Lifestyle Care Management Ltd

Brook House Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced focused inspection took place on 27 and 28 September 2016 to follow up on information of concern from a number of safeguarding concerns being investigated by the local authority. At our last inspection on 29, 30 and 31 March 2016 the service had been rated Good across all the key questions we inspect against.

Brook House Care Centre is registered to provide accommodation and nursing care for up to 74 adults. People using the service include adults with a range of disabilities, people with nursing needs and people with dementia. At the time of this inspection there were 62 people using the service.

There was a registered manager who had managed the home since November 2015. 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.

At this inspection we found some serious breaches of regulations in respect of identifying, assessing and managing risks to people; systems to monitor risk and the quality and safety of the service and a lack of adequately trained and competent staff at all times. Full information about CQC's regulatory response to these serious concerns, found during inspections, is added to reports after any representations and appeals have been concluded.

We were aware that the home was in the process of drawing up an action plan with the local authority to address concerns raised through the local authority provider concerns process.

We found other breaches of regulations in respect of safeguarding concerns not always being identified or reported. There were ineffective arrangements to comply with the Mental Capacity Act (2005) and in relation to a lack of person centred care. People's care plans were not always personalised and care in relation to some needs was not always identified or assessed. CQC were not always informed by the provider of notifiable incidents as required.

You can see the action we have asked the provider to take in respect of these breaches at the back of the full version of this report.

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

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

The expectation is that providers found to have been providing inadequate care should have made

significant improvements within this timeframe.

If not enough improvement is made within this timeframe, so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to consider beginning the process of preventing the provider from operating this service. This may 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 may 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."

Some people's care plans did identify risks and there was guidance for staff on how to reduce risk. Most people told us there was enough to eat and drink and that they had some choice about their food; however some improvements were needed to make the meal time experience more pleasurable. Medicines were safely managed. People were able to access health professionals when they needed to. Some health professionals had commented on the positive response from staff to training they had delivered at the home.

People had mixed views about how they were cared for. Some people told us they were happy with the care provided, they felt safe and were happy with the way the staff supported them. However, other people felt there was room for improvement. We saw some glimpses of care sensitively provided but overall observed little in the way of positive interaction between people and staff at the home. People told us there was not always enough to do and we saw little in the way of organised activities provided to help stimulate people.

There were mixed views about the management of the service. Most people felt the registered manager and senior team were approachable and listened to them. Staff also felt that the registered manager was approachable. However they told us the staff group did not work well as a team. There were systems to gather feedback from people, relatives and visitors to improve the quality of the service through questionnaires and meetings. However these did not work effectively to improve the quality of the service.

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.

Safeguarding concerns were not always identified or reported by staff. Risks to people were not always identified across a range of different areas and plans were not in place to reduce these risks. Risks in relation to the employment of agency staff were not identified or monitored.

People told us there were not always enough staff deployed to meet people's needs and we confirmed this from our observations both in the day and at night. There was also a high level of vacancies which resulted in a high level of agency staff use.

Medicines were stored and administered safely. Checks were carried out on equipment to reduce risk.

Is the service effective?

Requires Improvement

The service was not always effective.

Risks to people in relation to their dietary requirements were not always identified or communicated. Most people told us they had enough to eat and drink and that they had a choice of what to eat and where to have their meals. Some improvement was required to make the dining experience more enjoyable.

Staff did not always understand the requirements of the Mental Capacity Act 2005 code of practice and Deprivation of Liberty Safeguards. People's capacity to consent to specific decisions was not always assessed.

Staff were not up to date with the training the provider considered mandatory. There was not always training available specific to the varied needs of people staff supported. First Aid training was not provided to all staff and there was a risk that there may be no qualified first aider on duty to assist in an emergency.

People told us they had access to a range of healthcare services and there was a physiotherapist based at the home to support

people's needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People had mixed views about the way they were cared for and supported. They told us they were treated with dignity and respect. We saw some glimpses of sensitive care provided. People's cultural needs were not always respected. However, there was very little interaction between staff and the people they supported during the inspection.

We saw that people were provided with information about the service in the form of a guide but that some of the information in it was not accurate as it related to another service.

People's care plans did not evidence their or their relatives' involvement in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's records were not always personalised and accurate records of people's care were not maintained.

