

Prime Life Limited

Brackendale House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Brackendale House is a residential home that provides care, support and accommodation for up to 14 people with mental health needs. There were 14 people living in the home at the time of this inspection.

The service had a registered manager in post. 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.

This inspection found that the provider was in breach of four regulations. These related to safe care and treatment, staffing, dignity and respect and governance.

People did not live in a consistently safe environment because there were not enough staff to manage safety hazards appropriately and ensure the premises were always clean and hygienic.

Identified risks to people's safety were recorded on an individual basis and there was guidance for staff to be able to know how to support people safely and effectively. However, there were not always enough staff to ensure the guidance to minimise risks was followed consistently.

The manager and staff in the home cared about the people they supported and treated people with respect. However, some aspects of the home's environment did not always promote people's dignity and self-respect.

There were a number of systems in place to monitor the quality of the service. Regular audits were also carried out by the manager and provider, in order to identify any areas that needed improvement. However, some of the improvements identified as required were taking a long time to complete and some audits were not effective.

Medicines were managed and administered safely in the home and people received their medicines as prescribed. We identified that some topical medicines such as creams and drops, did not show the dates they had been opened. However, the manager rectified this completely during our inspection.

People were supported by staff who were skilled and knowledgeable in their work and new members of staff completed an induction. Staff were supported well by the manager and the manager was being supported well by their direct line manager. There had been an increase in the level of support from the provider, in respect of improving and maintaining the service, although provider level decisions and subsequent improvement actions were slow.

People were helped to keep safe by staff who knew how to recognise signs of possible abuse and knew the correct procedures for reporting concerns. In addition, staff received training that was relevant for their roles

and appropriate recruitment checks were carried out before staff began working in the home.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The manager and staff understood the MCA and ensured that consent to care and treatment was sought in line with legislation and guidance.

People had enough to eat and drink and made choices about their meals. People's intake of food and drinks was monitored and recorded when needed, although there were gaps in some of these records. When any needs or concerns were identified, appropriate action was taken and referrals were made to relevant healthcare professionals.

Assessments were completed prior to admission, to ensure the service could meet people's needs. People were involved in planning their care so they could receive care and support that was individual to their needs. However, there were not always enough staff to consistently provide individualised support to people.

People living in the home were welcome to have visitors and people were encouraged to be as independent as possible. People were able to voice their concerns or make a complaint if they felt they needed to. Staff listened to people and appropriate responses were given and action was taken where possible.

The manager was well intentioned. People's needs were being met to the best of the manager and staff's ability, with the resources available to them. Communication between the manager, staff and people living in the home was frequent and effective.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

There were not always enough staff to manage safety hazards appropriately and ensure the premises were clean and hygienic.

Risks to people's safety were recorded on an individual basis but there were not always enough staff to ensure the guidance to minimise risks was followed consistently.

Staff knew how to recognise signs of possible abuse and knew the correct procedures for reporting concerns.

Appropriate recruitment checks were carried out before staff began working in the home.

People were supported to safely take their medicines as prescribed.

Requires Improvement ●

Is the service effective?

The service was effective.

People had enough to eat and drink and made choices about their meals.

Staff were supported by way of relevant training, supervisions and appraisals to deliver care effectively.

People's consent was sought and nobody was being unlawfully deprived of their liberty.

People were supported to maintain their physical and mental wellbeing and had access to relevant healthcare services.

Good ●

Is the service caring?

The service was not consistently caring.

Some aspects of the home's environment did not always promote people's dignity and self-respect.

Requires Improvement ●

The manager and staff in the home cared about the people they supported and treated people with respect.

People were able to have visitors in the home and were encouraged to be as independent as possible.

Is the service responsive?

The service was not consistently responsive.

Assessments were completed prior to admission and people were involved in planning their care. However, there were not always enough staff to consistently provide individualised support to people.

People were able to voice their concerns or make a complaint if they felt they needed to.

Requires Improvement ●

Is the service well-led?

The service was not consistently well led.

Systems were in place to monitor the quality of the service and regular audits were carried out to identify areas that needed improvement. However, some of the improvements identified as required were taking a long time to complete and some audits were not effective.

People's needs were being met to the best of the manager and staff's ability, with the resources available to them.

Communication between the manager, staff and people living in the home was frequent and effective.

Requires Improvement ●

Brackendale House

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 was carried out by two inspectors on 13 October and was unannounced.

Before our inspection, the provider completed 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. However, most of this information had been completed generically by the provider and was not specific to the service provided at Brackendale House.

Other information we looked at about the service included statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

Prior to this inspection we were informed of concerns relating to health and safety and infection control from the environmental health officer and a care home audit officer for public health. We reviewed the action the provider had taken in response to these concerns to determine how the provider ensured that people's safety was maintained in the home.

During this inspection we observed care interactions between people using the service and members of staff. We met and spoke with 10 people who were living in the home. Some people were happy to speak with us, whilst others did not wish to engage in a full conversation. We also spoke with the manager, the regional manager and three members of care staff, including senior staff. In addition, we spoke with a member of the local authority's quality assurance team and the environmental health officer, to obtain their views on the quality of the service.

We looked in detail at the care records for four people and a selection of medical and health related records that included most of the people who currently lived in the home. We also looked at the records in respect of staff training and a selection of records that related to the management and day to day running of the

service.

Is the service safe?

