Care Quality Commission

Sure Care (UK) Limited

Brocklehurst Nursing Home

Inspection report

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Date of inspection visit: 16 June and 6 July 2015
Date of publication: 23/11/2015

Ratings

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

Overall summary

We inspected this service on the 16 June and 6 July 2015. Both days of the inspection were unannounced. This meant the service did not know when we would be undertaking an inspection.

The home had not had an inspection since it had been with the current provider. The home was previously managed by Anchor Homes and was last inspected in March 2014. Sure Care (UK) Limited began managing the home in May 2014. This planned inspection was bought forward following concerns raised with the Care Quality Commission (CQC) about the safety of people living in the home.

Brocklehurst Nursing Home is a large two storey detached building set in its own grounds. The home provides residential and nursing care for up to 41 people. The home had 38 people living there at the time of the inspection.

The home consisted of four wings across two floors. Each wing had its own kitchenette used for drinks and snacks. Each wing accommodated people needing both residential and nursing support. Both floors were accessible by two staircases, at each end of the building, and one central lift and staircase. There was a large lounge and dining room on the ground floor but we

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found this was little used as most people used the communal area on their respective wings. The kitchen and laundry facilities were situated on the ground floor as was the hairdressers who could be used weekly.

The home had a new manager who stated their intention to register with the Care Quality Commission. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The new manager had been in post since April 2015, three months prior to the inspection. The service had been previously managed by the area manager since the previous manager left in January 2015.

At this inspection we found a number of breaches to the regulations as identified below.

Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 focuses on people receiving the support they need. We found the home did not use all the available information to appropriately assess and meet people's needs. This included information from professionals and from the homes own assessments.

We also found people were not supported to be involved as much as they could be with decisions about their own care. We found family members were routinely used as the first point of contact rather than the individual themselves. We found and people told us that people's personal hygiene needs were not being met in a timely manner.

We found the home had not taken into consideration the practicalities of meeting people's specific support needs. This included the management of hearing aids, glasses and false teeth. This included an absence of detail as to how to review the person's condition and ensure their support aids remained in functioning and working order.

We also found a lack of assessment and review of people's needs, contradictions within care plans and across file information left a risk of people receiving care that was unsuitable or unsafe. This included the support people needed to prevent pressure areas and sores, and support people needed with the care of their mouths. We saw four assessments from the nursing home team for people in the home who required specific support with the care of their mouth and none of them had a care plan in place to deliver this.

We found this to be a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We found the people who lived in Brocklehurst were not treated with dignity and respect. We found staff acted without due care and diligence about people's feelings. Staff appeared too busy to be concerned about the things that would separate basic care from good care. This included asking people for their thoughts on their own care.

We also found the lack of regard for people's personal possessions and toiletries showed staff did not pay attention to people's choices around what they wanted to use or not.

We found this to be a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout the day we observed when staff communicated with people, it was often to instruct them as to what they were to do next. This included telling people they were now moving to lounge for the day or going back to their room for a rest. Within people's files there was a lack of evidence of formal consent. We noted a number of consent documents but these were mainly not signed. There was confusion within the files we looked at to ascertain if people were able to give their own consent or if suitable people had been appointed to support them in making decisions. There was a lack of appropriate and legal consent

We found this was a breach of Regulation 11 Health and Social Care Act (Regulated Activities) Regulations 2014.

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 focuses on the safety of people living in the home. We found a number of areas of concern under this regulation. We found the home did not have specific policies and procedures for managing medicines including receiving and destroying stock. The home had a complex system for administering medicines from two different pharmacies. A number of

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errors had been picked up prior to the inspection and there had been minimal action taken to improve the situation. We found people were not receiving their medicines on time which may have impacted on their health and wellbeing. Staff had not received any training on medicines for some time and some were not confident in the home's system as they continued to find errors.

We also found there was not an overall health and safety audit for the building and the people who lived within it. We found doors to stairwells were accessible to all, leaving a potential risk to people who required support with their mobility. None of the risks associated with the building and the people who lived there had been assessed.

We found when people had been assessed as requiring additional support it was not always provided. Staff were not delivering care in a safe way to people who lived in the home as they were not delivering care to minimise assessed risks. This was because when risks had been assessed appropriately, risk management plans and strategies were not being identified or implemented to best meet the needs of the people in the home.

We found the home did not have suitable plans in place to manage major incidents. This included a lack of specific planning to support the people who lived in the home and a lack of contingency planning if the home became uninhabitable.

When reviewing staff records and from speaking to staff it was clear they had not received the ongoing training and support they required to ensure their competence in specific clinical roles. We found care staff were expected to ensure people received their medicines had had no medicines training. The lack of support, supervision, training and professional competency testing of the clinical team had led to avoidable mistakes.

We found this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During the inspection we also found the home had not safeguarded people who lived there against potential acts of abuse due to a lack of effective systems to prevent and recognise abuse. This included acts of neglect and illegal restraint. Over the course of the inspection the CQC raised six safeguarding alerts to be investigated by the local authority to ensure people were safe and protected.

We found this was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We found the provider was not meeting the nutrition and hydration needs of the people living in the home. Where risks were identified the service was not acting to reduce the risks to people and thus not ensuring their health and wellbeing was maintained. We found records used to support people were inaccurately completed and referrals to specialist support were not always made.

We found this was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The home had an activity co-ordinator told us they were unable to develop the role as they would like as there was not enough time to do this.

The manager told us they did not have any records of any complaints made prior to them starting in post in April 2015. The CQC was however aware of two ongoing complaints that had progressed to safeguarding. The provider didn't record any issues/concerns/complaints received or what action was taken as a result.

We found this was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 focuses on how the home ensures the service is meeting the needs of people living there and looks at ways at improving service provision. We would expect this to be done by the home with the provider monitoring and auditing provision to ensure it meets the regulations outlined under the Health and Social Care Act. We would also expect them to be regularly sourcing feedback from people in the home and other interested parties to ensure they are meeting their needs. We found a number of areas of concern under this regulation.

We also found a lack of complete records for decisions taken and reached in relation to the care and treatment

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provided to people. This included procedures not being followed in line with the Mental Capacity Act 2005 to ensure people were supported lawfully and where they could make decisions around their own care they were allowed to do so.

A lack of monitoring and audits meant the manager had no information upon which they could seek to drive improvements. The quality of the service could not be measured. We found a number of acts of omission that could have led to people being at risk. These omissions would have been highlighted if the provider had monitoring in place

The provider was not seeking feedback from the people who used the service, their family members, other professionals or the staff who worked in the home. As a consequence they did not know how the service was perceived by those using it, commissioning and supporting it and from those who worked in it.