Arrangements to provide stimulation and social interaction required some improvement. Some people told us there was not enough to do at the home and looked bored. We observed people spent much of the day in the communal areas watching TV. Few organised activities were observed during the inspection.

The complaints procedure was accessible. People knew how to complain and some people told us they were confident the manger would address their concerns. However other people were less confident. Accurate records were not always maintained to evidence that complaints were investigated in line with the provider's policy.

Is the service well-led?

Inadequate

The service was not well led.

There were mixed views about the management of the service. The system for monitoring of risks to people was not robust and there was not always effective communication amongst the staff.

There was a system of checks to monitor the quality of the service and these included checks by the provider. However, while these had identified some of the concerns we found, little progress was made to improve the quality of the service or act on some identified issues.

There were systems to gather people's views about the service to improve quality but these were not always effective.

Brook House Care Centre

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 following concerns we were made aware of, 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 unannounced responsive inspection took place on 27 and 28 September 2016, following a number of concerns we were made aware of. On the first day the inspection team consisted of two inspectors 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. On the second day the team was made up of two inspectors and a specialist advisor. Two inspectors returned in the evening to observe the care at night.

As part of our planning we looked at the information we held about the service including the PIR. This 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. We also looked at information from any notifications the provider had sent us. A notification is information about important events that the provider is required to send us by law. We asked the local authority commissioners for the service and the safeguarding team for their views of the service.

During the inspection we spoke with fourteen people who used the service and eight relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with permanent and agency staff on duty during the day and at night. These included nine nurses, twelve health care assistants, the chefs, a kitchen assistant, administrative staff, three domestic staff and the maintenance staff member. We also spoke with the registered manager, clinical lead and regional manager for the home. We also contacted three healthcare professionals after the inspection to gather their views. We looked at 11 people's care records. We tracked people's care to see if the care they received was in line with their care plan. We looked at records related to the management of the service such as minutes of meetings, records of audits, and service and maintenance records.

Inadequate

Is the service safe?

Our findings

People and their family members told us they were safe from abuse and neglect. One person told us, "Oh yes, it's very comfortable and secure." A relative said, "It's very safe." Our findings did not always support these views. Staff told us they had received training on safeguarding vulnerable adults and knew the signs to look for and what they should do. However, this was not always put into practice. We found safeguarding concerns were not always reported to senior staff or where they were reported they had not always been addressed.

One person told us money had gone missing from their room and they had reported this to staff but no investigation had been carried out and no alert had been raised with the local authority or Police. Unexplained bruising for one person nursed in bed had not been reported or recorded adequately and was not being tracked for healing. We found another allegation of clothing being taken from someone's room had also not been reported or acted on. We discussed these concerns with the registered manager and regional manager about and safeguarding alerts were then raised with the local authority by them.

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

At least seven safeguarding concerns were being investigated by the local authority at the time of the inspection. The Registered Manager and provider were cooperating fully with these investigations. Two safeguarding concerns had recently been investigated and one had been substantiated. There had been a recent local authority provider concerns meeting with the home and an action plan was being put in place at the time of the inspection to address a number of issues. We saw that there was a letter for all visitors to Brook House in reception to inform and advise them of the situation and what action the provider was taking.

Risks to people's health and safety were not always identified, assessed or action taken to reduce the likelihood of them occurring. We found some risks were either not always identified, or assessed, or, there was insufficient guidance for staff in nine of the care plans we looked at. This was of particular concern, given the high level of agency staff working at the service who may not know people well. Moving and handling risk assessments were not always carried out to guide staff where people were not able to mobilise without the use of staff support or specialist equipment. Where these were completed, they did not always contain sufficient exploration of the risks or guidance for staff to reduce them. Falls risk assessments did not always guide staff on how to reduce risk of injury to people.

Risks to people's skin integrity were not always fully assessed or acted on. For one person, with risk of pressure areas, a pressure relieving mattress had been identified as required but no pressure relieving cushion for use on chairs. We observed this person sat in the lounge on a chair, for much of the day, with no pressure relieving equipment provided, thereby increasing their risk of pressure areas developing. For another person with a pressure area staff were observed to leave the hoist sling in place on their chair when they sat down; increasing the risk of deterioration to the pressure area. When asked about this staff told us

"It was easier," but removed the sling when prompted.

