Care Worldwide (Carlton) Limited

Brookfield

Inspection report

4 Brookfield Avenue
Castleford
West Yorkshire
WF10 4BJ

Tel: 01977559229

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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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 4 June 2018. At the last inspection in January 2018 we found the provider was in breach of two regulations which related to staff training and governance arrangements. The provider sent us a plan which told us they would not complete all their actions and meet the regulations until November 2018. At this inspection, five months after the previous inspection we saw the service had significantly deteriorated. They had made some progress in relation to basic staff training but new staff were still not receiving an appropriate induction. There were still significant issues with the governance arrangements. We also found there were issues around person centred care, meeting people's nutritional needs, management of risk including medicines, staffing arrangements, support to staff, safeguarding people from abuse, consent to care and maintenance of premises. We found they had not notified CQC about some significant events.

Brookfield provides care for up to three people who have learning disabilities. At the time of this inspection two people were using the service. People in care homes receive accommodation and personal care under a contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A manager had been appointed to manage Brookfield and two of the provider's sister services; they had been in post six weeks.

The service was not safe because risks were not assessed or well managed. We identified issues around fire safety and infection control. Accidents and incidents were not investigated. The service did not learn from incidents and prevent events from reoccurring. Medicines were not managed safely. People were not safeguarded from abuse. Staff were not appropriately supported and supervised. Only one member of staff was on duty for most of the time which resulted in people having limited opportunities to engage in person centred activities; one person was funded for one to one staffing but they did not receive this.

Support plans were not always accurate and did not reflect people's current needs. People had not been involved in the support planning process. People's health needs were not met because they did not always receive health checks and support from health professionals. People's nutritional needs were not met. Food records showed meals were not varied or balanced. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible.

We observed friendly interactions during the inspection. A member of the night staff was finishing their shift when we arrived and one member of staff was on shift during the day. People were comfortable with the staff who supported them.

There were widespread and significant shortfalls in the way the service was led. Some important records could not be located. Staff and resident meetings had not been held so people did not have opportunities to share their views. The provider did not have effective systems to assess, monitor and manage the service. They did not have processes to learn lessons and drive improvement. The provider did not respond to external reports.

We found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014, which related to person centred care, meeting people's nutritional needs, management of risk including medicines and infection control, staffing, safeguarding people from abuse, consent to care, maintaining premises and governance arrangements. We also found a breach of the Health and Social Care Act 2008 (Registration) regulations 2014 because the provider had not notified CQC about some significant events.

The overall rating for this service is 'Inadequate' and the service therefore has been placed 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.

People were not safeguarded against abuse.

Care was not provided in a safe way. Risks were not assessed and appropriately managed.

Staffing arrangements did not meet people's needs. Safe recruitment processes were followed.

Is the service effective?

Inadequate

The service was not effective.

Staff were not supported in their role. The provider was not acting in accordance with the Mental Capacity Act 2005.

People's nutritional needs were not met. They were not enabled and supported to help make sure they stayed healthy.
People were comfortable in their environment but the home was poorly maintained.

Is the service caring?

Inadequate

The service was not caring.

Care records showed people were not always treated with respect and their dignity was not always maintained.

People's care records had some good information about their background but staff were not always familiar with this.

We observed people were comfortable with the staff who supported them.

Is the service responsive?

Inadequate

The service was not responsive.

Support plans did not guide staff on people's care and support needs. The service had not taken steps to comply with the

'accessible information standard'.

People's individual needs were not met in relation to their hobbies and interests.

People were not enabled to use the complaints procedure.

Is the service well-led?

Inadequate

The service was not well led.

There were widespread and significant shortfalls in the way the service was led.

The provider's quality management systems were not effective and did not identify areas where the service had to improve.

Opportunity for staff and people who used the service to share their views was limited.

Brookfield

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 4 June 2018 and was unannounced. Two adult social care inspectors carried out the inspection.

Before the inspection we reviewed the information we held about the service. This included information we had received about the service and statutory notifications sent by the provider. We contacted relevant agencies such as the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

In April 2018 we received a safeguarding concern. We also had concerns about how the provider was managing their other two services. The same management arrangements were in place at Brookfield so we decided to carry out a focussed inspection. Soon after the inspection commenced we identified issues in a number of areas so decided to broaden what we looked at and changed the inspection to a comprehensive one. We informed the manager during the inspection that the remit of the inspection had changed.

