Winnie Care (Brantwood Hall) Limited

Brantwood Hall Care Home

Inspection report

10-14 North Avenue
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Ratings

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

Overall summary

The inspection of Brantwood Hall Care Home took place on 29 June 2015 and was unannounced. We visited for a second day, on 2 July and this was announced There was a registered manager in post who was away on holiday on the first day of the inspection. However, there was a deputy manager and home administrator who were in charge of the running of the home.

The service was inspected in February 2015 and found to be in breach of 11 regulations.

Brantwood Hall Care Home is in a quiet residential area of Wakefield. The home provides accommodation for up to 60 older people. The home consists of two separate houses, numbers 12 and 14, located in the same grounds.

Staff had a good knowledge of how to ensure people were safeguarded from abuse.

Staff recruitment was robust and all vetting was in place to ensure staff were suitable to work in the home.

Summary of findings

Staff understood their roles and responsibilities and demonstrated good teamwork. However, there were not enough staff available to attend to people in a timely manner.

Individual risk assessments for people's care were not in place.

Many staff had undertaken regular mandatory training, but lacked training in specialist areas such as dementia care, pressure care and healthy eating. Staff lacked knowledge of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

Medications were given safely on the whole but there were some minor issues with the recording of warfarin and the storage of unused medicines to be returned.

People enjoyed their meals and there were much improved opportunities for people to drink regularly. Staff replenished people's drinks frequently and reminded them to drink in the warm weather. Monitoring and recording of people's food and fluid intake was still an area to improve.

We noticed an improved quality of staff interaction with people since our last visit and staff were respectful and caring in their approach on the whole. People told us they felt safe and happy, although there were few activities for them to be engaged with in a meaningful way.

We saw the provider had responded positively to recommendations made at the last inspection and those made by partner agencies such as the local authority and the infection control team.

Although there was considerable work to be done, there was evidence of action being taken to secure improvements. However, audits and quality assurance systems were not robustly in place to ensure the quality of the provision.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

We saw no evidence of thorough risk assessments in people's care records.

There were not enough staff to keep people safe and people were not always assisted in a timely manner.

The environment was undergoing refurbishment and improvement in relation to infection control, but temperatures in the home were too hot for people to be comfortable.

Inadequate

Is the service effective?
The service was not effective.

People were not always asked their consent prior to any care intervention and staff lacked knowledge and understanding of the requirements of the mental Capacity Act 2005 Deprivation of Liberty Safeguards.

Not all staff training was up to date and staff lacked skills and knowledge in particular areas, such as healthy eating and end of life care.

There were improvements to the provision of food and drink, although there was no robust monitoring of nutritional intake to identify when a person may be at risk of malnutrition or dehydration.

Inadequate

Is the service caring?
The service was caring.

There was much improved quality of interaction between staff and people living at the home than we had seen at the previous inspection.

Staff acknowledged people individually and were kind and patient in their approach.

Staff were mindful of people's need for privacy.

Good

Is the service responsive?
The service was not always responsive.

We saw that people were not engaged in positive activity for much of the their day.

People and their visitors knew how to raise complaints and they were confident to speak with the registered manager about these. However, not all complaints had been recorded.

Requires improvement

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

The registered manager had taken our previous concerns seriously and begun to act upon them. The registered manager was visible in the service and staff were clear about their roles and responsibilities.

Although some quality assurance systems were being introduced, these were not sufficient or rigorous enough to ensure all aspects of people's care was being well met.

Documentation was not always organised well to demonstrate how people's needs were being met, or show the service was running safely.

Brantwood Hall Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over two days on 29 June and 2 July 2015 and was unannounced on the first day.

The inspection team consisted of five adult social care inspectors, one specialist advisor whose background was nursing and one Expert by Experience whose experience was in older people's services. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with 17 people who lived at the home and four relatives/visitors. We spoke with eight staff and the registered manager. We spoke with one district nurse.

We looked at eight care records. We also saw other documentation showing how the home assessed the quality of care including accidents and incidents, maintenance logs and action plans stemming from visits by external teams such as infection control and the local authority.

Inadequate

Is the service safe?

Our findings

People we spoke with felt that the home provided a safe environment although there were concerns raised about staffing levels, particularly in house 14.

People's comments included: "I feel safe here"; "Of course I feel safe here"; "There's always a shortage of staff"; "I feel safe, very safe. That's why I came here when I left hospital"; "I like it here. I certainly feel safe"; "I'm just content."

Comments from friends and families included: "[They] love it here and [they've] made some friends." and "I know that I don't have to worry about [them] when I go home. [They're] safe. I wouldn't send [them] anywhere else"

We looked at training records which showed staff had all had up to date training in safeguarding adults. Staff we spoke with had a good knowledge of how to ensure people were safeguarded from abuse. They knew the signs to be alert for that may suggest people were at risk of harm and were confident to follow the whistleblowing procedure if necessary.