There were no epilepsy risk assessments for three people with epilepsy to identify fully how to reduce risks. Smoking risk assessments did not clearly identify or assess the risks or provide adequate guidance for staff. Risks to people from faulty equipment were not always identified or action taken to reduce the risk. There was insufficient guidance for staff involved in one to one care of people whose behaviours could require a response. Where one to one care had been identified to reduce risk we observed on one occasion that this was not adhered to as the staff member had gone for a break. This increased the risk to other people from the person's behaviour.

Risks in relation to the employment of agency staff were not monitored adequately. There was no system to request or check profiles from the agency to ensure that agency staff had the necessary current qualifications, competence, skills and experience to carry out their work safely. Competency assessments were not completed to ensure agency nurses were competent to administer medicines or administer specialist feeding regimes, checks were not completed to ensure their training and nurse registration was current.

These issues were in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the registered manager told us that they had addressed a number of the issues and concerns identified. However, we were unable to verify this or their robustness.

Accurate records in respect of risks for each service user were not always maintained. Inspectors found care plans did not always accurately reflect service users' needs. For example, one person had a care plan titled with five different risks, but only information related to two risks could be identified in the plan. Another person's care plan for malnutrition stated they required a food chart and weekly weight but no records of these were located. Body maps for some people were found but no records of monitoring or progression of their wounds were located. Records to monitor risks of dehydration and lack of nutrition were not always completed or totalled to identify if any action was needed.

These issues were in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For some people some risks were identified for example in relation to their weight and skin integrity or risk of falls. We saw these were regularly monitored and there was guidance for staff on how to reduce the likelihood of risks occurring.

We were aware of the action plan the home had started to work on, as part of the provider concerns process in relation to the documentation of risks and people's care plans. The registered manager told us that supernumerary hours had been given to some staff to update the care plans and finish the transfer over onto the provider's documentation, which had just been completed.

Equipment maintenance and service checks were completed at regular intervals to ensure people were safe from risk. These included fire equipment checks, legionella, water temperatures, gas, electrical equipment and installation and checks on hoists.

People told us there were not always enough qualified and competent staff deployed to meet their care and support needs. One person told us, "No, there is definitely a staff shortage, a lot of agency – a hell of a lot;

they haven't a clue about the residents…. The carers are just run ragged…I have to go shopping today but I'm not sure I will get a chance to as they won't have time to take me." Another person commented about staffing levels, "There's a shortage all the time." A family member told us they thought there were not enough staff, especially at the weekends. Only one relative commented they thought there might be enough staff, they said, "They are often busy, but there is always a staff member in the lounge."

Our observations throughout the inspection were that there were not always sufficient qualified and competent staff deployed to meet people's needs at all times. The registered manager told us that when she had first arrived, staffing levels had been decided by occupancy levels rather than people's needs and she had increased staffing during the last year. She was due to complete the provider's dependency tool at the time of the inspection. However she said she had concerns about the tool being used and believed that this could result in a reduction of the numbers of staff for each unit.

The registered manager told us there were difficulties retaining employees due to competition for similar employment in the area. She had recruited a number of staff who then left. Currently the home had three nurse vacancies and 11 care worker vacancies. There was a high reliance on agency workers although they usually managed to get the same agency staff to maintain some consistency. On one unit, on one day, we found there were no permanent staff on duty. The registered manager told us it was not always possible to have the two nurses for the two separate units on the second floor that she had assessed was required to meet people's needs on some nights. Adequate staffing levels were not always maintained.

We observed that staff on the first floor were rushed and breakfast did not finish until 11am on both days. This left little time before lunch was served at 12.30pm. On the second floor dementia unit, on both days, we found some people waited an hour later than when other people were first served their lunch, because, there were not enough staff available to support people with their meals.

We visited the service at night as we had received an anonymous concern raised about staffing levels at night. On the ground floor we found a nurse and one care worker for 14 people. They said it could be difficult as when people who required one to one care and wanted to get up in the night for a period it meant that a member of staff needed to focus on their needs which left one remaining staff member to meet the needs of others, some of whom required double handed care.

