Care Quality Commission

Yunicorn Limited

Brooklands

Inspection report

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Tel: 01386423178

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Brooklands is a residential care home providing accommodation and personal care to four people with learning disabilities. The service can support up to nine people. Brooklands accommodates people in one adapted building consisting of a converted period house. Bedrooms were located on the first and ground floor of the property. A communal lounge, kitchen and conservatory/ dining room were on the ground floor.

The service has been developed taking into account best practice guidance and the principles and values underpinning Registering the Right Support. The home is located close to Evesham town centre and the facilities provided for the community.

People's experience of using this service and what we found
People living at Brooklands did not receive a safe, effective and well led service. The registered provider had not ensured oversight was in place to maintain people's safety and welfare. Shortfalls identified as part of previous inspections regarding the service were not always actioned to prevent further or similar occurrences.

Care plans and risk assessments did not contain up to date and accurate information to inform staff how to provide safe care to people. Records were not always completed to evidence the care and support people had received and in line with people's health care needs.

People were at increased risk of experiencing harm because the systems in operation failed to identify concerns with the premises and repairs were not promptly actioned. Fire prevention best practice was not adhered to. Risks regarding the building were not always considered and were not in line with the provider's own procedures. Practices to reduce the risk of Covid-19 infection within the home were not always implement by staff members and areas of the home were not able to be effectively cleaned.

Safe systems were not always implemented to ensure staff were aware of protocols regarding people's medicines. Accurate records regarding people's medicines and prescribed creams were not always maintained placing people at risk.

The dependency needs of people were not considered to establish the required staffing levels to meet these needs.

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 and in their best interests; the policies and systems in the service did not support this practice.

The service didn't always apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and

achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support. For example, in addition to restrictions in place due to the Covid-19 pandemic people's freedom of movement without supervision was further restricted. Terminology used in recording and while supporting people was not always in line with person-centred care.

Staff had received training in line with the provider's procedures. Skills and knowledge were not always in place during the inspection and within the record keeping and management seen.

The governance of the service had not ensured people received the care and support required to meet their individual needs. Systems in operation had not identified shortfalls and had not driven continual improvement.

The provider had failed to notify the Care Quality Commission of certain important events which had occurred within the home as required by law.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 03 October 2019). There were two breaches of regulations and we served a Warning Notice highlighting the areas requiring improvement and a timescale for this to be achieved. The provider informed us of the actions taken following the inspection.

This service has been rated requires improvement for the last two consecutive inspections.

At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to the management of the service including the management of Covid-19. As a result, we undertook a focused inspection to review the key questions of safe, effective and well led only. We were also aware of the death of a person and an injury to another. The information CQC received indicated concerns about the management of the incidents. These are currently subject to a police investigation. As a result, this inspection did not examine the circumstances surrounding these.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Brooklands on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and people's treatment, staffing, personalised care, management of a safe environment and the governance of the service at this inspection.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Care Quality Commission

Brooklands

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of two inspectors.

Service and service type
Brooklands is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we have received about this service since the last inspection. We reviewed information of concern received from the local authority and other professionals who work with the service. We carried out a second Emergency Support Framework (ESF) assessment with the registered manager which highlighted further concerns regarding the management of Covid-19.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spent time to see how people were cared for by staff throughout the day. We spoke with one person who used the service about their experience of the care provided. We spoke with two members of staff at the home and with the registered manager who is also the nominated individual on the telephone. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with two staff members employed by the local authority who were working at the home to provide assistance and support.

We reviewed a range of records these included two peoples' care records and multiple medication records. We looked at a variety of records related to the management of the service including policies and procedures, management of the environment and the management of risks to people. We observed staff interactions with people in communal areas of the home.

After the inspection
We continued to seek clarification from the registered manager to validate the evidence we found during the inspection. As the registered manager was not on site at the time of the inspection staff were unaware of or unable to access information regarding recruitment and managements checks. We asked for this to be supplied to us. Following this inspection, we discussed our findings with other stakeholders including the local authority and Hereford and Worcester Fire and Rescue Service, so they were aware of the safety risks and concerns we identified.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

At our last inspection the provider had failed to keep people safe from unsafe care and treatment. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