The above showed us that systems and processes had not been established and operated effectively to assess, monitor and improve the quality and safety of support provided to people that lived in the home. The home had no way to ensure they were meeting the regulations of the Health and Social Care Act.

We found this was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the kitchen and laundry were well managed. There were systems in place for appropriate risk assessment, cleaning and audit.

Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 focuses on ensuring the home has enough suitably qualified and trained staff to meet the needs of the people living in the home. We found the home were not assessing the needs of the people within it to determine the staffing levels required to support them. We found when circumstances changed staffing did not change to reflect this. On the day of the inspection staff numbers were not proportionate to people's needs. We saw people waiting for a long time to have their call bell answered and staff waiting for a second member of staff to enable people to be moved safely.

Staff had received minimal training and formal support since the current provider had taken over the home in May 2014. New staff had not received an induction and staff had not received an appraisal by the time of the inspection. There was a lack of formal support and training for staff to confidently complete their role.

We found this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Upon reviewing the information within the home. It was clear the Care Quality Commission had not been informed of all information required under the provider's registration. This included notifications for allegations of suspected abuse including omissions of care and potential neglect. We had received information directly from the local Authority and not from the home via a notification**.**

We found this was a breach of Regulation 18 of the Health and social Care Act (Registration) Regulations 2009

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 begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of

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inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The service did not have effective contingency plans and personal emergency evacuation plans to support people in the event of an emergency.

Medicines were not managed safely and risks identified had not been managed.

There were not enough suitably qualified and trained staff to meet the needs of people living in the home.

Risks to people living in the home had not been appropriately assessed and managed.

Is the service effective?

Inadequate

The service was not effective.

We found procedures in place to protect people from malnutrition were not effective.

Applications to deprive people of their liberties under the Mental Capacity Act 2005 were not completed in line with the Act and liberties that were restricted were therefore unlawful.

Staff had not received the required training in the last 18 months.

Is the service caring?

Requires improvement

Some aspects of the service were not caring.

People who lived in the home and relatives we spoke with had mixed views on how the staff looked after them.

We saw some staff were respectful to people.

Staff did not give people choices as to how and when they wanted support once the support was being provided.

Is the service responsive?

Inadequate

The service was not responsive.

An activity coordinator was in post but only for two hours a day and they did not have the time or the resource to develop the role as they would like.

The provider had not sought the views of people living in the home about their care and support,

Care plans and assessments were not always accurate which resulted in people receiving care which was not tailored to meet their individual needs. .

Summary of findings

The home did not keep records of complaints or actions taken to resolve issues.	
Is the service well-led? The service was not well led The home did not use audits or monitoring tools to review and improve service provision. Risk assessments were not completed as required. Staff were not supported to fulfil their role safely. There was a lack of available policy and procedure.	**Inadequate** 

Brocklehurst Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on the 16 June and 6 July 2015. Both days were unannounced. The inspection team included three adult social care inspectors, a pharmacist inspector, a nurse specialist advisor and an expert by experience. An expert by experience is someone who has experience of, or has cared for someone with specific needs. On this occasion the expert by experience had experience of working with older people. The pharmacist inspector, nurse specialist advisor, expert by experience and one of the adult social care inspectors were on site only on the 16 June 2015. On the second day two adult social care inspectors were on site.

Before the inspection, we asked the provider to complete a Provider Information Return (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. They did not return a PIR and we took this into account when we made the judgements in this report

Before our inspection, we reviewed the information we held about the home, requested information from Manchester City Council, the local safeguarding team and the lead safeguarding nurse of the Clinical Commissioning Group (CCG).

During the inspection we spoke with 16 staff including the recently appointed manager and deputy, administrator, nursing staff and carers. We also spoke with the chef and laundry and domestic staff and the activity coordinator. We spoke with two visiting professionals including an end of life care co-ordinator. This is a professional recruited usually regionally to implement good practice when managing people's end of life choices. We also spoke with 15 people who lived in the home and four visitors. We observed how staff and people living in the home interacted and we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who cannot talk with us. We observed support provided in the communal areas including the dining room and lounges during lunch and during the medication round. We looked in bedrooms, in the kitchen, laundry and staff offices and in all other areas of the home.

We reviewed 15 people's care files, 11 of them in detail to track assessments of support needs through to provision of the support delivered. We looked at extra care monitoring records for personal care, nutrition and hydration records and complex needs records. These are records which are kept for people with complex clinical care needs. These included records used to support people who were required to use clinical equipment to meet their basic needs including PEG (Percutaneous endoscopic gastrostomy) tubes. We looked at how the home monitored and improved service provision, managed medication and undertook risk assessments.

We looked at seven staff personnel files to ensure staff were recruited safely and received the support they required during employment at the home.

Inadequate

Is the service safe?

Our findings

We spoke with people who lived in the home and asked people if they felt safe. We were told by most that they did.

Two members of staff we spoke with were able to give a detailed understanding of their responsibilities in relation to reporting safeguarding concerns and who to report them to. This gave us some assurances that people would be kept safe.

However, over the period of the inspection the CQC identified six safeguarding concerns and raised these with the Local Authority for investigation. We found the basic principles for care delivery were not being followed. This included people not getting the required amount of hydration in accordance with specific care plans, people not receiving the required support to reduce the risk of and improve pressure sores, and a lack of clarity one person had received the required support to manage a long term head wound. We found the six incidents we reported to the Local Authority were potential acts of omission and neglect.

We found the home had not safeguarded people who lived there against potential acts of abuse due to a lack of effective systems to identify and prevent abuse. This included acts of neglect **This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

We reviewed available information on how the home kept the people that lived there safe. We looked in 15 people's care files to determine how the home minimised identified risks to individuals. In two files we saw professionals including the Tissue Viability Nurse (TVN) had advised positioning and turning schedules for two residents. This support was advised as the two people had been assessed either as being at risk of pressure areas or had pressures sores already. The home had not implemented the intervention recommended to reduce the risks to the two people. The home were not working with other professionals to ensure people's needs were met. The two people lived on the ground floor of the building and we asked staff for the positioning records for that area. We were told none were available as no one on the ground floor needed that kind of support. These people were not receiving the support they needed.

We looked in four files where within the pre-assessment information the social worker and assessor from Brocklehurst had assessed people needed a care plan to support mouth care. None of the files for the four people had a dedicated mouth care, care plan. We looked at the mouths of two of the people and found their mouths were dry and their lips were cracked. These people were not receiving the support they needed. This information was included with information reported to the safeguarding team.