On the first floor there was a nurse and two care workers. At 10.45pm, we found one person distressed and they told us they were very tired and had wanted to go to bed for some time. The nurse was involved in the medicines round and the two staff said most people required double handed care. Staff had been supporting people to bed since they arrived on duty at 8pm and were busy supporting another person. Call bells were ringing, and, the two staff needed to break off from supporting people to go to bed to attend to other people's needs. Staff told us they also had difficulties because one to one care for people at high risk of falls, finished at 8pm which was often before the people needing one to one care went to bed. This meant one staff member was left to support people who may need two staff members to support them whilst the nurse administered medicines for people. We observed the medicines rounds on the first floor did not finish until 11.30pm and people were in bed, some of them asleep, as the medicines were being administered. On the second floor there was one nurse across two units which left one staff member alone on a unit for five people who all required double handed care. They told us they had to wait for another staff member to join them if someone needed assistance or repositioning.

These issues were in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received their medicines when they needed. One person told us" I get my medicines when needed. " Another person commented; "Yes, that is not a problem, they bring that when it needs to be given." Medicines were stored safely at correct temperatures. Medicines were stored securely in locked trolleys and controlled drugs stored in a cabinet in the locked clinical room. There were safe systems for storing, administering and monitoring of controlled drugs and arrangements were in place for their use. Medicines were disposed of safely.

We observed some of the morning medicine round on two units and the administering of the medicines by the agency nurse on duty. We saw people's medicines were safely administered. Permanent nursing staff were trained in the safe administration of medicines and we found their competency to administer medicines at the home was observed and assessed. We looked at the medicine administration records (MAR) for eight people using the service, these recorded information about their health conditions and any allergies. We checked the balances of medicines stored in the medication cabinet against the MAR and found these records were up to date and accurate with no unexplained gaps.

Requires Improvement

Is the service effective?

Our findings

People did not comment on this aspect of their care, but, we found risks in relation to people's dietary requirements were not always identified. On the first day of the inspection we found kitchen staff did not have a current list of people's dietary requirements to protect them from possible health risks or risk of choking. Kitchen staff told us they had requested this previously. On the second day some limited guidance had been provided about some people's health needs and diets but there was no guidance in relation to allergies or the need for any fortified diets. There was therefore a risk of unsafe care.

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

We found the mealtime experience required some improvement. People gave us mixed views about the food and drinks provided. Most people told us there were enough food and drinks provided. One person remarked, "The food is good, there is a choice." A relative said, "I think so, I always see some sort of drink on residents tables in the lounge." However, two people told us that drinks were not regularly offered. "For drinks of tea they never come and ask, I ask them. I'm waiting a long time, more than an hour. They say very simply they're busy." Another person commented, "If I want a drink I'll have to buzz and ask for one. Today I've only had two drinks all day." We observed one person's relative, asked for vegetables to accompany the meal. Staff told them that as it was not written on their daily requirement list they had completed then they could not have them at that meal. Our observations at meal times across the home were that interaction between staff and people they supported was mainly task focused in nature.

People and their relatives told us they thought staff received enough training to support them. Staff told us they received regular training and this was refreshed. However we found staff training was not up to date in all areas. We asked for details of first aid training for staff, but this was not readily available at the inspection. Following the inspection, the registered manager told us she had not been aware that first aid awareness training was no longer provided to all staff. Nurses, senior care workers and those staff who were new to social care completed first aid training at work. The registered manager told us that due to the high level of vacancies she could not guarantee there would be a staff member with this training on each shift. Additionally we were aware that individual staff supported people to access the community. Staff may not therefore have sufficient first aid training and awareness to support people's needs.

Staff mandatory training was not always up to date to ensure staff were competent to carry out their roles. The registered manager sent us details of the training the provider considered mandatory, 70 out of 82 staff members did not have up to date training for COSHH, 45 did not have up to date training on diet and nutrition, 28 did not have up to date training for Mental Capacity Act (MCA) and DoLS, 35 did not have up to date understanding and managing behaviour that challenges and 11 did not have up to date safeguarding training. 23 staff had not completed dementia awareness eLearning. 17 staff did not have up to date moving and positioning theory and 34 staff required manual handling practical updates. We were told two training sessions had been booked to address the manual handling training in November 2016.

The Registered Manager said that they were not aware of any clinical requirements identified for nurses working at Brook House. This was despite the varied needs of service users and requirement for specialist feeding on at least two units at the service. The Registered Manager told inspectors they had arranged all the clinical training in the past year for nurses (except recent syringe driver training). Nurse competencies in clinical areas were not recorded as assessed to ensure they were competent other than for medicines management. There was therefore a risk that service users would be exposed to care or treatment from staff that may not have sufficient qualifications or competence.