● People were placed at risk of harm as actions required by the registered manager and provider to keep people safe had not been taken.
● People's care records and risk assessments were not always updated to provide staff with the information they needed to ensure people were safe. For example, when a person spent time in the community. The guidance provided for staff through the person's care plans and risk assessment was contradictory. This increased the risk the person would not receive the care they needed, and their safety needs would not be managed.
● At the time of the inspection temporary staff who had not received any induction were working at the home. Risks to people were therefore increased because temporary staff had not been made aware of people's needs or how to support them safely.
● Risks to people were increased because action had not been taken to mitigate harm. Fire doors were propped open including the kitchen door. A notice on the kitchen door stated it was to be kept shut when the kitchen was not in use. We saw a brick in one person's bedroom which could have potentially been used as a door wedge and other bricks propping open other doors. Having wedges in place would prevent doors closing and therefore not provide a defence against a fire spreading. We asked to see how one fire door held open by an electronic devise would close. The member of staff was not aware of how to deactivate the devise for the door to close.
● Although regular testing of the fire alarm had taken place this was not including all of the fire break glass points within the home. This meant the provider could not demonstrate the whole fire system was checked to ensure people were safe.
● Further environmental concerns were highlighted. The inspection team and a member of staff became entrapped within an empty bedroom because the handle to open the door from the inside was missing. In order to leave the room inspectors and the staff member had to obtain assistance by telephoning another staff member on site. This could have proven to be a distressing experience had it happened to a person

living at the home who may have lived with anxiety.
● Staff had continually failed to ensure suitable action was taken following the testing of water temperatures to ensure they were at a safe level in relation to both hot and cold water. It was evident immediate action was not taken once concerns become apparent. Failure to take action once risks are identified potentially place people at risk.
● People were exposed to additional risks to their safety as trip hazards were present. For example, a piece of carpet was seen in a downstairs passageway. This had not been recognised by staff as a potential trip hazard and needed to be highlighted by inspectors.
● Medicines were not always safely managed. The previous two inspection reports had highlighted shortfalls with protocols to guide staff members in the use of PRN (administered as and when needed) medicines. We remain concerned there is increased risk of people not receiving their PRN medicines as prescribed as staff were not considering the guidance in people's PRN protocols before administering their medicines.
● Systems for ensuring people's PRN medication was reviewed were not embedded. For example, people's PRN protocols were not always dated and did not consistently show when these needed to be reviewed. This increased the risk people may not have these medicines safely administered.
● People's medicine records contained gaps whereby staff had not signed to evidence staff had administered these items or had applied their prescribed creams. The records did not always provide staff with details about the dose people were prescribed or due to take. For example, in relation to the number of painkillers and the strength of the medication to ensure the right dose is administrated. Handwritten details on medicine records were not witnessed by another member of staff to check they were correct. This increased the risk of errors in recording and medicine administration.
● People's medicinal cream records and related care plans were not always up to date, accurate and fully completed. One person's care plan, daily routine and medicine record referred to them having a prescribed cream. This cream was mentioned by a member of staff when we spoke about the person's care needs. The last time staff signed to evidence the application of this item was in December 2018. Other cream records were not consistently showing medicinal creams had been applied as required.
● This inspection took place during the Covid-19 pandemic. The systems in place to prevent and control infection had not always followed good practice. Although staff had a thermometer to take peoples temperatures, they did not test the inspectors on entry.
● Staff were seen wearing Personal Protective Equipment (PPE) such as masks, gloves and aprons. One member of staff was seen to be wearing a mask the wrong way around.
● Not all areas of the home, equipment and furniture were clean and in a good state of repair to afford suitable cleaning. For example, there was no soap available in a toilet, a staff member was unable to tell us when soap was last available. In another toilet the flush button was missing. In addition, we saw cob webs, walls where cleaning would be ineffective due to cracks in the plaster, damaged furniture with exposed porous areas and a rusty radiator. Although not currently in use we saw a hoist which was rusty. The work surface where medication records were held was damaged with areas where effective cleaning to reduce the risk of the spread of infection would not be able to take place.

We found no evidence that people had been harmed however, systems were not in place to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The wedge from the kitchen door was removed once inspectors brought this to the attention of the senior member of staff on duty. Following our inspection, the registered manager informed us they had removed the bricks we found and told us the provider had agreed to have door closures fitted. It was evident from our subsequent check however at least one door remained held open three days after inspectors brought their

concern to staff's attention.
● We brought our findings regarding fire safety to Hereford and Worcester Fire and Rescue Service for their information and for them to consider their response.
● Upon our request staff locked the door of the bedroom with the missing door handle to prevent anyone else getting locked in.
● Records of the temperature of hot water when people had a bath or shower showed a consistent temperature was maintained. Staff told us they tested water either using a thermometer or their elbow. It is important accurate testing of water temperatures are taken to reduce risks to people.
● Guidance on how masks and the importance of using this correctly was on display for staff information. Staff were expecting further training to be delivered later in the week.
● Staff confirmed they had enough supplies of PPE.
● Staff were seen using different coloured mops and buckets in different areas of the home to assist with infection control prevention.