We spoke with six care staff and all said that they had received training in safeguarding adults. Staff were able to describe some different types of abuse, including physical, psychological, neglect, sexual, discrimination and financial abuse. Staff said that they would not hesitate to report any suspected abuse to their senior or manager. One member of staff told us that, if nothing was done, they would then report to social services.

We asked what staff would do in case of an emergency, for example if someone was found on the floor. One member of staff told us that they would summon help by pressing the emergency buzzer. They would try to make the person comfortable. They would then report any bruising or injury and complete a body map and incident report form. They would also ensure that information was passed on at staff handover, so that other staff could look out for any bruising that may later occur.

We saw the service acted in accordance with safe recruiting practices. There was evidence staff had applied for each of the posts and an interview process had taken place. Two references had been obtained and where there had been any issues with the references, the service had taken steps to address them. For example, they contacted referees if the original reference was not on an organisation's headed paper. The service had carried out disclosure and barring service (DBS) checks prior to the staff being confirmed in post. One staff member had not had an update to their DBS since 2007 and although it is not mandatory that these checks are renewed, the provider was unable to confirm that ongoing suitability of staff is routinely monitored and verified to ensure they remain suitable to work with vulnerable people.

In one of the files we looked at we saw evidence the service had addressed allegations of bad practice and poor conduct through their disciplinary procedure.

The provider had attended to some of the concerns with the premises we had found at the previous inspection. For example, fire exit doors opened with ease, the door to the steep steps in house 12 was secured and unused rooms and storage areas were inaccessible. The kitchen had been redecorated and the cook told us it was now much easier to keep clean and said they were doing much more steam cleaning now. The kitchen had been awarded a 3* hygiene rating by the local authority, although this was inspected before the improvements were made.

There were some aspects of the premises that still needed attention to ensure safety. For example some rooms in the environment were far too hot and we had to request the maintenance staff attended to these to ensure people lived in a comfortable environment. We inspected the home on a day when it was very warm outside but the heating was also on inside and was very warm in some areas of the home. One person said "how can people be comfortable when they're being roasted?" We discussed this with the registered manager who agreed to ensure the home was maintained at a safe and comfortable temperature.

Window restrictors we saw in one person's room had loose screws and we asked the provider to attend to this with immediate effect to ensure people's safety. The laundry in house 12 had large areas where the plaster was coming off the wall which would prevent effective cleaning.

There was a flagged area which was open from the hallway and the conservatory on the first floor in house 12. The flagged surface in this area was uneven and had large weeds growing between the flags, which posed a trip and fall hazard. There was also a step to get out to the garden which would make it difficult for wheelchair users to access.

Inadequate

Is the service safe?

There were no detailed risk assessments to identify specific aspects of the premises that may pose a trip or fall hazard to people. In house 12 we saw doors between floors were fastened open with magnetic catches that we were assured would close upon the fire alarm sounding, but there was no risk assessment with regard to the potential for people to fall down the stairs.

We were told one of the passenger lifts had been out of service but we were unable to be assured the lift and lifting equipment was safe as there was no documentation in place to verify this.

The above examples illustrate the provider was in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 17(2)(b) because systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of people were not robustly in place.

We saw there were some improvements since the last inspection to the way accidents and incidents were recorded and there was analysis of what had occurred each month. However, we only saw records up to the end of May and the registered manager told us she had not done an analysis for the month of June because she had been on holiday. Although records contained more detail than at the previous inspection, we saw accidents and incident records were not well organised. For example, some were in the accident file, others in a filing cabinet and some in the handover file.

We saw one person had a dressing on their leg and this appeared to be very sore and in need of attention, which staff attended to. We looked at this person's care plan but found only very limited information on what the injury was or how it had happened. There was a note in the daily record which stated the person had been found with the injury and an accident form was filled out. However we were unable to locate the accident form in the accident book and staff were unable to produce it. We eventually found the form in the handover file which was kept in the dining room. The form was not detailed and there was no explanation of how the injury occurred. There was no evidence of any investigation into how the person was injured and there was no evidence it had been reported to safeguarding.

We saw a body map in one person's file which showed they had a bruise, yet there was no corresponding accident or incident form to explain this and staff were unable to locate this record.

The above examples illustrate the provider was in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 17(2)(c) because accurate, complete and contemporaneous records in respect of each person were not maintained.

In a number of people's rooms, we saw that individual slings were hung on people's doors, for use when using moving and handling equipment. Staff we spoke with told us there were more slings than at the last inspection and these were used on an individual basis to minimise the risk of infection.