People with a wide spectrum of different needs were cared for and supported at Brook House. There was no record of any action to establish that staff had the required, training or competence to understand how to meet these different needs.

These issues were in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff followed an induction along the lines of the care certificate. A recognised training programme for staff new to social care. This included training and a period of shadowing. We saw checklists were completed to ensure new staff had developed sufficient skills in different areas of work. We were shown positive comments from health professionals who had engaged in training at the home organised by the registered manager about skin integrity and falls reduction. They felt staff had engaged well and there had been a reduction in some pressure area concerns and numbers of falls following the training.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's capacity and rights to make decisions about their care and treatment were not always assessed in line with Mental Capacity Act 2005 (MCA 2005). Decision specific mental capacity assessments were not always completed in line with current guidance and the law. Best interests meetings were not recorded in relation to specific decisions about care or treatment, for example regarding the use of bed rails to prevent injury or the use of sedation. Staff told us they received training on MCA and DoLS, but, they were not always aware of the need to consider each decision being made separately or clear about their responsibilities under the Mental Capacity Act 2005.

People's rights in respect of decision making were not always upheld and therefore the provider had not always acted in line with the requirements of the Mental Capacity Act (2005) Code of Practice and Deprivation of Liberty safeguards.

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

Authorisations for DoLS require providers to submit applications to a supervisory body for authority to deprive people of their liberty for their own safety. We found appropriate applications had been made in respect of DoLS authorisations and these were monitored to ensure new applications were made where appropriate.

People told us they saw the dentist, doctor or chiropodist when they needed to and we saw records were made of the advice provided. These included the dentist, GP, podiatrist and dietician and the home's physiotherapist where relevant. People spoke positively about the input from the home's physiotherapist, who was at the home three times a week. There was a small gym at the home where people told us they could go to practice their exercises and see the physiotherapist where this was relevant and appropriate.

Requires Improvement

Is the service caring?

Our findings

There was mixed feedback from people and relatives about their involvement in decision making about their care and support planning. Relatives told us they were generally updated about any changes to their family member's care but that they were not consulted about the care plan or invited to any reviews of the care plan. Care plan records documented some discussion with relatives; for example, for one person regarding the use of bed rails but there was no record of people or their family's involvement in the drawing up of nine of the 11 care plans we looked at. People's life history had not always been completed, and, particularly for those people living with dementia, this could impact on staff ability to understand and communicate with them.

People's individualised needs with regards to their disability, race, religion, sexual orientation and gender were not always met. The provider's cultural assessment document to record any cultural needs was not always completed to guide staff. We found for one person cultural dietary needs had been recorded but these had not been communicated to the kitchen.

Interaction between people and staff in all units across the service was observed to be limited and task focused. On the dementia unit, staff were observed to ignore people who attempted to interact with them, or, acknowledged them but not stop to converse or find out what they wanted. On the nursing unit staff were observed to be rushed and not engaged in conversations.

One person told us "One or two of the senior carers are a bit bossy, and they might say, "ask someone else to do that, it's breaking my back." Another person remarked, "Most of the staff are OK, a lot of them are lovely, some are nasty, it depends on their mood." A third person stated, "The staff are not all friendly or interested."

Those staff engaged in one to one work did not always know people they were supporting well. We observed an agency staff member sit beside the person they supported for much of the day and only interact in a task focused way, or, to intervene with regard to their behaviour. There was no positive interaction observed or any attempt to occupy them constructively in any activity. Three people commented that agency staff did not know them, or, what their care and support needs were. One person told us "They have to get in agency and they don't have a relationship with us. They don't know how the person likes it done."

These issues were in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives had mixed views about their relationship with staff and there was room for improvement. Half the people told us that they were happy with the way their care and support was provided and with the majority of staff. One person commented "The staff are alright." A relative said "The staff are lovely; they're worth their weight in gold. They know how to treat [my family member], even though they [family member] shouts at them. Even the cleaning staff are nice." Another relative stated "They're good, not bad, it's to a standard. Everybody has been pleasant, they're all helpful."

