Brampton View Limited

Brampton View Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Brampton View Care Home is a care home providing personal and nursing care to 76 people aged 65 and over at the time of the inspection. The service can support up to 88 people.

The care home accommodates 88 people in three separate areas, each of which has separate adapted facilities. One area specialises in providing care to people living with dementia, one for people with complex nursing needs and one for people who are semi-independent.

People's experience of using this service and what we found
The quality of care had deteriorated since the last inspection. People's safety was at risk as there was a lack of oversight of people's care needs. Staff were not always following the instructions given to them to ensure that they were providing the care and support people needed. Risks to people had not always been assessed and plans in place to reduce risks were not always followed. Some people had not received their medicines at the times prescribed. There was insufficient staff to meet people's needs.

The lack of consistent management had impacted on the ability of the provider to drive the necessary improvements. The systems in place to monitor the quality of the service and audit systems were not adequate and shortfalls were not being picked up. Lessons were not always learnt from incidents and information from complaints were not sufficiently analysed for trends to help improve the service.

Some people's nutritional and hydration needs were not met, despite assessments being undertaken and advice given. The quality of the food varied, and people's experience of meals differed. People needing specialist diets were not always given the snacks and drinks they required to help them maintain and improve their weight. People were not always supported with their meals in a timely way and specially prepared food was not appetising and not always at a consistency people could eat safely.

Staff had not all received the training and supervision they required to provide consistent and effective care. Staff from outside agencies did not always have the induction they required to provide the care needed.

People's dignity and privacy was sometimes compromised. Staff had no time outside delivering basic care needs to spend with people. We observed some good interactions with people but also some poor ones. Comments made by people and relatives included, 'Staff are a pretty good bunch here, they just need some organising.'

People's needs, and preferences were not always known by staff and there was limited opportunities for people to undertake individual or group activities. We have recommend that the Provider seeks guidance around the Accessible Information Standard.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

The last rating for this service was Good (published 26 June 2018)

Why we inspected
The inspection was prompted in part due to concerns received about lack of staff, people being left for long periods of time without support, poor monitoring of people's nutrition and hydration needs, and a notification of a specific incident. Following which a person using the service sustained an injury.

The information CQC received about the incident indicated concerns about the management of percutaneous endoscopic gastrostomy (PEG) feeding.

We have found evidence that the provider needs to make improvements. Please see the safe and effective 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 Brampton View Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, ensuring there are enough staff to meet people' needs, supporting people to eat enough and remain hydrated, respecting people's dignity and privacy and monitoring the service to maintain quality standards and improve the service.

Please see the action we have told the provider to take at the end of this report.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Brampton View Care Home

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.

This inspection was prompted in part by concerns raised by the local NHS clinical commissioners and local authority following a series of monitoring visits, some of which had been prompted by concerns relating to safeguarding.

Inspection team
The inspection was carried out by two inspectors, an assistant inspector, a specialist nurse advisor and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Brampton View Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the CQC. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager had left in August 2018 and a manager was appointed in October 2018, however the new manager resigned and left during our inspection. A regional manager took over the day to day running of the service during the inspection.

Notice of inspection
The inspection was unannounced on the 26 June 2019. The provider was informed we would be returning on 1st July 2019.

What we did before the inspection
We reviewed information we had received about the service since the last inspection in June 2018. We sought feedback from the local authority, the NHS clinical commissioning group and professionals who work with the service. 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 spoke with 12 people who used the service and 11 relatives about their experience of the care provided. We spoke with 15 members of staffing including the regional manager, regional clinical support manager, manager, nurses, senior care workers, care workers, activities co-ordinator and housekeeping. We spent time observing people to help us understand the experience of people who could not talk with us. We also spoke with a health professional who regularly visited the service.

We reviewed a range of records. This included 14 people's care records. Staff training information and a variety of records relating to the management of the service, including safeguarding records, refurbishment plans and fire procedures.

After the inspection
We continued to seek clarification from the provider to validate the evidence found. We looked at staff rotas, quality assurance records, mental capacity assessments, risk assessments and improvement plans. We also sought assurance about the management arrangements in place following the departure of the manager and regional clinical support manager.