We sometimes ask the provider to complete a Provider Information Return (PIR), which is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. On this occasion we did not request one and took this into account when we inspected the service and made judgements in this report.

During the visit we looked around the service and observed how people were being cared for. We spoke with both people who used the service, two members of staff, the manager and the regional manager. We spent time looking at documents and records that related to people's care and the management of the home. We reviewed two people's support plans. In the report we have referred to the regional manager and manager as the management team.

Inadequate

Is the service safe?

Our findings

We found people were not safeguarded from abuse. Safeguarding incidents were not dealt with appropriately, which included making safeguarding referrals and reporting to CQC, and people's personal allowances were not managed safely. We saw from records one person had been involved in three incidents with other people from one of the provider's sister services and sustained injuries which included a head injury and 'a clump of hair pulled out by another resident'. However, we could not find any record to show the incidents were investigated or measures put in place to prevent the risk of repeat events. We concluded people were not protected from abuse.

One person's bank card and PIN was held at Brookfield and kept in a safe. Staff had access to this and withdrew cash from the ATM on behalf of the person. We asked to see copies of bank statements/audits to show the withdrawal of cash from the person's bank account was being monitored. No records or statements were found.

We asked the management team to look at financial transactions records completed by staff; none could be located for May 2018. Financial records were available for April 2018, however, these did not have sufficient information around transactions to evidence the person's finances were being checked or were correct. Another person's relative paid £25 into the provider's bank account every week. Finance sheets showed the person received regular payments but there were no checks in place to make sure they were receiving the full amount. We concluded systems and processes were not operated effectively to safeguard people from financial abuse.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they would report any concerns to the management team and knew they could contact CQC or the local safeguarding authority if they wanted to speak with someone outside of the organisation. The manager told us there were no open safeguarding incidents at the time of the inspection.

We found medicine systems were not safe. We saw in each bedroom there was a secure cabinet for people to store their medicines. We checked the medicines stored in the locked cabinet for one person. We found two medicines which the staff member told us were no longer being used. These medicines should have been returned to the pharmacy. Another person's support plan stated they sometimes had pain in their legs and had been advised to take Paracetamol for this. The member of staff said they would not be able to give the person Paracetamol because they were not prescribed this and did not have any in stock. The person's medicine administration record (MAR) did not list Paracetamol as a medicine that could be administered. This meant staff could not follow the guidance for managing pain.

We found prescribed creams for one person were being stored with cleaning products in the 'Control of Substances Hazardous to Health' (COSHH) cupboard. This was not a person-centred approach and had been raised as an issue at the last inspection. The registered manager at the time of the last inspection told

us this would be addressed but it had not.

There were no PRN protocols in place for medicines prescribed on an 'as required' basis. Daily records showed one person had been prescribed a vitamin supplement as blood tests taken by the GP had identified a deficiency. Staff told us the person refused to take the medicine but there were no records to show this was followed up appropriately with the GP or any other healthcare professional.

This person was prescribed three different creams and there was a body map which showed where on the body each cream should be applied. One of these was a steroid cream prescribed for a skin condition. The printed instructions on the MAR for April and May 2018 stated the cream was to be applied twice a day sparingly only when there was a flare up of the condition for a period of one to two weeks. The MAR showed this cream had been applied twice daily for four weeks.

This person's medicine support plan was dated October 2017 and did not reflect the medicines the person was currently taking. A review of the support plan in January 2018 showed all the person's medicines had been changed to liquids yet the support plan had not been updated and stated, 'I usually pour all tablets into my mouth at once'.

The staff member on duty told us they had received medicines training and had their competency assessed. This was confirmed in the staff records we reviewed. However, we observed the staff member left medicines unattended on a table next to the person while they went to answer the door. We concluded medicines were not managed safely.

Risks to people were not always fully assessed or mitigated. One person and a member of staff told us about an incident that occurred at the end of May 2018. The person said staff refused to give them their medicines because they had got drunk. There was no incident form or a record of this in the person's care file. However, there was a note in the staff communication book which stated the person was only allowed two cans of beer. The reason for the decision was not recorded. There was no risk assessment in place to show the risk of the person consuming alcohol was assessed.