Most people told us they were treated with respect and dignity by staff. We observed some limited sensitive communication between people and the staff during the inspection. Some staff were observed to speak respectfully with people and asked for their consent before they provided care. Staff were able to describe ways in which they respected people's privacy and dignity, such as closing people's doors while they provided personal care and checking they were happy with the support they provided. We observed there was a sign that was used on people's rooms to show that personal care was taking place. However, three people told us that staff attitude towards them was not always respectful and this required some improvement. One person told us "Some of the staff are rude sometimes in the way they speak to you." Another person told us, "They're not very friendly; the manner of them is not good. Sometimes they can be very blunt. There are always changes, they use agency so it's not always the same people." A third person commented that staff always turned the music on in the lounge without asking people for their views as to whether they wished to have it on or not.

People were provided with information about the service although it was not always accurate. Notice boards displayed activities on offer, although, we found these were not always reflective of what occurred that day. People were provided with a service user guide with information about how the home was run, although, we saw that some of the information contained in it was not accurate as it referred to another home.

Requires Improvement

Is the service responsive?

Our findings

People told us they had a plan of their assessed care and support needs, although four people said they were not sure they were used by staff. A relative told us "I'm not sure anyone reads the care plans; my family member does not always get their shower when they want." The clinical lead told us people had an assessment of their needs before they came to Brook House to ensure that staff could provide the right care and support. However pre-admission assessments were not always available in people's care plans to check that their care needs had been fully identified. We were aware that some care plans had been recently transferred onto the current provider's documentation.

Care plans were not always personalised to reflect people's individualised needs and preferences. Aspects of the care plan were not always completed to guide staff about aspects of people's care; for example parts of people's dietary assessments or, foot care assessments, or, their family involvement and other social contacts assessment was not completed. There was no care plan in relation to people's mental health needs where there was a formal diagnosis. This meant care workers and agency staff had limited information about people's needs and there was a risk that people may receive inappropriate care.

These issues were a further breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People's opportunities for social interaction and stimulation required improvement. The registered manager told us there were two activities coordinators, although, at the time of the inspection, one coordinator was on leave. People told us there was not always enough to do at the home. We observed very little in the way of organised activities for people. There was a coffee morning for a limited number of people on one floor one day and on the second day the activities organiser was seen taking people to and from the hairdresser. One person told us "The only activity is the TV." Another person told us they used to play chess but there was no-one to play with now. A third person said "I am bored. There is nothing of interest." People sat in front of the television or in their rooms for long periods of the day. There were animals including chickens and guinea pigs but we did not see many people enjoying watching them during the inspection. The second floor dementia unit had little in the way of objects or activities to aid reminiscence to help engage people in conversation. The activities board in the lounge on this unit, on the second day, displayed the day's activities as a morning pamper session and in the afternoon, ball games; however these activities were not observed at any point, and no other activities were observed taking place. Staff were busy and had very little time to spend with people in communal areas. There was one staff member present in the lounge at all times, however they were with someone who required one to one support and did not engage with anyone.

Processes to deal with complaints required improvement. People told us they were aware of the complaints policy and knew how to make a complaint but there were mixed views about whether issues would be responded to. One person told us the registered manager had acted to resolve a complaint they had satisfactorily. Three other people told us that when they raised issues these were not always addressed. One person told us they found staff attitudes could be defensive when issues were raised. We looked at the

complaints records and saw actions in relation to one complaint had not been recorded. There was no record of a response from the registered manager, or, of the action taken in respect of the complaint. We raised this with the registered manager, who told us, they were sure they had responded; but no records in relation to the complaint were made available at the inspection or subsequently.

Inadequate

Is the service well-led?

Our findings

We did not ask people for their views about this issue as they had no direct involvement. The registered manager had been in post since the end of 2015. They understood their responsibilities as registered manager. They had sent notifications to CQC but we found that there were four occasions when CQC had not been notified as required about significant events or incidents for example in relation to safeguarding allegations and when the lift was out of order and affected the running of the service .

This was in breach of Regulation 18 of the Care Quality commission (Registration) Regulations 2009).

People gave us mixed feedback about the management of the service. Three people and two relatives told us they thought it was well managed. One person told us, "It's well managed, let's give them that." A relative said, "It's well managed definitely." However, four other people and two relatives expressed dissatisfaction with how the home was run. One person remarked; "Management is very poor. They don't do things in time." A relative said, "It was worse in the past but having said that there hasn't been much improvement."