We observed people being appropriately assisted to mobilise and transfer by staff who were patient and caring. We saw on several occasions people were assisted to move from a chair to a wheelchair. Appropriate moving and handling techniques were used by two members of staff each time and they reassured the person throughout. On another occasion we saw staff were patient and reassuring as they carefully assisted a person into their chair.

However, we observed some instances of poor moving and handling. For example, a person was supported to move using a mobile hoist which had been poorly modified, there was foam and duct tape wrapped around the centre post of the equipment. Although this was intended to protect the person from injury, this was damaged and potentially posed an infection control risk. We saw the manoeuvre caused the person some discomfort and they did not appear to be comfortably positioned in the sling.

On a different occasion we saw another person was assisted in the hoist and they complained to care staff that it was hurting. Staff said "it will do" and told the person "I know you hate being hoisted". We discussed this with the deputy manager who agreed to review the practice with regard to moving and handling.

We spoke with one person who was unhappy with the arrangements for their moving and handling and said these were not in keeping with their wishes. They said "They took me off the frame and told me I had to be hoisted. The hoist bruises me. I hate the hoist. I shouldn't be on it by rights. It's killing me, my legs get banged. My legs are sore. I'm

waiting for the manager to decide whether I can have a small frame to help me walk. She's on holiday." We asked the deputy manager to review this person's needs the same day and she agreed to do so.

We looked at care plans for eight people who lived at the service. There were no detailed risk assessments in place for any aspect of their care. There was a single record sheet which recorded a judgement of low/medium/high risk for various areas but there was no detail as to what risks were identified or what measures had been put into place to reduce/eliminate these risks. Additionally there was no evidence as to what information was used to make the judgement recorded on the sheet. We asked the registered manager if individual risk assessments were recorded and held elsewhere, but we were told that they were not.

The above examples illustrate the provider was in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12(2)(a)(b) because risks were not securely assessed and mitigated.

Monthly reviews/evaluations within the care files were completed, and included information in relation to, for example, continence needs and personal care needs. There was a clear improvement since February 2015 and records were more thorough from February 2015 onwards.

We looked at the daily records for one person who had been admitted to hospital but there was nothing recorded for the day of admission. We saw the person had a history of falls but there was no evidence of any risk assessment for falls. The person had needed the use of the hoist since their discharge from hospital, but their moving and handling plan had not been updated to reflect this.

The above examples illustrate the provider was in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 17(2)(c) because accurate, complete and contemporaneous records in respect of each person were not maintained.

Staffing levels at times were not sufficient to ensure people's needs were promptly met. In some parts of the home we saw there were no staff in communal areas and in house number 12 we had to find staff on three occasions in order for people to be assisted when they needed support. We observed that there were not enough care staff throughout the day to care for people effectively. We saw people were left for long periods in armchairs. One person was not feeling well but this was not picked up promptly by staff.

One person living in the care home said they felt the staffing level was not adequate as they wanted to return to their bedroom after breakfast but there was nobody to take them. Eventually a member of ancillary staff was asked to assist them. Another person told us there was always a shortage of staff and staff were always busy.

In house 14 we saw there were three care staff who worked over three floors. There were 16 people living in this part of the home and we saw staff were extremely busy. The senior care staff member was administering medication which started by 9am. We were told five people lived on the middle floor where the senior carer was giving out medication in the dining area. We observed there were no other staff in the dining area with the people who were in there having breakfast.

We saw one person who required support with eating but there were no staff in the dining room for 10 minutes whilst people were eating. Another person was identified as being at risk of choking, yet they were left unsupervised in the dining room.

On one occasion in house 10 we heard a call bell sounded for ten minutes. We asked staff what this was for; staff checked and said "it is someone upstairs, someone else will go". The call bell was still sounding for a further three minutes after this, which meant a person had to wait for staff to attend to them.

We noticed one person called out intermittently through the day. We asked staff about this and they told us this was part of this person's usual behaviour. We saw this person needed assistance with repositioning and looked at the records for this. It was not clear from the records or the person's observed position that they had been supported appropriately.

Staff we spoke with gave differing information about whether staffing levels were appropriate. Staff told us that there were always two carers and a senior member of staff on duty each day and two night staff in each house. We were told that agency staff were used to cover sickness or absences. Staff gave us examples of when people had to wait because there were too few staff on duty.

Inadequate

Is the service safe?

The above examples illustrate the provider was in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 18(1) because there was ineffective deployment of sufficient numbers of competent staff to meet people's needs.

We looked at how medicines were managed within the care home and how they were administered. The senior carer administering medication engaged positively and patiently with people while offering water / juice with medication.

We observed one person took medicines from the senior carer from a pot and asked to return to their room but there was nobody to assist them there. We saw that even though the person had the medicines with them, the medications administration record (MAR) sheet was signed as the medicines having been taken.