We found the home did not use all the available information to appropriately assess and meet people's needs.

We found this to be a breach of Regulation 9 of the Health and Social Care Act 20008 (Regulated Activities) Regulations 2014.

In three files we looked at we saw high risk scores on nutritional screening tools. These tools are used to assess if people may be at risk of malnutrition. Risk management strategies should be developed which would include steps to reduce the risk of malnutrition. These could include increasing how often the people were weighed to ensure further weight was not lost and if it was prompt action could then be taken. The home could also monitor the food and fluid intake for these people to ensure they were eating and drinking enough and again if not it would be a prompt for the need of further action. We did not see any risk strategies for these three people. This meant there was a risk of these people not getting the support they required.

In one person's file we saw they had a number of pressure sores. Documentation within their file used to manage the risks of the pressure sores was contradictory. This included information on a body map used to identify where the sores were (one body map identified them in one place and another identified them on another part of the body) and information recorded to identify how bad the sores were. Different assessments and records dated the same time graded the scores differently. There were no records over time to identify if the sores were improving or not and records to show the risks were being managed were kept within the daily records. These records were not easily accessible and lost in the bulk of the text within the records. This did not allow staff to review this information quickly. As a consequence we saw the person was not being supported in line with their care plan and risks were not being managed.

Inadequate

Is the service safe?

We found the above information showed us that staff were not delivering care in a safe way to people who lived in the home. This included risks not being assessed appropriately or accurately and risk management plans and strategies not being identified or implemented to best meet the needs of the people in the home.

We found this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw assessments for moving and handling and support with personal care identified two staff were required to reduce the risks in these areas for a number of people. We reviewed the personal care records for two of these people and found only one staff member was recorded as supporting them on a regular basis. This meant people were at risk of receiving support which did not meant their needs and increased risks.

We saw one person had fallen three times in one month. The manager told us that after two falls people would be referred to the falls team to ensure further support was provided and action was taken to reduce the risk. We found this person had not been referred to the falls team and their records were not consistent within their care records and accident records. In one it was clear they had fallen three times in the other there was only one record. This meant that staff did not always have the correct information on which to make a referral.

We saw in the minutes of a nurses' meeting held on 14th May 2015 that concerns were raised on how extra care monitoring charts were completed and used. The action recorded to support and monitor improvements was that there was to be a daily check of the charts at 2pm. We reviewed the available charts which covered approximately three weeks. There was no evidence on the charts that they had been checked and the quality of the completion remained poor. This leaves a risk of people not getting the support they need.

The above showed us that systems and processes had not been established and operated effectively to assess, monitor and improve the quality and safety of support provided to people that lived in the home.

We found this was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked to see the information the home had on how they would deal with a major incident such as a fire, as there was no evidence of any Personal Emergency Evacuation Plans (PEEP`s) on people's files. These are individual personalised plans to assist staff to safely evacuate people in the event of an emergency. On the second day of the inspection the manager informed us the PEEPS were now completed. We reviewed the PEEPS and found them to be generic and not based on each individual's needs in the event of an emergency. For example, they did not make distinctions between the moving and handling needs of the different people in the home. Documentation was misleading and could cause confusion during an emergency situation putting people at risk. The home did not have any contingency plans which identified how the home would continue to support people in the event of an emergency. The absence of this information left people at risk of not receiving the required support if this situation should arise.

A fire risk assessment had been completed in February 2014 which identified the home was required to undertake monitoring and testing of fire equipment at regular intervals. No testing or monitoring of fire equipment had taken place. There was no evidence to suggest the home had a fire drill or had routinely tested fire equipment since Sure Care had become the owners.

There was no overall health and safety audit for the building and the people who lived within it. We found doors to stairwells were accessible to all which was a potential risk to people who required support with their mobility.

We found this was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We found the kitchen and laundry were well managed. There were systems in place for appropriate risk assessment, cleaning and audit.

During our inspection we spoke to seven staff to determine if they thought there was enough staff to meet the needs of people who lived in the home. All of the staff we spoke with thought things had improved recently. One member of staff said all ten people on their unit required two staff to support them with their personal care needs and one person required individual one to one care support. People on the unit told us they sometimes had to wait up to half

an hour to be supported to go to the toilet. We noted the length of time taken to respond to buzzers increased considerably after 2pm from approximately five minutes to between seven and 18 minutes. This left a risk of people not receiving the support they needed when they needed it.

The home did not use a dependency tool to assess if the staffing numbers were adequate to meet people's needs. Each unit in the home, irrespective of people's needs, had two staff. This did not seem proportionate to the unit where most people required the support of two staff. We were told a recent incident had led to staff supporting one person in pairs at all times, yet staff numbers had not increased to support this. The lack of a comprehensive assessment of the needs of people living in the home and the impact of this on staffing had led to staff managing an increase in care needs with the same number of staff. This in turn had led to people not having their needs met in a timely manner.

Throughout the day we observed people left unsupported in the lounges on the wings for up to 20 minutes at a time. When people were out of their room they did not have access to call bells to call for support if they needed help. This left people at risk of not receiving support when they need it.

We found this to be a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at seven personnel files for different staff working at the home. We found in all but one of the files an application form had been completed. We did not see any details of interviews but all had appropriate criminal records checks such as POVA (Protection of Vulnerable Adults) or DBS (Disclosure and Barring Service) information on file. However one applicant did not have a receipt to say the check results had been received back at the home. The manager was not aware of this and told us they would source the information to ensure the person was suitable for the role. All files had photographic ID and evidence to support they were eligible to work in the UK.

The CQC had been contacted prior to the inspection by the safeguarding team from the Local Authority who identified concerns with how the home was managing medicines. On the first day of the inspection we took a dedicated pharmacist inspector to review this. We observed two medication rounds. We saw registered nurses administer medicines including tablets, liquids and eye drops. Nurses spoke to people respectfully and administered medicines in a dignified and professional manner. We observed staff accurately record on the Medicines Administration Record (MAR) medicines they had given.

We found the medicines stored in the Controlled Drugs (CD) cabinet were correct with the balance in the register. A new register was opened on 24 May 2015. We noted the balance transfer was only done by the duty manager and was not counter-signed. We requested the old CD register which was eventually located and confirmed the transcription was correct. We found when medicines were first received into stock double signatures were obtained.

We spoke with the nurses about the system the home had in place for administering medication. We were told the home currently had two pharmacy providers. One which provided regular monthly medication in a multi dose system (blister pack) and another which provided acute medication and also any mid-cycle medications. As a consequence the home had two different MAR chart systems concurrently in operation that had different coding and a range of blister packs and original packaging. Whilst the MAR chart did have a picture of the tablet to aid identification we were told that sometimes the image was not representative of the medication.