People were positive about the registered manager and senior staff including the clinical lead. One person said "I know the manager; she's very open, to me and everybody. She comes round every day." A second person informed us "The manager and [the clinical lead] do come round and they are helpful." A relative told us "When I'm visiting the manager seems to be more visible than the last."

At this inspection we found serious concerns about aspects of the way the home was run. Systems to monitor and manage risk were not effective. There were registered manager's audits carried out across all aspects of the care provided. The provider also carried out their own audits however we saw that some issues were either not identified or if they were they were not acted on.

Communication among some of the senior staff group did not appear to be effective. The registered manager had not been made aware of some safeguarding issues and risks that were known to other senior staff. The action plan developed with the local authority stated daily 'flash meetings' would be held with nurses / team leaders from each unit. This was to monitor those most at risk. The registered manager was not aware that these were being held weekly not daily. The flash meeting system for the oversight of those people most at risk, because of their complex needs, was not effective monitor risks adequately. Notes from the meetings were hand written in a book which was not available at the inspection to staff or inspectors and minutes were not distributed to remind staff about issues raised. Concerns flagged at one meeting, were not always recorded as followed through at the next meeting, or referred to, and there was no overview of the different risks for each person at each meeting. For example one entry referred to someone being found on a crash mattress, but no details of actions taken or risk monitoring was recorded.

The handover record to document changes in risks and any concerns was not always effectively used. The handover for one unit did not include the risk of choking identified for a new admission. We observed that staff who attended the handover were aware of the risk and had acted on this during meal times, but the nurse, who had not been present at the handover meeting, was not aware of this risk when we spoke with

them because it was not documented on the record. There was therefore a risk that information about people's safety could be lost. Agency staff we spoke with did not have a summary of people's needs or methods of communication to help guide them on how to best support people.

Systems to monitor risks in relation to emergencies were not always maintained. We looked at the Fire Risk assessment carried out in November 2015. It had identified that the fire evacuation register had not been kept up to date and that regular fire drills had not always been held, or, information recorded about the effectiveness of the drill. We found the Fire Register was out of date on the first day of our inspection. This meant emergency services would not have an accurate list of which rooms were occupied and how people needed to be safely assisted to evacuate. While most staff had received fire safety training there had only been one fire drill recorded in 2016. This was on 26 January 2016 and had involved approximately 23 of the 82 staff at Brook House at that time. There were no details about the effectiveness of this drill other than the word 'No' recorded against the question 'Was the response appropriate?' on the report. This meant no learning could take place to reduce possible risks and improve responses.

There were no health and safety audits to monitor the safety of the premises. There were Clinical Governance Health and Safety meetings carried out every three months. We identified a number of health and safety issues at the premises during the inspection. The lounge carpet on the first floor was threadbare in places and posed a potential trip hazard. Hoist batteries were being charged on the ground floor corridor and three air mattress pumps were located on the floor, of one unit, both of which posed trip risks for service users, visitors and staff. At night an unsecured oxygen cylinder was seen lying in the path of a bedroom door. This posed potential risk should the door close automatically in the event of the fire alarm sounding. The clinical waste storage was also seen to be open and accessible to the public and animals with waste bins overflowing and this posed a possible infection control risk. These risks had not been identified by the provider in the last Clinical Governance and Health and Safety Meeting of 24 June 2016.

Systems to monitor the quality and safety of the service were not adequate. Most people told us their call bells were not always answered promptly. One person said, "It depends on how many buzzers are going, if there are three or four at a time then you'll be waiting half an hour." Another person commented "It can vary sometimes five minutes, other times longer if they are seeing to others." A third person remarked "At night they come very late. There is not enough of them."
However, one relative said "I can hear them attending to other people quickly, within minutes."
We asked to see a print out of the call bell response times. The registered manager told us that this aspect of the system was broken so that it was not possible for staff to check call bell responses to establish if there were any delays or any problems in the system. We found emails from the registered manager to the provider which showed the call bell system had been broken since at least January 2016 and the registered manager had identified this issue at regular intervals, but yet no action had been taken to improve safety for people. The senior staff carried out some checks on call bell response times during spot checks in a couple of rooms when they visited but this did not address the problems with the system.