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

● People were at risk of not receiving their care as planned, or in a safe way. Risk management plans were not followed, and staff failed to identify potential risks to people. We saw one person, identified as at risk of falling, sat in a tilted chair, with wheels with their feet suspended; a risk management plan stated the person should be sat in a chair without wheels with a sensor mat to alert staff when they mobilised. This meant the person was put at unnecessary risk of falling from height when they tried to get out of the chair.

● One person was left in bed without bedrails having been assessed as at risk of falling out of the bed and requiring the use of bedrails. Staff said they were looking for clean bumpers but had failed to recognise they had left the person at risk. A relative told us their loved one had been left for 12 minutes one day with their bed raised without bedrails up whilst the two staff attended an emergency call. The staff had failed to ensure the person was left in a safe position and the provider had failed to ensure that there were enough staff deployed to cover both the emergency and routine work of the service.

● We saw two mattresses placed on top of one another next to beds instead of crash mats. An airflow mattress on the floor next to a bed plugged in with wires trailing. These were a trip hazard and put people at risk of injury due to a fall from height from the mattress to the floor and possible entrapment between the mattress and the bed frame. The provider had failed to recognise the risks this had created to people's safety.

● There was not enough staff deployed to effectively monitor people in communal areas exposing them to an increased risk of falls. People were left unsupervised in communal areas when it had been identified they should be kept under observation, we observed on the nursing floor four people left unsupervised for up to 30 minutes in the lounge area. One person was identified as being at high risk of falls.

● People were not protected from the risk of unknown visitors entering the premises and accessing people's bedrooms without permission. During the inspection we observed several occasions when the reception area was left unmanned. Visitors entered without anyone available to check the purpose of their visit or ensure visitors signed in so that in the event of a fire the provider knew how many people were in the building. We found the front door unlocked at 7.20am and no staff visible in the reception area. We were able to access both the nursing and residential floors without being challenged. The provider told us that front door should be kept locked during the night and not open until 8am when the day staff were on duty.

● There was a door leading from the nursing floor into a corridor where people lived independently in their own apartments. The apartments were not part of Brampton View Care Home and were owned and managed separately by another company. The provider had no way of knowing who was visiting the apartments and potentially accessing the care home. The provider told us the building was owned by a company and they as providers of care leased the area designated as the care home. The provider had failed to assess the risk and have a system in place to effectively manage the risk of unknown persons entering the

care home.
● The provider failed to have sufficient daily health and safety checks to identify and address general failings in safety.
● People were at risk in the event of harm in the event a fire as fire doors were propped open by chairs and laundry baskets. There was a Fire Assessment document dated 2013. The fire risk assessment and people's personal emergency evacuation plans were not regularly updated. The regional manager told us they were in the process of addressing this. Fire drills were poorly recorded, they were not always dated, nor did they always evidence which areas of the home were tested. A folder containing information in case of a fire was not up to date. Following the inspection the provider sent copies of fire drills which did detail the areas of the home tested and a Fire risk assessment undertaken in May 2018 which had been reviewed following the inspection.
● The provider had not protected people from substances and materials that could be hazardous to their health. People who may be confused or living with dementia had access to thickener that had been left unattended in people's rooms and disposable gloves were left in a corridor, they were at risk of accidentally ingesting these.

Failing to assess, monitor and manage the risks identified putting people at unnecessary risk is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider did not employ enough staff to ensure people's safety. People and relatives told us consistently there was not enough staff and people were left waiting for help. One person said, "I can be left waiting for anything from 20 minutes up to 45 minutes." Another said, "There is never a day here that there are enough staff, you have to make do with what you have got." A relative told us, "We found our relative still in bed at 10.30am one morning, then 11am another morning, I felt the room smelt odd, and then realised relative was soaked through and had badly soiled sheets and clothing." Staffing rotas confirmed that there were several days in June when the provider had failed to maintain their own assessed staffing levels.
● There were not enough staff deployed to meet people's nutritional needs. People were left waiting for their meals and without the support they required.
● There were vacancies for nursing, care and management staff which meant there was an over reliance on use of staff from an agency. Agency staff received a basic induction around health and safety but were reliant on staff handovers to gather the information they required to deliver safe care. One agency nurse commented that they had been shown Fire safety procedures and used a handover document to identify what they needed to do, they had no time to read people's care plans. The provider had not ensured there were a mix of staff with the skills and knowledge to support agency staff.