We looked at medication records for 16 people who lived in the home. It was not clear from the MAR sheets the dates when medications were received or commenced. For example, there was no evidence of warfarin administered on the medication administration record sheet, no codes or signatures. We spoke with the senior care about this, they informed us that they follow, and record in the yellow book, used for the monitoring of warfarin, and also on the anti coagulant chart. They said 'we used to record on the MAR sheet before but not anymore, I don't know why.' Our observation made on all these MAR sheets was there was a problem which should be resolved by staff liaising with the pharmacy. The deputy manager agreed to look into this with immediate effect.

We saw one person was being given long term antibiotics since 2014, covertly. We saw there was consent obtained from their GP and family, but no evidence of consent from the person, no Mental Capacity Assessment done and no evidence of a best interest decision discussed.

We looked at the care of three people on food and fluid charts and who needed care with catheters. Care plans in relation to catheters were robust, although there were no evaluations or risk assessments recorded. Records we saw evidenced good management by district nurses who also advised staff to offer more fluids. People told us and we saw evidence of regular drinks being offered and available. We saw people's care records showed where they needed thickened fluids. However, the care plan we saw for one person had no risk assessment for choking or safe positioning when drinking.

Infection control in the home had improved since our last visit; new equipment such as carpets and commodes that were easier to clean had been obtained. However, we saw some areas with carpets and chairs that were stained and in need of replacement. The provider told us refurbishment was ongoing and we saw evidence of equipment and furniture that had been disposed of and rooms being renovated.

Staff told us they felt there had been improvements to the cleanliness of the home and the systems for ensuring the prevention of infection. Staff wore appropriate clothing when entering the kitchen/food preparation area. Aprons were hung outside the kitchen door for staff to wear.

There were cleaning records hung up on the rear of the communal bathroom doors. We saw that in one bathroom cleaning record had been completed on only five days of the month, yet our visit was on the 29th day of the month. Other dates were not completed. In another bathroom cleaning had been recorded on the 6th, 8th, 9th and 12th only.

We saw in the bathrooms, notices were displayed showing how to wash hands effectively. The staff we spoke with were aware of when to wear personal protective equipment (PPE) and were able to state where this was stored. We saw there were appropriate accessible supplies of PPE for staff to use when necessary.

Inadequate

Is the service effective?

Our findings

One person told us “They've done a good job up to now. I don’t have anything against them”. One relative said: "Since [my relative] has been here [they’ve] been in the best health for ages."

The service offered mandatory training which included; safeguarding, mental capacity, deprivation of liberties and moving and handling. Two of the staff we spoke with were being supported to complete National Vocational Qualifications. They said they had received training in areas such as infection control, dementia awareness, health and safety, moving and handling and fire safety. Staff confirmed that some of these sessions, such as moving and handling and fire safety, included a practical element so that they could practice safe procedures. One member of staff told us that they had the opportunity to shadow more experienced carers as part of their induction, when they were initially employed in their caring role.

However, from the records we looked at not all staff had undertaken up to date training relevant to the needs of the people living in the home. For example, out of the 50 staff in post, only 33 had training in moving and handling, 24 had training in Deprivation of Liberty and 24 in the Mental Capacity Act. There were very few staff who had received training in end of life care or nutrition and hydration. The service had a high number of people with a diagnosis of dementia and only 14 out of 50 staff members had received training in dementia awareness. We could see no evidence the service offered training in dignity and respect and only eight staff members had received training in equality and diversity.

We found staff had not received training in end of life care and there was nothing in the care records we looked at to show people's end of life wishes had been discussed with them.

Some people who used the service were assessed as being at risk of developing pressure ulcers and only two staff members had training in wound care and no staff had training in prevention and detection of pressure ulcers. This meant people who used the service were at risk because the service had not taken steps which ensured the staff had the knowledge and skills to support people’s specific needs. We discussed the training with the manager. They told us there was a trainer in place and they were in the process of updating all the training for the staff. Mental Capacity Act training was being delivered by an external agency and they would be ensuring all staff attended the training to update their skills and knowledge.

The above examples illustrate the provider was in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 18(2)(a) because staff did not all have the knowledge and skills to support people’s specific needs.

In the staff files we looked at we saw evidence that two staff members had a period of induction. In the other files we could not see any evidence induction had taken place. One staff member had not finished their induction paperwork three months after they had been in post. The service stated all new staff had a probation period and they would have a review after one month when they would be given their employment contract. In four cases, we saw new staff had not had a review after they had been in post one month and in two cases there was no contract of employment in place. We brought this to the attention of the manager who told us they would address this.

The staff we spoke with said they received regular supervision. They said they felt supported in their roles and they would feel able to raise any issues or ideas in supervision. One member of staff said “They are always wanting you to learn more. There is always plenty of training on offer”.