One person had a personal emergency evacuation plans (PEEPs). However, this was not dated and the risk level was not completed. They also had a Herbert Protocol in their care file. Their name, age and address was completed but other sections were blank. Herbert Protocol is a national scheme introduced by the police in partnership with other agencies to compile useful information which could be used in the event of a vulnerable person going missing. A member of staff told us no-one had explained the risk assessments. They said they had looked at the one's in people's files but 'the scoring on the risk assessments didn't say what the risk is'.

We asked to look at accident and incident reports. An incident report was found by staff in the home from the beginning of May 2018. The information was very limited and did not describe any injury or harm caused. However, care records for the same date showed the person had sustained a head injury and had been seen by a doctor. The staff, manager and regional manager could not find any other accident or incident form yet care records showed two other incidents had occurred; one in March and another in April 2018. We concluded care was not provided in a safe way for people who used the service.

A fire risk assessment report from November 2016 identified hazards; for example, intumescent strips were not on the doors to the lounge and kitchen, and there was no smoke detector in the washing machine cupboard. Intumescent is a substance that swells as a result of heat exposure used in fire protection. We saw these hazards had not been attended to. Records showed regular fire tests and drills were being completed,

and the premises and equipment was serviced by competent contractors. The electrical installation certificate was out of date and should have been inspected and tested in April 2018. The regional manager wrote to us after the inspection and told us this had been arranged.

The service looked clean and we saw staff had access to personal protective equipment such as disposable gloves. However, there were issues with infection control because we saw there was no toilet roll and a bin stored in the toilet area had no inner or disposable bag. Outside, at the front door we saw there was lots of salt sprinkled on the ground. The member of staff said this was to get rid of maggots which had been a problem because 'bin bags had been stacked up'. We concluded the provider was not preventing the spread of infection.

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

People did not receive care to meet their needs because there was not enough staff. One person was funded for one to one staffing three days a week but we saw they did not receive this. When we arrived at the home at 7.45am the person was up and asking staff if they would be going out that day as they didn't want to stay in. We checked the staffing rota which stated they should have had a member of staff allocated to work with them between 9am and 4pm. The member of staff on duty said there was no-one allocated for the one to one support. They rang the provider's other two services but were told no staff were available. The person was visibly upset and repeatedly asked throughout the morning if they could go out saying they were bored. They told us they had not been out all weekend. Staff told us the person usually went out on a Monday but had not done so for the last few weeks because there had not been any staff to take them. The member of staff told us the person got upset when they didn't go out. Staff and the management team were unable to locate any daily records for May 2018 so we were not able to establish what one to one support the person had received. We looked through the records for April 2018 and saw at the beginning of the month the person was being supported by staff to go out to different places, however, we saw this was not happening towards the end of the month. For example, one entry on 27 April 2018 stated the person was 'not in a very good mood as there were no staff to take [name of person] to [name of relative] tomorrow'.

Staff also told us that one person liked to go out very often but the other person liked to stay at home. This meant there were very limited opportunities to support people in the community because only one member of staff on duty most of the time.

Staff often lone worked at Brookfield. During the inspection only one member of staff was working between 8am-8pm. The rotas showed that everyday staff worked alone other than the days when the person should receive their one to one staffing. We saw a risk assessment for lone working was dated February 2011 and last reviewed in November 2016. This stated that when staff worked alone there would be a manager on call, staffing was to be reviewed to ensure it was safe for staff to work alone, to assess the behaviour daily of people who used the service and to ensure that staff were fully trained and deemed competent before they worked alone. We found these actions were not being followed. Staff told us they did not know of any on call arrangements. We concluded the provider did not ensure there were sufficient numbers of staff deployed at Brookfield.

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

We found safe recruitment processes were followed. We saw appropriate checks had been carried out with references and criminal record checks obtained before people started working in the service.

Inadequate

Is the service effective?

Our findings

At the last inspection in January 2018 we found the provider was in breach of the regulation that related to staff training. The provider sent us a plan and told us they would complete all their actions and meet the regulations by November 2018. They said they would complete a schedule of training that included safeguarding, medication administration, infection control, fire awareness and manual handling by 30 May 2018; we saw they had achieved this although one member of staff was showing as not completed safeguarding training. In the action plan they told us they were introducing a new induction process and rolling out training around behaviour.