Staffing and recruitment
● Throughout the day time two members of staff were on duty. One member of staff was supporting people at the home for a continuous period of 24 hours, including a sleeping shift. The staff member told us, "It's been really hard, with two staff only working. It did not work when (people's names) were ill."
● Staffing levels at night were not sufficient to support people safely. If people required additional help during the night, when only one member of staff was on shift, the provider relied on the good will of an off duty member of staff who lived at the home to care for people.
● The provider was not using a dependency tool to calculate the correct staffing levels to meet people's needs. This meant there were insufficient staff to provide key areas of people's support and safely. For example, the provider's medicines policy stated two members of staff were required to administer people's medicines. This was not always possible due to the number of staff members on shift at times.
● Staff told us the lack of available care staff meant the registered manager had undertaken some care shifts. This meant the management resources available across the two homes they had oversight and responsibility for was reduced.

We found no evidence that people had been harmed however, the registered manager was unable to evidence how they ensured staffing levels were sufficient to meet people's needs. This placed people at risk of harm. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection, the registered manager informed us the provider had agreed to increase staffing levels during the day time.
● The registered manager supplied evidence of DBS checks carried out on staff in March 2019 by an employment agency. We also saw evidence of checks made upon references for these staff members at the time.

Systems and processes to safeguard people from the risk of abuse
● Staff we spoke with told us they had no knowledge of any abusive practice having taken place at the home. However, information shared from other organisations indicated a lack of awareness regarding the reporting of potential abuse to others such as the local authority and to the Care Quality Commission.

Learning lessons when things go wrong
● The provider had failed to have the oversight to ensure lessons were learnt and to sufficiently improve in order to keep people safe following our previous inspections.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support
● People living at the home had done so for several years. The ongoing assessment of people's needs was not evident within the care documentation.
● People's care plans were not regularly assessed and reviewed in line with the timescales identified at the previous reviews. For example, one person's care plan and risk assessment showed it to be due for review in October 2019, this was not recorded as having taken place. Another risk assessment was due to be reviewed in July 2019. There was no evidence of this review having taken place. This increased the risk people's needs would not be identified and appropriate care provided.
● The provider was unable to evidence people's health and wellbeing needs were being met. The records available did not evidence one person had received an injection in line with the healthcare professional's instruction. The care plan did not name the correct medicine. This could have placed the person at risk if the incorrect information was communicated to another healthcare professional.
● People's health care needs were not always managed effectively. We were not assured people received the support they needed to access the regular health care they required for their individual health conditions at the times they needed. For example, the time gaps between scheduled appointments and actual appointments was at times longer than the person's treatment plan specified.
● Weight records were not always completed. We highlighted concerns around the people's weights in the previous inspection report. For example, on this occasion we found one person did not have their weight recorded for a period of three months. When their weight was taken after this period the record showed a weight loss. There was no indication of prompt action by staff to address this concern. We found a similar gap within another person's records where they were not weighed for two months. People therefore continued to be at risk of not having the support they required from external health specialists, as arrangements for monitoring people's underlining health conditions were not fully effective.
● The terminology used in people's records was not always person centred to ensure people's human rights were respected. For example, we saw labels were given to people which could be viewed as judgemental and value based and not always respectful to the individual. We saw terms used within records which were not professional. During the inspection a member of staff stated, 'Good girl' when attending to a person's personal care needs. This is not in line with good practice and does not acknowledge staff were working with adults.

We found no evidence that people had been harmed. However, people's health care needs were not regularly assessed, and planned for to ensure these were met and opportunities were not missed focusing

on them as individuals. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the registered manager managed to obtain evidence from healthcare professionals evidencing a person's healthcare treatment had been carried out. This demonstrated the provider's records were not an accurate reflection of the actions taken to support this person.
● People had attended annual health check-ups.
● Staff told us they could call emergency services themselves if needed and did not need to refer to the registered manager before doing so.
● The registered manager told us they had devised new care records, and these were to be implemented.

Adapting service, design, decoration to meet people's needs
● The standard of items of furniture was not always conducive to valuing people and demonstrating their self-worth. We saw Items of furniture which were broken or damaged as well as worn and or stained surfaces which could therefore not be effectually cleaned. The registered manager was not able to supply us with a programme of ongoing improvement and replacement acknowledging they had identified the improvements required or plans to replace damaged items and maintenance of required areas.

