflets explaining their right to make comments about the care and support they receive - as well as details of the CQC. One relative we spoke with told us 'I have no complaints.'

Inadequate

Is the service well-led?

Our findings

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Not all relatives spoke confidently about the management of the respite service. They had concerns about the overall running of the discharge process One relative told us "I just wish [my relatives] things could come home packed properly - instead of just being stuffed into bags." Another person told us "They need to take care of things - it's about upholding dignity." In contrast other people told us "We have every faith that [my relative] is in the right place - I can rest at night knowing [my relative] is in good hands" and "You can go to the [registered manager] about anything - [registered manager] has been there a long time."

The provider did not have an effective system to regularly assess and monitor the quality of service that people received. We saw that the provider had introduced a number of quality monitoring audits. These included areas such as weekly fire checks, support plans, medication checks and performance monitoring. On examination of records we found audits had not been completed in all identified areas. Certain areas were identified for review on a weekly or a monthly basis. Of those audits completed, where action had been identified there was no evidence to show appropriate action had been taken. For example we checked the systems in place for auditing medication. We looked at the medication audit completed on 18 November and 27 December 2016 which identified that the service was compliant. The audit was not robust enough to identify the issues of concern that we found in relation to medicines management. It is essential to have a robust system of audit in place to identify concerns and make the improvements necessary to ensure medicines are handled safely within the home.

Monitoring of peoples care records to check that information was up to date and accurate were inadequate. Examination of five peoples care records showed that these did not reflect what we had been told by the care staff about people's care records about people's changing needs.
The lack of robust and regular auditing meant that the service had no effective systems in place to continually monitor the service provided to ensure people received safe and effective care.

This is a breach of Regulation 17 (1) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found evidence in records we reviewed there had been concerns raised about the conduct of some staff at the home we asked the registered manager what action had been taken to address these concerns and to see the records of these actions. The registered manager was unable to tell us of any actions which had been taken or produce any records.

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed about had been notified to us by the manager. This meant we were able to see if appropriate

action had been taken by management to ensure people were kept safe However during the inspection we the registered manager had not raised concerns when they should have. For example we found a record of a medicines error in October 2016 however this had not been reported to CQC.

We saw there was a service user guide and statement of purpose. These documents gave people who used the service and professionals the details of the services and facilities provided at this care home.

We looked at three records of staff meetings. The minutes of the last meetings showed areas for discussion included people's health and welfare, property matters, staffing matters, future plans, occupancy, rota, annual leave, handovers and daily logs. The staff meeting agenda also included standing items of whistleblowing and equality. Meetings were informative and gave staff members the opportunity to contribute and ask questions.
During our inspection our checks confirmed the provider was meeting our requirements to display their most recent CQC rating. A copy of the latest inspection report was also made available for people to read.

There were policies and procedures for staff to follow good practice. We looked at several policies and procedures which included safeguarding, whistleblowing, medicines, infection control, recruitment, moving and handling, accident reporting and confidentiality. These were accessible for staff and provided them with guidance to undertake their role and duties.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not provide sufficient guidance to staff and assessments were not accurate and up to date

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not have adequate training to enable them to do their job safely and effectively

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Unsafe management of medicines

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
Treatment of disease, disorder or injury	Ineffective quality assurance systems

The enforcement action we took:

Warning notice