We spoke with two staff who commenced in March 2018; both had not received an appropriate induction and told us they had not received good support. One member of staff told us they had completed their induction in a couple of hours and had then started working on their own. They said they didn't do any shadowing and had to 'learn as I went along'. The other member of staff told us they completed their induction in one day with the previous registered manager and said, "When we talked about things we ticked it off." They told us they had shadowed experienced staff for two days, and had competed e-learning training and some face to face training. They said no-one had spoken to them about completing the 'Care Certificate' which is an identified set of standards workers adhere to, and should be completed when staff are new to the social care field. We looked at both staff's records which showed they had completed an induction but this was done in one day.

We looked at three staff files which showed they had not received appropriate support and supervision. One staff member had no supervision records. Another member of staff had started in May 2016 and had one supervision record dated 19 July 2016. The third member of staff had started working in March 2018 and had one supervision record dated 16 April 2018. However, this record related solely to a health issue and did not review or consider the staff member's practice or professional development. We concluded staff were not being appropriately supported and supervised.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). One person told us they had a DoLS so were unable to do certain things like go out into the community unsupervised. However, a note in their care record stated the DoLS had expired; the management team said they did not know if this had been had

been followed up. A copy of the DoLS was not available so no one knew if the person was being legally deprived of their liberty. Another person's support plan showed they had a DoLS in place.

There was a lack of understanding about assessing people's capacity to make certain decisions. Although there were some capacity assessments and best interest decisions in place, we found this was not always the case. For example, we saw consent forms for one person's care and treatment had been signed by their relative and consent for the person to undergo a medical test had been requested from the same relative. Although the care records showed the relative was an appointee for the person's finances, there was no evidence to show they had the legal authority to make decisions about the person's health and welfare. There was no evidence to show these matters had been discussed with the person or that their capacity had been assessed for these particular decisions.

One person told us they made decisions about some aspects of their care. For example, they said they chose when to get up on a morning and when to smoke. However, they raised concerns because they said they did not have a choice about when to go to bed and how much alcohol to consume. They told us, they had to go through to their room at 11pm but said, "I should be able to stay up, especially on a Friday, Saturday and Sunday." We reviewed their care file. There was no assessment or best interest decision about either of the two issues the person raised with us. However, we reviewed the communication book which had an entry stating the person was 'only allowed two cans or bottles of beer a day'. Another entry stated another person needed to be in bed by 11pm. There was no reference to this in their support plan and no evidence the decision was made in consultation with others. We concluded people's rights were not respected and the provider was not acting in accordance with the MCA.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's nutritional needs were not being met. Weekly food records showed people did not receive a varied and balanced diet. For example, the week before the inspection, one person's meals had been recorded on five out of the seven days and showed they had eaten 'wedges' four out of five days, twice on one day. They had 'quiche' and 'kievs' twice in the week. There was no record of any fruit or vegetables being eaten. They had cereals for breakfast and supper. The person had a 'diet notification' and nutritional support plan which stated they needed encouragement to eat vegetables, high fibre and a high protein diet because their muscles were weak.

Another person's care records showed they required a low fat, healthy diet and portion control as due to a medical condition they were prone to weight gain. The nutritional support plan stated the person was good at choosing healthy options and was involved with staff in planning the shopping. Monthly reviews of the support plan stated the person continued to choose a healthy diet. We saw in March 2018 the previous registered manager had raised concerns with staff about this person's diet and asked staff to support the person by reducing portion sizes and replacing carbohydrates with fruit, vegetables and salad. Yet records we saw of the meals the person had eaten in the last few weeks showed this advice was not being followed.

The person's weight records showed in the last two months they had gained over one stone in weight and their body mass index (BMI) had increased to 37.4. The MUST tool assesses a person with a BMI over 30 as obese. There was no evidence to show this weight gain had been discussed with any health care professionals or that any specialist dietary advice had been obtained. We concluded people were not in receipt of suitable and nutritious food which was adequate to sustain good health.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

The provider used standard care documentation at Brookfield for risk assessing and support planning. Support plans had three sections- 'this is what you need to know about the support I need, aims and objectives, and this is how to support me'. The support plan identified if a risk assessment was in place. People also had daily records of care. It was evident at the inspection the care recording and support planning system was not effective and it was unclear where some records were being stored. We were told some records, including recent entries, were kept at another of the provider's services but when we asked staff and the management team to look at some specific records they could not be located. This meant the provider could not assess and monitor risk and quality of the service.