Whilst we were observing one medication round the nurse identified a medication error. One person had been started on a new medicine but the previous one had not been discontinued. The nurse consulted the communication diary but it was unclear if the previous medicine was to continue or should be stopped, The nurse thought it unusual for both of the medicines to be prescribed together and contacted the surgery to clarify the situation. Once clarified they discontinued the medicine from the MARs chart. We asked about the process of medication changes if prescriptions changed mid-cycle. We were told that rather than the whole blister pack being sent back to the pharmacy to amend a member of staff would identify the stopped medication and remove it from the blister pack. We found the diary held a number of records including changes in medicines following discharge from hospital. It was not always clear to people reading records retrospectively what had changed.

We asked the manager about medication errors and near miss reporting. We were shown two incidents that had

been reported to safeguarding since April. There were no other records of near misses, shared learning or any evidence of root cause analysis. Recording and analysis of this type would ensure all relevant staff knew about incidents and each understood how they had happened and indeed how to avoid them reoccurring.

We asked nurses if they had seen the policies and procedures the home had for managing medicines. We were told they had not. We asked the manager to review the available policy and procedures. Whilst there was an overarching medicine policy around administering medication, this was not specific for the home. There was no PRN policy or CD policy that was accessible and the manager was unable to produce a policy or procedure for ordering and receiving pharmacy stock.

We reviewed the care plan of someone living with Parkinson's to ascertain if there was relevant information about the importance of receiving their medication on time and there was not. MARs were not completed with the precise time it was administered. There was a note in the care plan to regularly review medicines to ensure they were meeting the person's needs but no changes had been made in the last three months. We asked if there was an early morning medicines round and was told there was not. This meant that people who should receive medicines before their breakfast were receiving it afterwards.

During the discussions we had with carers it became apparent that the nurses were sometimes stretched. We were told of occasions where nurses left medicines on tables for carers to remind people to take. The carers we spoke with were not comfortable with this as they had not completed any training and felt there were risks of people receiving the incorrect medication or it not being taken at all. We raised this with the manager on the day who assured us they would talk to the nursing staff.

We looked at five medicines care plans and found they were not very well completed. None of the records we looked at included details of any allergies and simply said if someone required assistance with their medicines. The care plan was not used to highlight changes in medication or to help transfer information about medication between settings including hospitals. They did not hold specific person centred information about people's medicines including those that were administered 'as required' or through a PEG. We reviewed the MARs for two people who received medicines 'as required' and with a variable dose.

We found accurate records were not being kept as to what exact dose was being administered. MAR charts identified if someone was to have their medicines administered through their PEG but did not include any further details on how to do this, including if medicines could be crushed together or if time needed to be given between certain medications. We also found that someone who was in receipt of an oxygen prescription had not been risk assessed to ensure this was done safely.

We observed the MAR charts for topical products including creams and pain reduction patches. We did not find any specific instructions for applying topical products and there were no available body maps to give added direction as to where they should be applied.

We spoke with the manager and asked to see audits and monitoring the CQC had been assured had been undertaken. We were told the deputy manager was on site the day of the first inspection to complete their first audit of the medication system. One had been completed in March 2015 by the area manager; the manager of the home had recently received the action plan from the area manager. We saw a feedback consent form for the audit to be signed by the manager identifying they understood their responsibilities to complete the action plan but it had not been signed and the action plan had not been met. The audit begun on the first day of our inspection was shown to us. This included a medicines count for five people who lived in the home. The audit found none of the five people had accurate records for the period being audited. We found the actions from the area manager audit in March such as ensuring supplement drinks were being given as prescribed were still not being implemented.

Both nurses we spoke with during the medicines round told us they had not received any specific competency based assessments in the two years prior to the inspection. We asked the manager if there were any competency assessments or training logs for staff around medication and were informed there weren't any available.

We found the home were not managing medicines safely and were in **breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Generally we found the home to be clean and tidy and in in a good state of repair. However we did note the vinyl flooring throughout the home was sticky underfoot on both

Inadequate

Is the service safe?

days of the inspection. We were shown comprehensive cleaning schedules which were to soon be introduced. People appeared to have their personal hygiene needs met but we did note that staff did not support people to wash or wipe their hands either before or after a meal.

Inadequate

Is the service effective?

Our findings

We spoke with people who lived in the home about how staff got their consent before they supported them and how they shared their needs. One person said to us," I don't feel listened to at times, staff get me up and put me to bed, I have no say in the matter, I do not report anything as it would do me no good."

We looked at records the home held for consent. In four of the files we looked in we found an assessment for the use of bedrails. Some of these had been completed and indicated the use of the rails had been discussed with the person themselves yet none had been signed. Two of the people whose bedrail assessment had been discussed with them had other information within their files to state they did not have the capacity to make choices. We saw three consent forms for people to agree to have their photograph taken and used but again none of these were signed. We did not find any formal consent for the home to administer and manage people's medication or for any other interventions given by the home. Without formal consent for the care and support to be delivered the home would be required to seek consent at every intervention. We did not find this to be the case. This meant the home were delivering care and support without appropriate consent.

The Care Quality Commission has a statutory duty to monitor the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) which apply to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA). The aim is to make sure that people in care homes and hospitals who lack the capacity to make decisions for themselves are supported in a way that does not inappropriately restrict their liberty.

We reviewed records kept at the home of meetings with family members and the nursing home team. The nursing home team are commissioned by the GPs to support nursing homes with medication reviews and health care assessments. The next of kin had been consulted and given their consent for certain care interventions. We did not see any documentation to support that the person living in the home had given their consent for their family member to have this authority.

We discussed with the manager and deputy manager the authority of people's next of kin. There was little understanding that the home either needed the consent of the individual in question for this or a capacity assessment to determine the individual could not give consent. Once this was agreed then the next of kin could be involved in decisions. There was also little understanding of the authority of the next of kin specifically concerning DNAR decisions. We discussed at length the home's over reliance on the nursing home team's reviews and assessment without the required consents from the people who were the focus of the meetings. When consent is not gained as it should be there is a risk of people not receiving care they want or receiving care and support they do not want.