Failing to employ or deploy enough staff to meet people's needs is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● At the last inspection in June 2018 we found people had not received their time critical medicines as prescribed. During this inspection this concern persisted. We observed time specific medicines were over half an hour late being given on the second day of the inspection and were told by staff time specific medicines for another person had been an hour late a few days earlier. This could impact on the ability of the person to manage their condition. One person told us they had not received their medicines the night before the first day of the inspection and another person commented at 10am on the first day, they were still

waiting for their medicines that day. A senior carer told us the medicine round had started at 8am but had been interrupted as a GP had arrived and needed assistance.

● Medicine Administration Record sheets (MARs) were not consistently being kept. On a random check we found gaps in recording which had not been identified. A safeguarding concern had recently been raised following an incident when someone had been given a double dose of medicine. The procedures in place left if down to one staff member to check medicines in with no other checks in place to ensure that records were correct for staff to follow.

● Staff had received training in the administration of medicines and their competencies tested. Staff stayed with people when they gave their medicines to ensure they had taken them. One person said, "I get my pills each day and they watch me take them."

Learning lessons when things go wrong

● Incidents and accidents were monitored and reviewed to identify any learning which may help to prevent a reoccurrence. However, the provider had failed to ensure that lessons learnt were followed. One person had received a gastric burn as their percutaneous endoscopic gastrostomy (PEG) tube had leaked because it had not been secured properly. An action plan was put in place following the incident, however, we saw that the same incident had happened twice again to the same person. Although we saw that the nurse involved no longer worked at the home the provider had failed to ensure the plan in place following the first incident was enough to prevent the situation happening again.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe in the home with the staff. One person said, "I feel I can talk to any of the people here. I feel I have no worries at all."

● Staff knew what signs to look for to keep people safe from harm or abuse but had failed to recognise when they did not follow people's care plans and complete tasks at the required time or left people in unsafe situations that this was a form of neglect.

● The manager had raised concerns appropriately with the local authority and notified the Care Quality Commission as required. However, they had not recognised that failing to maintain staffing levels and ensure people receive the care and support as detailed in their care plans was a form of abuse.

Preventing and controlling infection

● There were cleaning schedules in place for staff to follow, however, we did come across a couple of areas on the nursing floor used by visitors which had not been maintained as well. Once this was pointed out the housekeeping staff took the necessary action.

● Staff wore protective clothing such as aprons and gloves when they supported people with personal care and most staff had received training in infection control.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

● People identified as being at risk of losing weight or dehydration remained at risk as staff did not record people's food and fluid intake consistently nor at the time the person ate or drank. This meant records were not a true and accurate reflection. Fluid records were incomplete and not always totalled each day. Nursing staff did not always review what people's intake had been to assess whether they had enough to drink. A relative told us, "They (staff) are a bit lax at completing fluid charts regularly. I can be here at 4pm and see that there are no entries since 10.30am and then in the morning, entries hourly from 10.30am have miraculously appeared right through the day. It's a job to know what actually does go on…."

● People requiring food and drinks containing extra calories, did not always receive these. One staff member reported at the afternoon handover two people had not received any drinks or snacks that morning as they had not had time to give them. People told us the only access to drinks were at meal times or when the hostess brought a trolley around. One person said, "I do like a cup of tea after lunch, but that isn't on offer. You can ask, and you may get one in due course, but usually when the trolley comes around."

● People were left waiting for assistance at mealtimes, which meant some people had cold meals, and did not drink or eat their meals fully, putting them at risk of not eating enough and dehydration . We observed on one floor two care staff struggling to serve food and provide the support people needed. One person sat for 15 minutes with their food in front of them. The person needed encouragement to eat, the person was left without staff to encourage them as they were serving meals.

● People's experience of the food provided varied. People described the food as bland, not always cooked properly and at times cold when it reached them. One person said, "The food is so-so. It's always brought to my room, but not always still hot when it gets here. I would give it three out of 10." Another said, "I am not a fan of the food here. It can be bland. I get a choice at lunch time, but if I change my mind in the evening and don't want the fall-back choice of cheese omelette, then I am unlucky…unless there is something left over from lunch, as there are no kitchen staff around by then. Weekend food can go haywire as there are no managers around."