Although the service stated it offered staff four supervision sessions a year, these were not necessarily on a one to one basis. The registered manager told us they had recently changed the way supervision was carried out. Instead of supervisions being either one to one, departmental or observations, additional supervision was to be undertaken on a one to one basis. In the files we looked at we found four staff members had no supervision in 2015 and only one staff member had a personal development plan in place for 2015.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

Inadequate

Is the service effective?

We asked staff about their understanding of mental capacity and Deprivation of Liberty Safeguards. Staff had limited understanding of mental capacity and how decisions might be made in someone's best interest if they lacked capacity. Staff did not understand Deprivation of Liberty Safeguards. Staff told us that they had received some information regarding mental capacity with their payslips, but they had not yet read this. In some people's care records we saw their family members had signed consent to the person's care. For example, one person's care record stated 'I am able to make my own decisions' yet consent for care had been signed by their relative.

Although we found that staff's knowledge around mental capacity and Deprivation of Liberty Safeguards to be lacking, there was evidence in one person's file that an assessment of mental capacity had been requested, in relation to whether this person could manage their finances. Notes stated that "Dr [name] called to do mental capacity check and has found not to have capacity to manage financial affairs". There was no record of the actual assessment or any resulting best interest decision in the person's care file.

Staff told us that there were alarms on the doors. When asked what they would do in the event that someone tried to leave the home, staff told us that they would talk to the person and try and encourage them to return or distract them. Staff said they would inform family. Staff told us that the garden was secure and there were key pads on external doors, so people could not come and go as they wished. This meant people were being unlawfully deprived of their liberty.

The registered manager told us they had been in discussions with the local authority lead for mental capacity and they were in the process of securing training for all staff as well as beginning the process of assessing whether people in the home should be protected with a DoLS. We saw the provider had obtained copies of MCA 2005 and DoLS legislation to support them in this task.

We saw improvements in the way staff encouraged people to make choices in everyday decisions. For example, people were asked where they wished to sit at lunchtime and what they would like to drink, with staff respectful of their choices. However on some occasions we saw staff acted without seeking people's consent. For example, we saw one person was approached to be supported to the dining area and told it was time to move. The person said they did not want to move but staff did not listen to what was said, and referred to the person not liking the hoist. The person clearly said on three separate occasions that they did not want to be moved to the dining table yet and would go later, but they were moved anyway. The person was left at the table for 20 minutes before lunch was served, with no-one to speak to. The person had a drink of juice which the carer said would be taken with them but this was not done.

The above examples illustrate the provider was in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 11(1-5) because the provider had not obtained consent from people before carrying out care.

We saw there had been significant improvements to the provision of drinks for people in the home. A variety of hot and cold drinks were on offer throughout the day. One person was staying in their own room on the day of our inspection, because they had been unwell. This person had a supply of juice placed within reach.

We saw the cook was attentive to the people who lived at the home. They ensured that there was a plentiful supply of hot and cold drinks throughout the day; they also made sure that drinks were not left for long periods and then consumed in the heat. The cook came out and removed all used glasses at lunchtime and gave everyone a clean glass and fresh drink.

The cook told us that they were currently revising the menus and they worked on a four week rolling menu. Breakfast was served from 7am to 10am, but the cook said they made anyone who slept in a breakfast if they wanted one. The kitchen assistant told us that people were offered a choice of breakfast every morning. For example, people could choose cooked food, such as bacon and eggs, or toast or cereal.

When asked about fortifying food, the cook did not understand the terminology but was able to describe some fortification she was doing. We spoke with the kitchen and care staff about people who required thickener in their drinks. Although this was not specified on fluid record charts, all staff were clear who had thickener and how this was diluted.

Inadequate

Is the service effective?

One person who we spoke with told us they had eaten some toast for breakfast. They said “I like toast for breakfast”. They had some juice in front of them, within reach. This person said “I like it here”.

We observed a lunchtime experience in both houses. There was a calm and relaxed atmosphere. People chatted while they ate. Staff were aware of who may require assistance and people were encouraged to be independent but were given assistance where required. A variety of drinks were offered. Portion sizes were large and people were asked if they had enough. One person could be heard saying to another person “There’s too much. If they had bigger plates it would look better”. We heard four people give compliments regarding the food, when plates were taken away, such as “very tasty” and “lovely”.

We observed the lunchtime service in house 12. The service took about an hour. There was a very quiet and calm atmosphere in the room. Care staff were encouraging to people, asking them what they preferred to eat. When one person chose one meal but failed to eat anything, staff offered them a second choice. There were a number of very positive comments from people after they had finished the first course (steak pie) including, “That was very tasty” and “I really enjoyed that”. The portions were very generous and, although there was some wastage, a number of people cleared their plates. There was good interaction between care staff and people who lived at the home.