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

People's health needs were not met. One person told us they had not seen a GP. We looked at the person's care records but these did not contain any information about any health appointments. The member of staff on duty told us they were not aware that the person had attended any health appointments and could not find any records of health appointments.

We saw some entries which showed another person had seen their GP in March and April 2018. However, we found advice given had not been acted upon. For example, the GP had recommended moisturisers to be used for the person's skin condition before one of the prescribed creams was applied. There was no reference to this in the person's support plans or on their MAR. In April 2018 the GP had advised the person required a medical test. We asked staff if this had been arranged or booked and they said not yet. There were no records to show the person had seen an optician or dentist. We concluded the provider was not enabling and supporting people to access relevant health professionals to ensure care is appropriate to meet their needs.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw people were comfortable in their environment and accessed all areas. However, the home was poorly maintained. Some areas looked tired and shabby. The carpet by the back door was heavily stained and the wall near the light switch in kitchen was marked. There was no blind at the kitchen window. Wallpaper was lifting in places in the hall. Paintwork was scuffed and a large patch of paint was missing by the handle on one person's door to their room. A toilet seat was not secure so moved when you sat on it and there was no toilet roll holder. One person had a lock on their bedroom door but said they did not have a key so could only lock it from the inside. Staff told us they held the key. We discussed the environmental issues with the manager and regional manager. They acknowledged that the service required decorating throughout. We concluded that the premises used by the provider were not properly maintained.

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

Inadequate

Is the service caring?

Our findings

One person told us they were reasonably happy living at Brookfield although they were unhappy about some recent decisions that had been made by staff and management. We spoke to the management team who agreed they would review the decisions with the person. The person also said, "Staff are nice." However, they told us they 'did and didn't' get on with one member of staff because they 'gossiped'.

Staff we met during the inspection were kind, caring and compassionate, and people were comfortable and relaxed with the staff who worked at the service on a regular basis. We observed one person was upset throughout the morning because they wanted to go out and the member of staff who should have supported them did not arrive. Staff attempted to arrange for one to one support cover but this was unsuccessful. The person asked staff continuously if they could go out and stated they did not want to stay in. The member of staff explained that their one to one worker had not arrived. They responded to the person every time and tried to reassure them that they would try and organise for them to go out. The member of staff also tried to arrange for both people to go out together but the other person declined.

People's records had some good information about their history, likes and dislikes. For example, we saw one person had a detailed overview of their life before they moved to Brookfield. However, information in people's care records was not always known by staff who supported them. A member of staff told us no one had gone through the care records with them and it was not included in their induction. They said another agency had visited the service and reviewed people's care records. The member of staff said the agency had highlighted that one person had a medical condition but they, and other staff had not known about this.

We observed a member of staff squirting oral medicine they had measured up in a syringe directly into the person's mouth. When we asked the staff member about this they said the person liked to take the medicine this way, yet there was nothing in the person's support plan to confirm this.

Care records showed people were not always treated with respect and their dignity was not always maintained. An entry in February 2018 stated one person needed new underwear as they had been wearing the same underwear for three days. An entry two days later asked staff again to buy new underwear as the same ones had now been worn for five days. The member of staff told us the person displayed a certain behaviour which meant they went through a lot of underwear. There was no reference to this in their support plan. We concluded the care the person received care that was not appropriate and did not meet their needs.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One bedroom was unoccupied and we saw a bin bag full of clothes. The staff member thought these clothes belonged to one of the people living in the home but did not know why they were in the room. Two other bags had clothes and books in them, the staff member did not know who these belonged to.

Records were kept locked which ensured they were confidential. The management team told us they had recently purchased the cupboard to help make sure records were organised, secure and accessible.

One person told us they were enabled to do things independently. They said they carried out some tasks around the service such as 'a bit of cleaning', and used the washer and dryer. We saw on the day of the inspection the member of staff encouraged them to assist with sweeping outside and tidying the garden.

Inadequate

Is the service responsive?