● People on special diets such as pureed food due the risk of choking, were presented with plates of food which were not easily identifiable. We saw a bowl of pureed food which was solid, a staff member said they did not know what it was and were concerned how they were meant to encourage the person to eat it and that it put the person at risk of choking as it was not soft. Pureed meals were not presented in a way to help encourage people to eat. There were eight people on the nursing floor who were losing weight, two of which needed pureed foods.

The failure to have effective systems in place to ensure people's nutritional and hydration needs were met is

a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Care plans detailed people's care needs and support plans were in place which gave guidance to staff how to meet people's needs. However, we found that staff were not always following the instructions given and the leadership was lacking in ensuring the plans were followed. This meant people were being put at unnecessary risk.

● We found that people who had wound management plans did not always have their wounds dressed as regularly as they should, and people were not repositioned at the intervals required to prevent the breakdown of their skin. For example, one person's care plan stated they should be repositioned every two hours, records showed that this was not consistently happening and on one day the intervals were three hours and four hours.

The failure to follow instructions given to mitigate identified risks to people is a breach of Regulation 12 (Safe care and treatment) of the Health and Social care Act 2008 (Regulated activities) Regulations 2014.

● People's needs were assessed prior coming to the home. The assessment considered the level of care needs and people were offered accommodation in the area of the home that could meet their needs best. A relative said, "[Relative] was fully assessed before they came in here and for the most part, they meet their needs."

Staff support: induction, training, skills and experience

● People could not be assured that they were cared for by staff who had the training, skills and experience to meet their needs. People told us they thought the regular staff were trained but did not always feel any staff from an agency were.

● New permanent staff completed an induction, which included manual handling, infection control, health and safety and dementia. However, we saw from the providers records that training had not been kept up to date and specialist training such as the management of percutaneous endoscopic gastrostomy (PEG) feeding had been slow to be implemented following a recent incident. The provider was currently addressing this to ensure all staff had the training they required to fulfil their role.

● Staff had not received regular supervision and appraisals had not been undertaken. The manager told us they were addressing this to ensure all staff received the level of support they needed.

Adapting service, design, decoration to meet people's needs

● The area of the home for people living with dementia had limited signage to assist with people's orientation around the home. We saw there were some memorabilia cabinets on the wall outside people's bedrooms, but these contained limited information. Improvements were needed to make the environment more dementia friendly.

● The home was purpose built and everyone had spacious rooms where we saw some people had brought in items to personalise them. There were several adapted bathrooms to support people with limited mobility, however, we noticed in both the nursing and dementia care areas, the bathrooms were being used more as storage areas for equipment.

● People had access to the garden. Some people commented they liked to access the garden but were reliant on family members to take them.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People had access to various health professionals when needed, such as a GP, district nurse and chiropodist. However, referrals were not always completed in a timely way. For example, we saw one person had been constipated for 10 days before any action was taken to address this with other professionals.
● A GP visited the home regularly. One person told us, "The doctor comes in three times a week. The doctor is pretty good sorting out my medicines." A relative said, "If [relative] needs chiropody or optician appointments, the staff sort that out for them and if [relative] has to have a Hospital appointment, someone usually goes with them if we are not free to go."

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.

● We saw that mental capacity assessments had been undertaken and were people had been found to lack the capacity to make decisions best interest decisions were made and recorded. Applications had been made for authorisations to restrict people's liberty had been made.
● Consent to care information was recorded and people told us they could make decisions for them self and staff usually asked them before they supported them with any tasks.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

● People's privacy and dignity was not always maintained. People were left in undignified positions and their dignity was not protected. One person was left in their bedroom with the door open with no lower garments on, they looked distressed. When we pointed this out staff ensured the person was properly dressed. Another was left with their lower half of their body exposed when a maintenance person was working in their room; once this was pointed out, the person was moved to another room whilst the work continued. Relative's also told us of occasions when their loved-one had been left in soiled clothing and bedding.

● Staff were task focussed and had no time outside of delivering basic care to spend with people or monitor them. One person was left in bed until 11.20am sat in soiled bedding and night clothes, although care records indicated the person was not an early riser we saw staff had not checked the person since the night shift had had finished shift at 8am. The person was living with dementia and unable to call assistance for them self. Staff were alerted to the person's predicament when a visitor to the person came.