We found no evidence that people had been harmed. However, action to ensure effective management of the environment had not always taken place. This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● People did not always receive care from staff who used their skills and knowledge when supporting them. For example, staff did not use the skills they had gained when recording people's medication administration. In addition, staff had received fire training but did not apply this, leaving fire doors propped open and areas of the alarm system were not checked. These factors increased risks to people.
● Staff working at the home from the local authority told us they received no induction or handover regarding the people they were to provide care and support to.
● Local authority staff providing care to people also told us they received no basic health and safety instructions such as in the event of a fire.

Staff working with other agencies to provide consistent, effective, timely care
● At the time of the inspection other agencies were working with the registered provider due the safety and quality concerns identified. The local authority was providing additional staff throughout most day shifts to support the care provided.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the

Deprivation of Liberty Safeguards (DoLS).

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

● One person told us they were able to make their own choices and decisions. Also, they told us they were sometimes bored because they were not allowed to go out without a member of staff. We saw conflicting information about their understanding of social distancing as a reason to limit their ability to leave the home without staff accompanying them.
● Staff were uncertain whether anyone living at the home had an authorised DoLS in place. We were told information about DoLS and confirmation if anyone had one in place would be on file. Following the inspection, the registered manager told us no one required a DoLS as people who were not able to leave the home on their own would not seek to do so.
● Staff were aware of the principals of best interests decision and who may be involved in these.

Supporting people to eat and drink enough to maintain a balanced diet
● The menu displayed did not reflect the dietary needs identified to promote one person's health and well-being.
● People told us they liked the meals they had and were able to make a choice.
● Information on people's dietary needs was recorded and matched guidance completed by a specialist health care professional in eating and drinking in order to reduce the risk of choking.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

At our last inspection the provider failed to mitigate risks and assess and monitor the service effectively. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

- The leadership and overall management of the service continued to lack oversight and therefore had failed to ensure the service was consistently well-managed and led at both provider and service level.
- The provider was rated as requires improvement following the last full inspection as well as an earlier focused inspection. The provider has failed to make the required improvements at the home and the quality and safety of people's care had further deteriorated.
- Audits carried out by the registered manager remained ineffective. The monitoring undertaken had not identified shortfalls found during this inspection in relation to fire safety and water temperatures. Other key aspects relating to people's care, such as care planning did not form part of the quality assurance process. This increased the risk people's needs would not be identified and action promptly taken to ensure their needs were met.
- We found a lack of monitoring of the documentation. For example, staff had consistently recorded incorrect information regarding people's body temperatures. Systems had failed to highlight these errors and therefore had not effectively managed to ensure people were safe and not showing the symptoms of a pandemic infection.
- The monitoring of people's medicines was not effective and did not provide assurance people received their medicines as prescribed. The providers own procedures were not adhered to in relation to the administration of medicines and NICE (National Institute for Health and Care Excellence) guidelines were not followed.
- Policies and procedures were not always adhered to and did not determine practice within the home. Systems to identify potential risks to people's health and safety were not sufficient. Staff had failed to act in line with the providers procedures in relation to addressing concerns about hot and cold-water temperatures.

● The provider did not have a system in place to assess the dependency needs of people living at the home and therefore to establish the staffing levels to be able to meet these needs.
● The provider was not following their own fire risk assessment. The risk assessment dated February 2020 recommended a fire drill on a six-monthly basis. The most recent drill recorded within the fire log was in April 2019.
● Other environmental risks such as wedging fire doors open and a trip hazard were not recognised by staff and had therefore become general practice amongst the staff team. We found no management oversight in place to address this area of risk.

We found no evidence that people had been harmed however, systems in place to assess, monitor, mitigate and improve the quality of the service were not used effectively to ensure the health, safety and welfare of people using the service. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Registered providers are legally obliged to inform the Care Quality Commission (CQC) of certain incidents which have occurred within the home. These statutory notifications are to ensure CQC is aware of important events and play a key role in our monitoring of the service. During our inspection we identified occasions where incidents had taken place and no notification was submitted to the CQC.

Systems to ensure CQC were made aware of these incidents were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Following our inspection and upon raising concerns with the registered manager about the lack of notifications in relation to an injury. We also saw reference to incident which had resulted in police involvement. They undertook to retrospectively send notifications to CQC.

● The registered manager was at the time of the inspection dividing their time between two registered locations. They had a deputy manager working at each. The registered manager told us they planned to deregister from their role at Brooklands.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others
● At the time of the inspection the local authority and other stakeholders were supporting the care provider to ensure safe systems were in place and there were sufficient experienced, and skilled staff to meet people's needs.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● One person told us they were able to discuss items such as menus and holidays at their regular house meetings where they were confident their voice would be listened to.
● Records we reviewed indicated the views of family members were last obtained in October 2019.