People were positive about the quality of the food and comments included: "The food is very good. I had a bacon sandwich for breakfast"; "The food is good. You've always got a choice at breakfast. It's a hot meal at lunchtime with a pudding. For tea time they bring a list round to let you choose what you want”; “People that are poorly eat in their rooms. I prefer to go down to the lounge”; "The food is marvellous, we get a good choice."; "They come round with menus. If you didn't like the choices they would give you something else.”; "The food seems to be alright, as long as we're not too choosy”; "They could improve the food with a bit more variety. The food is quite eatable.”; "I can't complain at all. The food is alright, it's always what I like." "The food is very good."; "The food is very nice. I think if it was more low calorie it would be better”; "The food is very good. You can choose what food you want." The food is average."

We noted that one person had lost 4.6 kg from the end of January to the beginning of June. A referral had been made to the speech and language therapy team for this person. However, we saw from care records that weight loss was not always managed effectively. For example, we had concerns one person’s food diary was not showing any lunch had been taken when we checked the record at 3pm. Records showed the person had lost weight over the recent weeks, with a loss of 5kg in just over 6 weeks and the care plan did not show what action if any was being taken. We discussed this with the registered manager who agreed to review people’s weight losses following our inspection and make any necessary health referrals.

We spoke with a visiting district nurse who told us things had improved in the home recently with regard to people’s health care. District nurses and tissue viability nurses attended to people who require nursing needs and we saw from people’s care records that referrals had been made for this service as needed. Where people had pressure wounds with a grading of 3 or above, we saw this was referred appropriately to the local safeguarding adults team. We saw evidence district nurses and GPs had attended and notes from these visits were contained in people’s care records. We did not see evidence of speech and language therapists (SALT) input where one person had thickened fluids due to the risk of choking.

We observed one person asked for assistance to take their socks off. The person said that their toe nails were sore and they needed cutting. Staff commented that they were having problems with securing visits from the chiropodist. We had noticed that another person had toe nails that looked as though they needed cutting. This person was also choosing not to wear socks. The manager told us that they had experienced problems with ensuring visits from the chiropodist and they were in the process of following this up.

Good

Is the service caring?

Our findings

We found there was a significant improvement in the quality of staff interaction with people in the home. Staff acknowledged people and spoke respectfully with them. Staff spent time checking people were alright and had what they needed and they were kind and patient in their approach. Staff smiled at people, were friendly and showed an improved caring attitude towards people who lived in Brantwood Hall.

We saw staff spontaneously took time to care. For example, one staff offered a person a hat to protect them from the sunshine when sitting in the conservatory. We overheard one member of staff ask a person how they were feeling. The person told the care staff they did 'not feel so good today' and 'would love a cup of tea'. We saw the member of staff promised to be right back and they returned within a few minutes with the person's tea.

When kitchen staff took their breaks, they sat with the people who lived at the home, they made positive conversations and obviously knew the people well, as they talked about things which were important to them. They made efforts throughout the day to ensure people were comfortable, hydrated, well fed and happy. One member of kitchen staff made people laugh as they were going round with the tea trolley and they encouraged people to have a drink and a biscuit, or a cold drink.

People told us the staff were caring. Comments included: "The staff seem to be very good. The staff are caring"; "It's alright here. The staff are lovely"; "The carers knock on the door and come in for a chat"; "The girls are very good. They look after all my needs"; "The girls are ok. They don't take too long if you need something."; "The girls are nice"; "Some of the staff are nicer than others. Some are on top of the job more. Senior carer is on top of the job." "They look after me very well." "They look after you here." "They're very good to me." "They do their best. They work hard, the ones that are here." "The girls are all nice." "Staff are absolutely brilliant. I can't praise them enough."

Family members said: "The staff are very good. They are really helpful" and "The staff are absolutely lovely."

We observed care staff in house 12 were very attentive and had established very good and close relationships with people. Everyone we spoke was complimentary about care staff and felt that they were friendly, caring and looked after people's needs fully.

One person who we with spoke with said "staff are very kind. I can't say anything wrong about them".

We observed staff asking people if they would wear an apron at lunch-time, before assisting people to wear one. Staff explained to people that they (staff) were wearing them too and that "we are all wearing them".

One member of staff who we spoke with said "Staff are good at their job and they really care". Another member of staff said "I absolutely love it here. I can't imagine doing anything else".

Staff told us that they tried to maintain people's dignity, for example, by closing the bathroom door when in use and by ensuring that people were not left waiting when they required assistance with personal care.

We observed staff to be discreet with people's personal information and spoke quietly on most occasions with people when offering assistance with personal care. On one occasion we heard a senior care staff made a phone call for a GP visit for two people who lived in the home. However another person living at the home was present and listening to staff as they made the call which was a confidentiality concern.