Our findings

We found support plans were not accurate or up-to-date and did not reflect current needs. For example, one person told us they enjoyed going to the pub and drinking beer. There was no reference to this in their support plan. We saw they had a mobility support plan which made reference to them using walking aids at all times. However, we saw the person did not always use the aids. Another person's support plan stated they were prescribed a sedative and detailed the situations when this 'as required' medicine was to be given. The staff member told us this sedative was no longer prescribed and we saw it was not included on the current MAR. However, the support plan had not been updated.

One person's medical history showed they required a low salt diet due to a medical condition and had an allergy to oranges. This information was not included in the person's nutritional support plan. There was no reference to the person's recent weight gain and the support plan had not been reviewed since March 2018.

One person told us they knew they had a support plan but said, "No one has sat and done the support plan with me." We concluded people's care was not designed with a view to ensuring their needs and preferences were met.

One person's communication plan stated they could 'write their name, count simple numbers, copy write and read simple words'. Yet information in their DoLS authorisation stated the person could not read or write. Another person's support plan stated they 'can write and read some simple words'. However, we found information such as support plans, menus, and policies and procedures were not available in an accessible way such as an easy read or pictorial format that helped people understand information and enabled them to be involved in decision making processes.

The communication support plan showed it was important for this person to know what they were doing in advance so they did not become anxious. It said the person had a weekly planner which was completed with them on a Sunday ready for the following week. We asked the staff member on duty for the planner. They told us the person used to have a weekly planner which showed what they were doing each day but said these had not been in place for the last month.

Another person told us they used to have a planner where they decided activities they were going to do the following week but said staff did not do this anymore. We saw the last activity planner in the person's care file was dated February 2018. The person said they would like opportunity to go to the cinema. We saw the person had a care review in October 2017 which identified actions which included 'find a course that [name of person] would like to do' and 'exercise more'. None of these actions had been implemented.

We saw one person was funded for one to one staff support from 9am until 4pm on Monday, Friday and Saturday so they could go out and pursue their own interests and hobbies. However, we found the person had not received the appropriate staffing which had resulted in the person being unable to participate in person led activities. Staff told us they person loved to go out. On the day of the inspection we heard them ask throughout the morning if they could go out, and suggested going to a museum. During the afternoon a

staff member from one of the provider's other services arrived to do the food shopping. They asked the person if they wanted to go with them to the supermarket, which they did.

One person's support plan stated they liked to be involved in writing the shopping list to make sure the things they liked were added. We saw on the day of the inspection they were not involved. This meant guidance that was in place around meeting people's needs was not followed.

Staff told us one person attended a day centre in Leeds twice a week. These activities were not mentioned in the person's support plans. We observed there was little for people to do other than watch television. One person was given the home's laptop so they could watch YouTube, which they did for most of the day. The other person spent time on their mobile phone or outside smoking. We concluded people's care did not meet their needs.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the management team for any records of complaints received since the last inspection. They told us there were none. We saw a record which stated a complaint had been made by a relative the day before our inspection and emailed to management. When we asked the management team about this, they said they were not aware of the complaint but agreed to follow this up.

We read daily handover sheets which showed one person was unhappy with a recent decision that had been made by the manager and had shared this with staff. However, there was no evidence the person was given any information about how to complain. A member of staff had recorded '[Name of person] has continually gone on all night about not being able to drink. See daily notes'. We were unable to read what had been recorded in the daily notes because these could not be located. The person said they were still very unhappy when they spoke with us four days after the event and told us they did not know they could make a formal complaint. The regional manager said they would review the situation. After the inspection they told us the issue had been resolved.

Inadequate

Is the service well-led?

Our findings

At the inspection in January 2018 we found the provider was breaching two regulations and rated the service as requires improvement. The breaches related to staff training and governance arrangements. At this inspection we saw they had made some progress in relation to basic staff training. However, new staff were still not receiving an appropriate induction, and staff were not appropriately supported and supervised. There were still significant issues with the governance arrangements. It was evident from the inspection findings that the quality and safety of service provision had declined. We found the provider was still in breach of the two regulations from January 2018 plus seven more regulations; these related to safe care and treatment, consent to care, person centred care, nutrition, safeguarding people against abuse, maintenance of the premises and notifying CQC about significant events. This demonstrates that there were widespread and significant shortfalls in the way the service was led.