There was a malodour throughout the home during the inspection and the carpets in the communal areas were stained on some floors. This was discussed with the Registered Manager and the clinical lead, they advised that carpets were cleaned regularly but the smell remained. The Registered Manager told us that requests for the replacement of carpets along with other requests about the environment had been submitted on weekly reports to the provider over a number of months. The infection control audit of 26 August 2016 also identified the need to replace the carpets due to the smell and their condition however we did not see that the provider had taken any action in respect of these issues.

These issues were all in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Following the inspection we were told a new flash meeting record had been introduced and new hand over template to improve the monitoring and oversight of possible risks. The registered manager also told us that she had taken action to address some of the more serious issues we had found. However we were unable to verify this at this inspection and will check on this at our next inspection of the service.

Other aspects of leadership required improvement. Many of the staff were not wearing badges or identity cards to make them easily recognisable to people, relatives and visitors. It was difficult to distinguish agency staff and permanent staff or easily identify staff on some units. We asked three staff why they were not wearing a uniform and we received a range of answers. One staff member said their issued uniform was not big enough, another staff member said it was too tight and uncomfortable and a third staff member who started in post two months ago told us they had not been issued with uniforms as yet. Two staff said they did have name badges but they were not wearing them during our inspection.

The environment looked tired and in need of a refurbishment in places. We asked about a plan for refurbishment but there was no plan available at the inspection and one has not been received subsequently.

Systems to record and monitor supervision required improvement. We were sent a supervision matrix following the inspection. This showed staff were not all on track to receive supervision as required under the provider's policy at least four times a year. For example, nine staff had only received one supervision session to date in 2016. The registered manager told us the matrix was not up to date and there were a number of supervisions to be added in, and we will check on this at our next inspection.

Staff told us the registered manager and senior team were approachable and supportive. However they told us they did not work well together as a team and there were divisions in the staff group. This was confirmed from the minutes of a flash meeting from September 2016 we looked at. There were staff meetings held where issues were discussed. However, the last staff meeting minutes we were shown were from February 2016.

People's views about the service were sought through questionnaires and through the running of Resident and Relatives Meetings. However, one person told us these were not well attended and the last meeting had been cancelled due to lack of interest. We looked at the last meeting record dated 22 July 2016 and saw there was only one person recorded as being present. Issues about activities and people having access to enjoy the garden were raised at the meeting. These issues did not appear to have been addressed from our observations.

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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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not ensured that CQC were informed of all relevant and notifiable incidents as required under this regulation. Regulation 18 (Registration Regulations)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that service users care and treatment was appropriate, met their needs and reflected their preferences. A full assessment of service users needs was not always carried out collaboratively. Care was not always designed to ensure service users' needs or preferences were met or that they understood the care and treatment choices available. Regulation 9 (a)(b)(c)(3) (a)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Arrangements to comply with the Mental Capacity Act (2005) were not always in place. Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and

improper treatment

Service users were not always protected from abuse or improper treatment and systems to prevent or investigate abuse were not always operated effectively.
Regulation 13 (1)(2)(3)

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 Care and treatment was not always provided in a safe way for service users. Risks were not always identified or assessed or action taken to reduce their likelihood. Arrangements did not ensure that all staff had the necessary qualifications and experience to provide safe care. Regulation 12(1)(2)(a)(b)(c)

The enforcement action we took:

Urgent Notice to vary provider's registration to restrict any new admissions without the consent of CQC.
Urgent condition on the provider's registration to submit information to CQC about staffing levels and staff training.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess, monitor and improve the quality and safety of the service and risks to the health safety and welfare of service users were not effectively operated. Accurate and complete records of service users' care and treatment were not maintained. The provider did not always act on feedback from relevant persons when it was appropriate to do so. Regulation 17(1)(2)(a)(b)(c)(e)

The enforcement action we took:

Urgent Notice to vary provider's registration to restrict any new admissions without the consent of CQC.

Urgent condition on the provider's registration to submit information to CQC about staffing levels and staff training.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were

not deployed in order to meet the requirements of the regulations.
Staff did not always receive such appropriate training to enable them to carry out the duties they are employed to perform.
Regulation 18(1)(2)

The enforcement action we took:

Urgent Notice to vary provider's registration to restrict any new admissions without the consent of CQC.

Urgent condition on the provider's registration to submit information to CQC about staffing levels and staff training.