Even though at times there were not enough staff to promptly attend to the people who lived at Brantwood Hall, it was evident that the staff engaged well with them and staff showed a caring attitude towards colleagues, supporting one another in the team. For example, we saw kitchen staff came out to the dining area to help the care staff by offering people extra food, snacks and drinks. Kitchen staff asked one person if they would like to drink tea or coffee, then offered them tea from a pot maintaining dignity and respect.

Requires improvement

Is the service responsive?

Our findings

Many people told us there was not enough to do to keep them usefully occupied. Comments included: "Not really any activities." "They used to have bingo, but it seems to have died off now." "We did have a quiz and a sing song. I liked that very much. I would like that more frequently. Other than that it is a very boring place." "There are not many activities. We could do with some." "There are not a lot of activities."

One person told us "[Staff] arranged a bingo session and a fortnight ago we had a drinks party."

We found there was a lack of activity in the home overall and people told us they were bored. One person said they did not have enough to do and another said 'it's just the same thing day after day in here'.

During the first day of our inspection, we saw no activities and people were left in the lounge area with nothing to do, the result of this was that most people slept. There was a television in this area which was on for a very short period before lunch. There was no-one responsible for activities on the day of our visit, and the staff who were on duty did not have the time to spend socially with people.

One person who lived at the home was observed throughout the day singing and laughing and smiling. The person encouraged other people to join in and this created a pleasant atmosphere, as some people (and staff) occasionally chose to join in with this.

There were limited resources around the service to encourage people to entertain themselves. One lounge remained unused throughout the day we visited, despite this being a pleasant environment with television, music and books available.

One person we spoke with told us there were not enough activities. This person told us that there were occasional activities, such as a sing-a-long once a week but that they usually ended up watching television. We asked the manager about this and were told that there is an activities co-ordinator who works two days per week.

We saw some people did not receive care in line with their preferred routine. For example one person told us: "I missed my turn to get up this morning. I had to wait for the day staff."

The above examples illustrate the provider was in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 9(1) because people's care was not person-centred and in keeping with their needs and preferences.

There was a lack of signage throughout the building and it was difficult to navigate around the building without feeling disorientated. Toilet doors looked the same as bedroom doors. Bedrooms were indicated by numbers on the door. The numbers were sometimes placed up high and could be difficult for some people to see.

We found people's care records had improved since the last inspection and information was much easier to locate. However, there was still a lack of recorded social history for people to enable staff to understand each person and engage in meaningful conversation or activity with them. Some information in people's care records lacked detail and there was conflicting information in some of the records we saw, which would affect staff's ability to provide appropriate care.

We spoke with two members of staff and they both told us that people's needs were reviewed monthly. One member of staff said that they always included the person in that review. We saw evidence of this in one person's care plan, but we were unable to verify this with some of the other records we looked at because the service was in the process of updating all records electronically.

We asked the staff who we spoke with to tell us some information about the people who they cared for. Staff were able to tell us about people's care needs and also about the some people's life history. One member of staff outlined some of a person's likes/dislikes and also the person's life history and family background.

People told us they knew to complain to the registered manager if they had any reason to. People spoke positively about the service and comments included: "Overall, I have no complaints." "If I have any complaints I would tell them straight out." "I haven't any complaints." "They had a meeting for residents the other week. They asked if we had any complaints." "They're very friendly and it's very clean."

One family told us the service had responded well when they made a complaint. They said: "When my [relative] asked for a drink for their family member, the carer went to sit down in the office to do paper work. [My relative] has put in a complaint to the manager. [My family member] was

Requires improvement

Is the service responsive?

severely dehydrated when they went into hospital. [They are] getting regular drinks now. They've obviously taken the complaint seriously. The manager has taken it seriously and taken the steps to make sure it doesn't happen again."

We saw there was a record of complaints. However, we knew from information we had received prior to and during our inspection that some complaints to the home had not been recorded in the complaints book. We discussed this with the registered manager who told us they had recorded these as safeguarding concerns, not as complaints. The registered manager said she would make sure all matters relating to complaints were referred to in the complaints record.

Inadequate

Is the service well-led?

Our findings

People told us they were happy with the way the home was run. Comments included: "I can't think of anything that they could better"; "The home is very good. They look after me well"; "From what I've seen of it, it's quite nice"; "I'm really happy here"; "I've no reason not to like it here." "I think it's as good as any of its kind" and "I can't find any fault."

Comments from friends and families included: "There are some things that could be better"; "We're really pleased with the home. I've never seen anything untoward here"; "I think the home is very nice"; "I think it's beautiful, well run and efficient" and "I wouldn't want any changes to be made."