We found there was a lack of oversight and leadership at the service. We saw messages in the communication book which showed no one was taking responsibility or ownership to ensure issues raised were addressed and not repeated. For example, an entry in February 2018 stated one person was being overmedicated with a steroid cream which had been highlighted to staff seven days earlier and reported to the person's GP but was still happening. There were no other records about this incident or any evidence to show this had been reported to the local authority safeguarding team.

The day we inspected the food supplies were low and there were no toilet rolls, juice or potatoes. The manager told us this was identified as an issue the previous Friday and no one had done any shopping over the weekend. The communication book showed there had been previous problems with food and other supplies. In February 2018 staff wrote, 'Can we please have enough shopping to last the week. We've had nothing in, had to buy milk the last couple of days. We have nothing to make a meal because we have no veg, no potatoes and no salad stuff. Can we also have blue roll and paper towels so we don't have to dry up with toilet roll again'. Blue roll was a disposable paper towel. Another entry stated, 'Residents have had hot dogs for tea today with out of date baguettes they went off on the 22nd, it is now the 26th'.

We saw reports of visits undertaken by the regional manager in March and May 2018. The March audit stated support plans had been checked and appeared up to date. It stated MARs had been checked and identified PRN protocols needed to be put in place. There were no timescales for this to be achieved. At this inspection we found these were not in place. No other issues were identified.

The May audit identified items in the fridge were not dated; COSHH items were in a cupboard under the sink and not locked away, residents files had too much information in and the cupboard where they were kept needed locking. There were no timescales for these issues to be addressed. The audit also identified that a recently recruited staff member required a supervision or probation review by 1 June 2018. We checked this staff member file and saw this had not been completed.

We looked at recent audits which had been completed by the manager in May 2018. This included infection control, mattresses, health and safety, medicines, finances and catering. The catering audit scored 80% and

included a list of issues identified, the actions to be taken and timescales for compliance. This was the only audit we saw where issues had been identified and an action plan put in place. However, the audit showed most of the actions were to be completed immediately but there was no evidence to show these had been followed up. The financial audit scored 39% and identified weekly audits were needed and the safe was kept in an unlocked cupboard and not bolted to the floor. There were no actions or timescales recorded.

The medicine audit had been completed three weeks before the inspection. None of the issues we identified had been picked up in the audit. We saw a care plan audit had been completed for one person who lived in the home. The audit was undated and unsigned so it was unclear who had completed it. Only three pages of the eight page audit form had been completed. We established it had been completed in the previous month because it made reference to information from the beginning of May 2018.

We saw a 'home manager's walk around' report dated 30 May 2018. The only issues identified were one missing signature on a MAR and some food temperatures not recorded. There were no actions recorded. We saw a cleaning rota for night staff. This had last been completed on 11 March 2018. We concluded the provider's auditing processes were not effective. A fire risk assessment report identified hazards. It was dated November 2016 and had been carried out by an external agency; the provider had not taken action to address these.

We asked to look at minutes for staff and resident meetings that had been held since the last inspection. We were told none were available. The last staff meeting was dated 5 January 2018. The last resident meeting was dated 6 January 2018.

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

After the inspection the regional manager sent us information about action they were taking following the inspection findings. They told us they had improved on call and lone working arrangements, reviewed one to one support hours and ensured these were covered, and arranged for an electrical wiring installation test and intumescent strips to be fitted to fire doors. They also said moving forward they would be appointing a manager who would cover Brookfield and one of the provider's sister services, which is also registered to provide care to up to three people.

Providers have a responsibility to notify CQC about certain significant events such as safeguarding, serious injury and police incidents. Before the inspection we checked our records and found, since the last inspection we had received two notifications of abuse or allegations of abuse in the last 12 months. However, we did not receive a notification about allegations where one person was harmed by other people who used the provider's services; records we reviewed indicated this had occurred on at least three occasions between March and April 2018. We saw records which showed one person was being overmedicated with a steroid cream but the provider failed to notify us. We were also informed by the local safeguarding authority about an allegation of abuse which involved a member of staff towards one person who used the service. The provider failed to notify us about this allegation. We concluded the provider had failed to notify CQC about significant events.

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