Throughout the day we observed instructions being given to people as to their next action or intervention. We did not routinely see consent being requested before interventions. This included when supporting people to the dining room or lounge for their meals and to move either independently or with the use of aids. The lack of appropriate and legal consent is **a breach of Regulation 11 Health and Social Care Act (Regulated Activities) Regulations 2014.**

We found the manager had begun to undertake assessments to determine if people were being restricted and deprived of their liberty. We were told capacity assessments had been completed with all residents. We found this was not the case. No capacity assessments had been completed in the 15 files we looked at and four assessments had been completed to ascertain if people were being deprived of their liberty without the proper authority. The assessments showed these people were not safeguarded against unlawful restraint due to incomplete or inaccurate assessments.

One of the assessments we saw recommended a DoLS application was required as the person may be the subject of restraint if they refused support with their personal care needs. The application had not been made and it was confusing what evidence the manager had used to support the need for the application as we saw no evidence on the individual's care plan of restraint being required. There were no risk assessments in place to support the person if they obstructed or refused help with their personal care needs. There was also no evidence to show the person lacked capacity to make an informed decision about refusing support with their personal care needs. There were no records to suggest the situation had been discussed

Is the service effective?

with the person and if a best interest meeting may be required or had taken place. We could not find any documentation to show a DoLS application was required in line with the Mental Capacity Act 2005.

We found the home had not safeguarded people who lived there against potential acts of abuse due to a lack of effective systems to prevent abuse. This included acts of neglect and illegal restraint. **This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

On day one of the inspection we asked the manager to provide us with a training matrix for us to ascertain what training had been completed with staff over the previous 12 months. The matrix had begun in April 2015 and we were told there was no record of all staff training prior to the new manager coming into post. The manager included training that had been completed that they were aware of. We found there had been some recent electronic learning training for safeguarding, fire safety and moving and handling but only approximately 10% of the staff had completed this. Three of the care staff we spoke with on the two days of the inspection told us they had not received any training for nearly two years.

We looked at seven personnel files and reviewed the support staff had received since coming into post. Three staff had not completed an induction and no one had received an appraisal for at least two years. Staff had raised concerns and gaps in their own training within the staff meeting in May 2015. Concerns had been raised around the use of profiling beds. We spoke to the manager who assured us the company who supplied the beds had delivered additional training for the staff. However Staff we spoke with could not confirm this had happened. Concerns were raised around previously used training DVD`s which had gone missing.. The manager assured us new DVD`s were on order and should arrive in the next week. Two weeks later the DVDs had still not arrived. The manager also told us they were looking to introduce a new more comprehensive training programme to go alongside the DVD`s. We were shown a letter from a training provider to deliver more classroom based training but this was yet to start.

The lack of formal support and training for staff to complete their role is a **breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We looked at available information to ensure people's nutrition and hydration needs were met.

We spoke with the chef about the different dietary requirements of people living in the home and were told they supported people with Halal and vegetarian dietary requirements.

Family members we spoke with told us their relatives had good appetites and could always get something they liked from the kitchen. They told us that if they didn't like anything on the menu for the day, something else would be prepared. However another said they had to buy their own lasagne as it was not on the menu. We observed staff offering several choices to one person who no longer wanted what they had ordered.

We looked at the monthly menu and saw there were two choices on each day. We noted that the kitchen staff ask the people who lived in the home what their preferred choice of meal was for lunch time at around 10.40am, the kitchen staff told us they usually ask people about 90 minutes before the meal is served.

We looked in one file where there had been recent support from the Speech and Language Team (SALT) due to changes in the person's needs. We saw that advice from this team had been incorporated into the care plans and appropriate assessments.

However in another file a nutritional assessment stated the person needed extra care monitoring of their food and fluid intake and this had not commenced by the time of the inspection. In another file we saw a nutritional assessment which identified a risk of choking. The assessment was last reviewed in May 2015 and scored as a moderate risk. Part of the risk strategy completed in March 2015 was to weigh the person every two weeks and record their food and fluid intake. This had not been done by the first day of the inspection over three months after it should have been implemented. Monthly reviews were to be used as a trigger for a potential referral to the dietician for expert support. The plan had not been reviewed from March to May and no change was identified. The plan had not been reviewed in June 2015 and a referral had not been made to the

dietician. We also noted in one file that the person had lost 5kg in one month and no action had been taken. The CQC inspector raised a safeguarding alert to ensure this person was protected.

We reviewed the MUST charts (Malnutrition Universal Screening Tool) in five files. These are used to identify people who are underweight and at risk of malnutrition as well as those who are obese. In one file the nutritional assessment did correlate with the MUST chart however it was completed periodically and not reviewed monthly. The person's weight was not being recorded regularly which could result in them not receiving the support they required.

We also reviewed food and fluid charts (food and fluid charts are used to record the amount of food and fluid people have taken over a 24hour period to ensure they are receiving a nutritional well balanced diet and are taking enough fluid to maintain hydration), and noted they were not always completed correctly. The records from one wing highlighted that all the people had taken the exact same amount of fluids. This meant records were being made of fluid given or offered and not what was actually taken.

We spoke with a nurse and asked how they managed concerns when it was identified people were not eating or drinking as they should. We were told they would speak to the chef and alter their diet to include different things in an attempt to improve the situation. We were told by the manager that the nurses would complete a risk assessment to support this but neither ourselves or the manager could find one. Decisions made by the nurses to change someone's diet were not supported by specialist advice. We were told the decisions were made in the interim period whilst referrals were in to specialist support. We could not find any evidence to support that these decisions had been made or risk assessed.

We noted in two people's files a risk had been identified on their nutritional assessment which indicated they should be weighed weekly. One had not been weighed since April 2015 and one since February 2015. This showed us that the staff were not providing additional support identified as required to keep people safe.

A nutritionist from the local hospital had attended the home to complete an audit on MUST (malnutrition tool) and nutrition within the home. They audited 16 files and found five of them required care plans setting up. The remaining files needed more information and a complete audit of the information in them was needed to ascertain accuracy. Height had been recorded in hardly any of the files in order to ascertain an accurate Body Mass Index (BMI) score. The auditor also recorded that from the records they couldn't judge anybody's weight loss over a three month period as no one had consistently been weighed during a three month period. There were also no details of what people were on supplements to support a healthy diet. The audit was not dated and we were told it was the week before our visit. The information remained accurate in the care files we reviewed. We found the home continued to have an excess of unused supplements as identified by the out of area manager on the medications audit completed in April 2015.

We reviewed the information for people who received their hydration and nutrition via a PEG (Percutaneous endoscopic gastrostomy). Staff had not followed PEG nutrition and hydration schedules for three of the plans we reviewed. We found people were in receipt of up from half of their prescribed amount of water. We would have anticipated in the hot weather staff would have increased water intake but this had not happened.