● People told us staff were not always kind and polite. One person said, "The staff are very kind to me, there is just not enough of them." Another said, "The regular staff are good and know me well, but there are some who are not as polite and just throw the dinner tray at you and don't speak to you." The provider had failed to ensure that all staff respected people and provided a consistent kind and caring approach.

● Staff shouted from serving hatches in the dining areas across to people at mealtimes when ascertaining what people wanted. There was no attempt to go to speak to people individually. The staff were under pressure serve meals and then support people who needed assistance.

Failing to maintain people's privacy and dignity at all times is a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care

● People chose where they spent their day and were given choices about what they wanted to do, eat and wear. One person said, "I feel as I can do anything I like. If there is something special going on they will want you to take part. You can choose not to take part." A relative said, "They [staff] keep the family informed of anything that is happening and one of us is included in care planning meetings. We do feel like we still have a say if we need one."

● People and their relatives, if they wished were involved in care plan review meetings. One relative said, "We recently attended a care planning meeting, [name of staff member] came in on their day off to have it

with us. They said it was easier to do this as shifts were at times frantic and they would not always have the space to do it. We appreciated them coming in and spending the time with us."

● Information was made available to people using the service on using advocacy services when required. An advocate is an independent person who can help people to understand their rights and choices and assist them to speak up about the service they receive. At the time of the inspection no people using the service needed an advocate.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Care plans did not consistently contain detailed information around people's life history, preferences or interests which would have ensured their care was delivered in a more person-centred way. The level of information about people varied dependent on which area of the home people were in. Staff who were new or were relief staff from an agency did not have the information to fully support and interact with people in a meaningful way, particularly those people who were unable to communicate easily. This would be beneficial to staff to help them engage in more meaningful conversations and activities with people and enhance people's daily experiences. The provider told us they were in the process of reviewing the care plans.

● People told us the regular staff knew them well and were kind and caring towards them. However, if staff from an agency did not work alongside the more experienced staff they did not feel they always got the same support and attention they required. Relatives told us that sometimes, particularly at weekends, there were more agency staff and care was inconsistent. The provider needed to ensure there was a mix of experienced and skilled staff available to support new or agency staff.

● We saw the provider had facilitated a private sharing space for a married couple who both lived in the home; they had their own lounge area to spend time together.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication needs were recorded in care plans; however, we saw no evidence as to how people's varying communication needs were being met. We recommend the provider seeks advice and guidance as to how they can develop the service so that it fully complies with the AIS.

End of life care and support

● There were advanced care plans in place and this included Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) assessments for those people that wanted them in place. However, not all staff were aware of people's individual preferences and information about any changes to people's care was not communicated with all staff. For example, staff were unaware one person in receipt of end of life care could eat whatever they liked, we saw staff trying to assist the person with a meal they clearly did not want. Care records contained information indicating the person had eaten well the day before when offered yoghurt and ice-cream. The person's preference and wishes at the end of their life had not been respected.

● People had been asked about their end of life wishes and where appropriate families had been consulted. One person said, "I have told my family what I want to happen in the end and they have communicated this to the manager, so I assume it's in my file."
● Staff had training in providing end of life care to people..

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● There were three activity co-ordinators employed, however, on the first day of the inspection there was no one available and the expectation was for staff to carry our activities with people with the resources provided. However, the staff did not have time outside their care duties. A member of the housekeeping team who had previously worked at the home as an activities co-ordinator was asked to run an exercise session, which people enjoyed. The provider needed to ensure there were enough staff deployed to provide opportunities for people to be stimulated and occupied. One person told us, "There is no social buzz in this place. It has a flat dull atmosphere and quiet."
● People were encouraged to take part in activities such as chair exercises, crossword quizzes and sing-a-long sessions. However, people and relatives expressed there was not always enough to do, and staff did not have time to take people out in the garden. One person said, "It would be nice if the staff could help me to walk around the corridors to help my arthritis when it flares up, but I have to rely on family when they come as they tell me they don't have time to do that with me." Activity staff spent time with individuals in their rooms which ensured that people did not become socially isolated.
● Visitors were welcomed at any time. Several relatives told us they could come whenever they wished. We saw relatives spending time with their loved one. Some assisting them at meal times. One relative said, "We come in around meal times to help the staff out, [relative] needs help eating and we can do that, I am not sure how the staff manage with everyone who needs help."