Staff comments included: "It's good working here"; "They've made a lot of changes since the last inspection, especially the paperwork"; "I really enjoy working here" and "They've done quite a bit of decorating since the last inspection and we've done more on the cleaning side."

There was a registered manager in post who was away on holiday on the first day of the inspection. However, there was a deputy manager and home administrator who were in charge of the running of the home. Whilst the deputy manager was helpful, there were times when information requested could not be located.

We saw there had been marked improvements made by the provider in response to the issues identified at the last inspection, particularly in relation to ensuring improvements to the environment, the quality of food and drink and staff interaction with people. The provider had taken steps to improve systems and processes for auditing the quality of the provision and we saw there was a more methodical approach being introduced to check the home ran efficiently.

For example, we saw monthly room checks had been made and action recorded, such as the replacement of fixtures and fittings. The fire risk assessment had been updated and monthly fire evacuations were recorded.

However, although we could see the beginnings of new systems being implemented we were unable to fully assess the effectiveness of these due to the short time they had been in use. There were indications that systems were not yet rigorous enough to accurately monitor the quality of the provision and there were gaps in auditing procedures. For example, we looked at a daily random check of the environment for June and saw there were only 10 dates recorded. We asked the administrator about this and we were told missing dates may be due to staff absence or weekends. In the care plan audits we saw it stated 'to be reviewed' but there was no indication of when this may happen or who was responsible.

There were monthly medication audits and a weekly medication records chart, showing a random selection of people's records checked by the manager. However, we did not see records completed since May 2015.

There was a record of premises, equipment and maintenance checks. We had been told one of the passenger lifts had been out of order. We saw a quote in the file in respect of the passenger lift and although the registered manager stated all passenger lifts were in safe working order, we were unable to see any records to substantiate this. The registered manager agreed to forward the lifting operations and lifting equipment regulations (LOLER) safety certificate following the inspection, although these were not received.

There were no audits undertaken of people's food and fluid intake and we discussed with the registered manager the need to ensure all staff were aware of how to identify concerns and trigger contact with other health professionals to support people who may be at risk of malnutrition or dehydration. The registered manager told us she would develop a system to audit this aspect of people's care.

The above examples illustrate the provider was in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 17(2)(a) because systems to assess, monitor and improve the quality and the safety of services provided was not robust.

We were told the regional manager made regular supportive visits to the home and had helped to implement some of the changes. Staff told us that they felt supported in their roles. Some said they received regular supervision and support from management, although we saw from records this was not consistently in place for all staff. Staff told us they felt valued and confident to make suggestions. We saw evidence of staff meetings that had taken place in April and May 2015.

Inadequate

Is the service well-led?

One member of staff told us that they had received a survey with their payslip, asking questions such as whether they knew how to make a complaint, whether they were happy in their job and whether they were satisfied with the management. The member of staff told us that their response to this could be returned either named or anonymously.

There was a noticeable difference in atmosphere between to the two houses. House 12 seemed to be calm, well managed and had a happy atmosphere. People were very complimentary about staff and the way in which they were being looked after. In house 14 we heard more comments about a lack of staff and their ability to respond to the needs of the people who lived at the home.

The manager frequently interacted with people and was seen assisting a member of staff to complete a safe moving and handling procedure. We saw the manager knew people well and chatted with them as they walked about the home.

We saw evidence of good teamwork. Care staff worked well with ancillary staff who were seen to work as a team. District nurses were seen to come in and out of the home and there was good communication with staff. Although staff were clear about their responsibilities, it was difficult to see which role each staff member had by their uniform as these were varied and did not indicate what role staff had in the home.

We saw the provider had responded positively to recommendations made at the last inspection and those made by partner agencies such as the local authority and the infection control team and although there was considerable work to be done, there was evidence of action being taken to secure improvements. For example, the provider had responded to a local authority improvement notice in relation to reducing the risk from legionella and there were documented checks in place of the actions taken.

Care records for people were easier to understand with information more clearly set out in a new format and written in the style of each person's preferences. However, we noted the new care records had not been signed or dated. We saw the manager and the deputy met together to discuss the quality of the care records and how these could be further improved.

Staff reported improvements to the quality of care for people. Although we saw some audits were in place these were not yet robust or extensive enough to demonstrate how quality of care was being monitored and improved.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care There were not enough meaningful activities for people

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People were not always asked their consent prior to any care intervention and staff lacked knowledge and understanding of the requirements of the mental Capacity Act 2005 Deprivation of Liberty Safeguards

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Individual risk assessments were not always carried out for people's care and support

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Quality assurance systems were not sufficient or rigorous enough to ensure all aspects of people's care was being well met. Documentation was not always organised well to demonstrate how people's needs were being met, or show the service was running safely.

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not enough staff deployed to meet people's needs. Staff had not all had training to support people's needs effectively.