We found the provider was not meeting the nutrition and hydration needs of the people living in the home. Where risks were identified the service was not acting to reduce the risks to people and thus not ensuring their health and wellbeing. This is **a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

During the inspection visit we reviewed the local Nursing Home Service and family meeting file. The file held documentation following visits from the Nursing Home Service to the home. It included any discussions with family members following the visits. The Nursing Home Service undertook weekly visits and responsive visits (responsive visits are visits following a request from the home in addition to the weekly visits). The responsive visits documentation we reviewed included where there was deterioration in someone's health and we saw evidence of changes to medication and details of follow up actions required by the Nursing Home Service or the home. We saw evidence on file to support how this information was used to inform all nurses of the changes and follow up actions required on a handover sheet.

Requires improvement

Is the service caring?

Our findings

We spoke with the family members of one person who lived in the home who could not verbalise their needs. The family members told us they were involved with the decisions around their family member's care and understood the care plans to support them.

We found the family members were involved with people's care and had influence over how it was delivered. For example we asked three staff about how they found out about what people like and don't like and each of them said they would ask the family. They did not say they would spend the time with the person and ask them themselves. We noted people's preferences were not built into care planning and the plans were records of interventions rather than preferences. Plans did not show whether people were involved or had influenced decisions about their own care and in many the same words were used. For example 'likes a weekly bath'. We spoke with the manager about this who assured us they would ensure people's preferences were better recorded.

Staff we spoke with, were clear about confidentiality and respecting people's privacy. Staff were clear that they did not talk about people they supported outside of the home or put anything on social media sites. Staff we spoke with said they were proud to be a carer looking after the vulnerable people who lived in the home.

We completed a SOFI (Short Observational Framework for Inspection). This is a tool we use to observe interactions between staff and the people who live in the home. It is used to help us understand if people had their needs met when they could not or were not communicating with the staff supporting them. We completed two SOFIs over the inspection, one on each day. On both days we found staff and people who lived in the home mostly interacted when tasks needed to be completed rather than promoting autonomy and independence when possible.

We found staff didn't communicate with people about what they were doing. We saw one person administering medicines wake someone up with their medicine on a spoon. They put the spoon to the person's mouth waiting for them to open their mouth to take their medicine. They did not say it was medicine or ask the person if they wanted it. We saw two staff supporting different people to eat. We observed staff holding a spoonful of food to people's mouths while they were still eating their previous mouthful. We saw one staff member mixing together one person's food which had been softened and blowing on it before giving it to the person with no communication as to whether they wanted their food mixing together. They did not ask whether they were happy with the food's temperature and indeed what their thoughts were on the staff member blowing on their food before they ate it.

In general conversations with staff and the manager we noted the terminology used to describe people's support needs was inappropriate. From the manager down we heard people being described as 'feeders' referring to when someone needs support with eating. Supporting someone with going to the toilet was referred to as 'toileting'. We raised our concerns with staff when they spoke like this and they all seemed to acknowledge they could word things better but many said everyone talks like that.

However we also saw examples of positive interactions. We observed one person struggling to eat their meal in the main dining room. The kitchen staff asked if they could help by cutting the food up. They did this and then continued to ask if the person was ok or if they needed any additional help. This showed that in this instance staff offered support after first allowing people to try and do things themselves. Once an initial bit of support was offered the person was checked to ascertain if more was required, but staff did not take away this person's autonomy and allowed them to eat their dinner at their own pace.

Staff we spoke with could give us detailed explanations of people who lived in the home, but information was restricted to what people's needs were and what equipment was used when supporting them rather than about people as individuals, their thoughts and feelings about things that went on in the home.

We observed the administrator interacting with people as they had their lunch. The interactions were positive and respectful. However we were told the administrator would not normally have the time to spend on the individual wings.

We spoke with people about how staff treated them. One person told us staff treated them well and with respect. People who lived in the home were nicely groomed and some of the ladies had their nails done.

Requires improvement

Is the service caring?

We saw one person who read lips asking a question of a member of staff. The staff member sat in front of them to answer so they could see their lips. The person responded with another question and the staff member began to answer but then walked off whilst still talking leaving the person to only hear half of what they said. The person tutted and returned to their meal. This showed at this time this person's needs were not met, as by walking away the person could not read the staff member's lips.

One person who was eating their dinner commented that they did not like cucumber. The staff member removed the cucumber from the plate with their hands and then said the person was 'fine to eat their meal now.' The staff did not wash or wipe their hands prior to or after removing the food and did not ask the person if they were happy with them removing the food with their hands.

The meal time service we observed on one of the wings was undignified. For example. One unit had approximately 12 people sitting in a semi-circle in the lounge area. Each had their lap table pushed up to them and tightly fitted to the table next to theirs. People could not get out from their seat if they wanted to during the lunch time service. Staff supported people around the semi-circle.

We found that people's dignity was not always promoted in the best way, for example some rooms were joined by a shared bathroom. We found that some people were sharing the bathroom with a member of the opposite sex. When we asked the manager about this they said the families are happy with it. There was no evidence to support if the person themselves had been asked.

When we walked around the building we observed that many of the clocks in people's rooms told the wrong time. This could be very disorientating for people if they woke in the night. It would also make it harder for people living with dementia to associate themselves with time. We also noted there were a number of toiletries in communal bathrooms that did not appear to be owned by anyone and some prescribed creams that had not been returned to people's rooms or to the medication room. We also found named toiletries in some of the shared bathrooms that did not belong to any of the people in the rooms using the room. We also saw named equipment including wheelchairs stored in rooms and bathrooms of people who did not own the wheelchair. This left the potential for when people wanted to use their own personalised wheelchair people not being able to find it and another wheelchair having to be used.

Whilst sitting in the dining room at lunch time we saw one person had their PEG flushed in the main lounge area without any conversation as to if this was acceptable or not. This showed a lack of respect for the privacy and dignity of this person.

The lack of interaction with people whilst completing individual focused interventions and the disregard of peoples' options and choices and personal belongings showed us that the people who lived in Brocklehurst were not treated with dignity and respect. We found this to be a **breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Inadequate

Is the service responsive?

Our findings

People were able to make choices about some aspects of their day to day lives. Most people told us they could get up and go to bed when they wanted but two people told us they, "Do as they are told."

We asked people about how the home responded to their specific needs and were told by one person, "There are not enough staff. They don't have the time to see to me." A family member who was visiting told us if they did not check the batteries in their loved ones hearing aid they would be left to run out and if they did not clean their family member's nebuliser it wouldn't get done nor would their shaver be charged.