Improving care quality in response to complaints or concerns
● People told us if they had any complaints or concerns they would speak to staff. However, some people did not feel that anything would change if they did complain. One relative did comment that following a complaint they had made about no staff being available, staff now had different breaks.
● We saw when complaints had been made these were responded to. However, the complaints made in 2019 all raised concerns about the level of care and staff availability. Not enough staff was a theme shared with us throughout the inspection. Action taken to address these concerns had been ineffective.

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 good. 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

- The provider failed to have systems in place to assess, monitor and improve the quality and safety of people's care. The failure to have adequate systems to monitor health and safety checks put people at risk of harm from trailing wires and inappropriate mattresses on the floor, poor fire safety procedures and ingesting thickener.
- The provider failed to have adequate oversight of people's food and fluid intake or the safe consistency of foods. This put people at risk of losing weight, choking and dehydration.
- There was a lack of managerial oversight of the accuracy of people's repositioning, food, fluid and daily records. People's records could not be relied upon to be accurate, complete or contemporaneous.
- The provider failed to respond to concerns about staffing levels, leaving people to wait for personal care, not have access to all areas of the home or facilitated to have meaningful activities.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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

- There was no registered manager at the time of the inspection. The last registered manager had left 13 August 2018. There had been a few managers since, but none had completed an application to become the registered manager. The manager at the time of the inspection, had been in post since October 2018 but had given in their notice and left following the inspection. There had been no clinical lead since the beginning of June 2019. A regional clinical support manager had spent several weeks at the home but they too left following the inspection. This impacted on the stability and safety of the care within the home.
- The provider failed to have systems in place to ensure people received their planned care in a timely way. The provider failed to have systems to identify there were not enough staff to meet people's needs. Although individual staff knew what good person-centred care looked like, they told us they were unable to provide this as there was not enough time once they had met people's basic care needs.
- There was a lack of cohesive management. People and staff commented how disorganised the home was. One member of staff said, "We need someone to sit down and organise everyone and maintain respect." A person said, "This is a huge place and I don't think it runs particularly well with one manager. Each unit needs a head person, so the staff know they have someone they can turn to, otherwise at times they feel burdened. At least that is what comes across and they do have a bit of a moan sometimes."
- The provider failed to have systems in place to ensure staff had the support to carry out their roles. Staff

had not had regular supervision and agency staff did not have adequate induction and support.
● The provider failed to have systems in place to provide clinical oversight. People did not always receive their planned care, their prescribed medicines or prompt medical care when their health deteriorated. For example, one person had not opened their bowels for 10 days before action was taken.

Continuous learning and improving care; Working in partnership with others
● The provider failed to have effective governance systems. They had relied on outside agencies such as the local authority and NHS Clinical commissioning Group (CCG) to assess, monitor and evaluate their service. The regional manager had begun work on the local authority and CCG action plans but had not addressed all the issues in a timely way.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People did not have the opportunity to feedback their experiences of the living at Brampton View Care Home.
● The lack of consistent management had impacted on how people were able to give feedback on their experience of receiving care. There had not been a service user feedback survey since June 2018. One person said, "I have certainly never been asked for my views of the service. Certainly, the variable quality of the food might come up." This meant the provider had not identified how they could improve people's care. The regional manager informed us the June survey had been postponed until September 2019.
● We received mixed feedback from staff as to whether they felt listened to and how much opportunity they had to give their feedback.

The provider failed to have sufficient systems and processes embedded to assess monitor and improve the quality and safety of the service. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity and privacy was compromised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure there was adequate checks in place to meet people's nutrition and hydration needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff deployed to meet people's needs in a safe and timely way.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider failed to assess, monitor and manage the risks identified putting people at unnecessary risk.

The enforcement action we took:

Notice of Proposal to restrict admissions and impose positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to have adequate systems in place to monitor and quality assure the service to drive the necessary improvements.

The enforcement action we took:

Notice to impose restrictions and on admissions and positive conditions.