We were told by people, "Staff do what they have to do as that is all they have time to do." We did not see anyone being supported to the toilet throughout the day. One person we saw in their room said they wanted the toilet and a staff member was asked to help them by a member of the inspection team. When the staff member came into the room they told us the person had a bottle and was wearing a pad so didn't need support to the toilet. This meant people were left in pads as opposed to them being supported to the toilet which meant people were not supported to maintain their dignity. We were told most people in the home used incontinence pads. But we did not see comprehensive incontinence assessments within people's care plans.

One person was at in the lounge and was requesting to be moved so they could see the TV better. The person told us they would like to be moved yet staff had not supported them to do so. This person also told us their dentures were loose and they had requested to see the dentist to get them sorted but staff hadn't got round to sorting it out. The person told us they do get wound up when things don't get done as they should.

We found the home had not taken into consideration all the needs of the people who lived in the home. We looked in the files of two people who had specifically raised concerns with their hearing aids. It did not say in either of them what the practical tasks were to support them with their hearing aids. This included an absence of detail on how to clean them, turn them on, change the battery, review the person's condition and ensure they had their hearing aids at all times. We found the absence of specific assessment on this and concerns raised above a **breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

In the 15 care files we looked in improvements were needed to make sure care plans were up to date and reflective of people's current needs. Work also needed to be done to ensure care plans corresponded with other documentation, including the nursing home team's assessments. We found the home did not use the local authority assessments and the nursing home team information to develop their own assessments and care plans.

We found misleading information in a number of care plans. This included contradictions in people's capacity to make decisions and their support needs. For example we read in two people's pre-assessment information that they needed to be moved two hourly to reduce the risk of pressure sores. Staff were unaware of this and it was not happening. Other pre- assessment information stated one person could communicate their basic needs yet information within their care plan said they could not. We found this person was trying to read without their glasses on and was struggling to do so which confirmed to us they may not have thought to ask for their glasses. When information is confusing and contradictory there is a risk of people not getting the support they need.

We also found in four files a number of sheets of the same information but they did not hold the same detail. For example there were three allergy care plans in one file. One was in the correct place within the file which was left blank and another was misfiled and had information on it of allergies. This could result in someone having an allergic reaction to something as staff may assume because the plan filed correctly is blank the person does not have any allergies.

One other file contained confusing information about someone's pain medication and previous medical history. One assessment said their medication was making them drowsy and should be stopped for a week and another said they were on strong pain medication which they were not on at that time. The record dated 13 May 2015 outlined that this was to be reviewed four weeks later but there was no record of the review taking place in the file. The changes in medication had not resulted in reviews to other assessments. The falls assessment indicated no change

and the moving and handling assessment stated the person's pain was managed by the medication. This may result in staff thinking the person has had pain medication when in fact they have not and may also lead to the person being subject to unnecessary pain.

People had a one page profile of their support needs on the inside door of their wardrobe. We cross referenced this information with information held in their care plans. Information was often contradictory. For example for one person the information on their one page profile stated they required a soft diet and were at risk of choking and their eating and drinking care plan in their file stated the person had a normal diet. This meant people were at risk of not receiving the support they needed or of receiving additional support they no longer required.

One person's pre-assessment information contained information around a previous heart condition. However the medical history held at the home did not include this, resulting in a much lower risk score for this person. We found this same person was nursed in bed as they had a fear of being hoisted. This information was clearly recorded within their pre-assessment information. The moving and handling assessment said the person needed the support of two carers at all times and did not mention their fear. Again this left a potential for people to receive support inappropriately.

In another file we saw a completed body map from the 14/04/15 regarding a small wound to the person's forehead. The wound care plan was not dated but did identify the dressings prescribed and that the wound was possibly MRSA positive (Methicillin-Resistant Staphylococcus Aureus). MRSA is a bacterium responsible for several difficult-to-treat infections in humans. When looking at information predating the body map it was clear a number of actions were required including a referral to the dermatologist. There was no recorded conclusion to this referral or a confirmed positive result of MRSA, this could result in delayed improvement of this wound and how it should be managed. We raised a safeguarding alert with the Local Authority to ensure this person received the support they required. The alert has been substantiated and the support is now being provided in line with this person's needs.

We found the home did not appropriately assess the risks to the health and safety of the people who lived in the home. We found when risks were identified the home did not take the required action to mitigate those risks. **This is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

We spoke with the activity coordinator about the available entertainment within the home. We were told external performers visit at least monthly. We saw bookshelves with books and puzzles which were available for people to use if required and saw one person involved in an informal quiz with a staff member. People we spoke with said they would like more to do and would like to get out more. One person told us, "I get bored sitting watching TV all day."

We were told records of when people had a bath or shower were kept in the communications diary and transferred into the respective care plan at the end of the day. We reviewed these daily records and found whilst there were not many of them they were written in a person centred way detailing what had happened and any observations to note. We checked the records held for baths/showers of seven people. Most care plans stated people wanted a bath/shower weekly yet this was not implemented. We found the most frequent gap between baths/shower was two weekly and one person had a six week gap between baths/showers.

We reviewed the Waterlow assessments for three people. We found two of them scored over 20 determining them at high risk of pressure areas. The Waterlow identifies how the risk can be reduced and how often the condition and assessment should be reviewed. High scores of 20 should be reviewed weekly. Additional assessment including skin integrity should be completed as appropriate. There were no observations or extra care monitoring in place for these two people to monitor the risk areas. We saw one person sitting in a recliner chair and did not see them move for the duration of the day and another nursed in bed. This meant people who lived in the home were potentially at risk of pressure areas due to a lack of movement.

We found the lack of action on assessed areas of need and appropriate review of people's needs leaves a risk of people receiving care that is unsuitable or unsafe. **This is a breach of Regulation 9 of the health and Social Care Act 2008 (Regulated Activity) Regulations 2014.**

A complaints procedure was not available. The only available information on how to make a complaint was an old CQC poster on display in the foyer. We reviewed the

Inadequate

Is the service responsive?

complaints file and found only one complaint which was a brief note referring to a complaint received on the 8 May 2015 but no further details were available. We spoke with the manager who explained they had received a complaint by email on the 8th May 2015, but it was being investigated by the area manager.

The CQC were aware of two complaints that had been made and a number of concerns that were not recorded. We asked the manager if they had any examples of any other concerns raised and the action taken as a result of them. The manager gave examples of issues raised by families and the action taken however none of these had been documented. When concerns and complaints are raised but not documented or investigated following the complaints procedure, providers are not able to evidence any learning from these. The provider cannot identify if there are any themes or trends in the concerns raised. Nor can they ensure any action taken is effective in reducing the risk of further similar complaints. On the second day of our inspection, one of the care plans we looked at identified a compliant made by family members about another person living at the home. There was no evidence of the outcome of this concern and it had not been managed under the complaints procedure as we would have expected.

The manager told us they did not have any records of any complaints made prior to them starting in post in April 2015 and they had not recorded any concerns or complaints made with themselves since being in post. The Management didn't record any issues/concerns/ complaints received or what action was taken as a result. We found this was a **breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

Inadequate

Is the service well-led?

Our findings

One staff member we spoke with told us, "Since the new manager has been in post things have improved 100%. The manager involves staff, they listen and take the time to speak to me and informs me of any additional work that needs to be done on any particular day, the atmosphere is better and it's nice to have a manager that listens, I enjoy coming to work, the staff are all very friendly." Staff were clear about the management structure and they could tell us who they would go to for specific advice.

Another staff member told us, "As the new manager hasn't been here very long it's too early to say if the home is well run, but there is a slight improvement and the manager is approachable and respected." When asked if they were happy in their job they said, "Depends who you are working with, if you're working with good staff who work together it's a nice place to work."

Another member of staff told us, "That since the new providers had taken over the service, the running of the home had dropped. However since the new manager arrived things had started to improve." We were told there were concerns over relationships between the nursing and care staff and one staff member told us they felt the nurses could do more to support the care staff when they were busy. We discussed this with the manager and they told us they were aware of this and it was being addressed.

We were told a recent incident had led to staff working in pairs with a particular person. This improved staff confidence in supporting the person and also ensured the person was protected. Staff were grateful for this but acknowledged it had an impact on their time as staffing had not been increased as a consequence.

We observed literature around the home that was old some of it had not been updated since the previous provider Anchor had left approximately 18 months before the inspection. This left ambiguity as to what procedures the home were following and indeed what service they were providing.

Upon reviewing the available management information within the home It was apparent that the Care Quality Commission had not been informed of all information required under the provider's registration. This included notifications for allegations of suspected abuse including omissions of care and potential neglect. We had received information directly from the Local Authority and not from the home via a notification**. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009**

The deputy manager was also the clinical lead within the home and was responsible for ensuring clinical provision was delivered to people who had nursing needs. We reviewed the records for one person who received their nutrition and hydration via a PEG (Percutaneous endoscopic gastrostomy) tube into their stomach. We saw that on monitoring records used to ensure the person received enough fluid. This person was under their prescribed daily amount on 10 occasions. We spoke with the deputy about this and were told, "I'll have a word with the nurses." We asked if they monitored the records and were told they had not started to do this as yet. The weather was particularly hot and this person may have been at risk of dehydration if their prescribed amount of fluids were not given.

We asked the manager how they monitored the quality of service provision within the home. We were told that they would start to monitor practice but at the time of the inspection this had not begun. We asked to see the previous audits completed and were told that none were available.

We reviewed the available information for accidents, incidents and complaints and found there were none recorded prior to April 2015 and were inconsistencies in what was being monitored following April 2015.

A lack of monitoring and audits did not provide the manager with any information upon which they could seek to drive improvements which meant the quality of the service could not be measured. **This is a breach of Regulation 17 of the Health and social Care Act (Regulated Activates) Regulations 2014.**

We spoke with the deputy manager who was a qualified RGN and had been recently appointed. We saw the deputy manager talking with the people who lived in the home, it was evident they were aware of the needs of the people they spoke with. They noticed one person did not have their radio and they went and got it. The deputy explained the person really enjoyed listening to a particular radio station throughout the day and this was important to them.

Inadequate

Is the service well-led?

For any provider to be confident they are delivering a high quality service they must source feedback from the people in receipt of the service. There was no evidence of any questionnaires or surveys being sent out to people who lived in the home and their families since the provider had taken over. The people who lived at the home and their relatives were not given the opportunity to highlight any issues or concerns or indeed share good practice. The lack of information of this type did not give the provider an opportunity to evaluate provision and implement improvements. As a consequence the general satisfaction of the people in the home was not known. We did however note some recent thank you cards from family members in the foyer.

The home had begun to have meetings with the people who lived in the home and invited the families to these. However it was too early to say whether these were going to be used effectively to drive improvement.

The manager had not undertaken any audits for Infection Prevention and Control, health and safety or on the care plans since coming into post. The manager had not completed any monitoring or auditing of any of the home's systems or procedures to ensure staff were implementing them correctly. We saw one action plan for an audit completed by the area manager on medication. The action plan had not been completed and there was not a system developed to meet the action plan and ensure procedures remained safe.

There had been concerns and safeguarding alerts raised for how the home had managed some people's medication. The inspector had a number of conversations with both the area manager and the provider prior to the new manager coming into post. They had both assured the inspector that steps were being taken to monitor and improve medicines management. It was clear on the days of the inspection this had not happened.

We reviewed the accident records and noted they did not contain all incidents resulting in an injury to the people who lived in the home. There were no records at all prior to April 2015 and attempts to track them down had been unsuccessful. Records since April 2015 did not correlate with records in people's files.

The extra care monitoring records used to manage the risk to people living in the home were in a cupboard, unorganised and in no date order. This meant it was very difficult for them to be used over time to monitor conditions or risks. It was not evident on any of the forms that they had been used to assess or monitor risks.

The lack of health and safety audits meant that risks associated with the building and the equipment had not been picked up. We found nine faults on the nurse bell call system that had not been picked up by the staff at the home. The manager assured us this would be rectified.

There was a lack of established systems and processes in place for the provider to monitor provision at the home. Without this the provider could not ensure they were compliant with the regulations as monitored by the CQC to ensure people are kept safe, services are effective, caring and responsive to people's needs, and they are well led.
This is a breach of regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 8 HSCA (RA) Regulations 2014 General **The registered person had not complied with regulations 9 - 20A of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People's support was not assessed in line with their specific needs. People's needs were not always met.**

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 were not treated with dignity and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Care was not always provided with the relevant consent.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment was not provided in a safe way to people who lived in the home.**

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The home did not have systems to identify and respond to potential acts of abuse.**

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 **Procedures in place to ensure people were in receipt of enough nutrition and hydration were ineffective.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Procedures for managing, investigating, recording and responding to complaints were not implemented.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The service did not have effective systems to monitor the quality of the service provision.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider had not notified the CQC of other incidents that occurred at the home.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	There were not enough suitably qualified and trained staff to meet the needs of people living in the home.