Our findings

People living in the home had individual risk assessments, regarding various aspects of their everyday lives. We saw these covered areas such as nutrition and hydration, smoking, personal hygiene, mobility, falls, alcohol consumption, going out in the community, specific health conditions and people's physical and mental wellbeing. Where risks to people's safety had been identified, we saw that these were recorded clearly, with guidance for staff that showed how to support people safely and effectively. Staff had easy access to these documents and we saw that they were reviewed and updated on a regular basis.

However, we observed that the guidance in place to minimise risks for people was not always being followed.

For example, we noted that risk assessments and care plans were in place for one person, in respect of the cutlery and crockery they used. This information explained that because of the specified risks identified, the person should only be given plastic cutlery and crockery. During the lunch period, we saw this person receive their meal on a china plate and use standard metal cutlery. The drinks the person had were also in china mugs.

Although the house rules did not permit it, some people smoked in their rooms. We had some concerns about how safely this aspect of people's lives was being managed. For example, in two people's rooms we noted cigarette burn marks on their furniture, bedding and floors. One person had a half smoked cigarette on their sideboard, plus an unlit cigarette on their table. Another person had a smoked cigarette on the floor by their feet. We also noted that one person had four lighters under their pillow. The manager and staff told us that they had been working with people to try and discourage this. We observed that some people voluntarily left their tobacco and lighters in the office and had agreed to only smoke outside the premises. However, we were concerned that some people had not been supported to understand the risks of smoking in their rooms and that practical steps to reduce the risks had not been implemented.

We observed that a number of people were using multipoint extension leads in their rooms. We saw that some people had kettles plugged into these, as well as other electrical items such as mobile telephone chargers and portable heaters. One person also had a mini fridge. There was a risk that when multiple appliances were plugged in at the same time that the maximum current rating stated for the extension lead could be exceeded.

The provider told us that the extension leads that people living in the home were using had been identified as a source of ignition within the homes fire risk assessment. A fire officer from Norfolk Fire and Rescue Service also visited the home following this inspection, and did not raise concerns in respect of these or the way they were being managed. The provider also explained that all electrical circuits were protected by RCD circuit breakers which would detect an overload. In addition, portable electrical appliances and leads were tested on an annual basis. We acknowledged that these actions helped mitigate the risks of overload and fire.

However, we remained concerned that some extension leads were trailing across the floors in some people's rooms. Some were also visibly dirty and surrounded by clutter. Guidance supplied by Electrical Safety First (formerly the Electrical Safety Council) recommends having additional sockets installed if extension leads and adaptors are relied upon regularly. The extension leads we saw were in constant use. In addition, in the case of portable heaters, guidance from Electrical Safety First also states to make sure that heaters are at least a metre away from combustible materials and never to power a heater from an extension lead. This was not the case in some of the rooms we saw. We were concerned that the risks in this regard were not being managed and reduced sufficiently. This was because people living in the home were not fully supported to understand how to use the multipoint extension leads safely.

A number of areas relating to cleanliness had been reported as requiring improvement action by a care home audit officer for public health in April 2016. We reviewed the action the provider had taken in response to these concerns and saw that a number of improvements had been made, although some areas were still 'work-in-progress'. We saw that the manager was completing regular audits on the cleanliness and hygiene in the home and the maintenance person had a schedule of works that they were in the process of completing. Although the remedial works were in progress, some of the improvements had not been completed in a timely fashion.

For example, although some sanitary ware had been replaced in the home, the toilet in one shower room remained very badly stained and needed replacing. One person's commode was also visibly unclean and worn and also needed replacing.

One person's room was very cluttered and the floor was deeply littered with various items. We saw it was recorded that this person's room had been deep-cleaned by an external contractor in July 2016. When we asked how much the room had been cleared out for deep cleaning, we were told that it had not. We were told that the cleaners had only deep cleaned the areas they could get to. The provider told us that substantial efforts had been made to clear the room prior to its cleaning. However, this meant the deep cleaning could not have been effective and there had been insufficient oversight by the provider to ensure this had been done to the required standard.

These concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff supporting people living in the home had a good knowledge and understanding of people's individual needs. However, we identified that there were not always enough staff to be able to consistently provide the necessary support to each person individually. For example, one person's care records stated that they needed regular support to clean and tidy their room but we saw that this was not happening.

We determined that the standard ratio of two support staff during the days, plus one to two days per week for domestic staff, was not enough to ensure 14 people were supported fully with their identified needs. This arrangement was insufficient to support people with their physical and emotional needs in addition to cooking, general cleaning and maintenance, laundry, medicines, shopping and record keeping.

At the time of this inspection, the cleaning hours were being undertaken by a designated member of staff on one to two days a week. During this inspection, the provider confirmed that external cleaning contractors were being sourced and were expected to be in place by the beginning of November 2016. This additional resource would be cleaning in the home seven days a week for two hours a day.

The manager explained that additional staff were always brought in to accommodate people's individual

appointments or activities when needed. In addition, the manager told us that they had recently applied for additional funding for one person, in order to be able to provide them with one-to-one support that had been identified as needed. Following this inspection we received confirmation that this additional one-to-one member of staff was now in place on the daily rotas. The manager also told us that the provider had agreed for the care staffing hours to be increased by approximately 20 hours extra per week.

We acknowledged that the steps that the provider was taking to improve the staffing levels would have a positive impact on the people living in the home, as well as the environment as a whole. However, as the changes had not yet taken place, we were unable to determine the overall impact at the time of this inspection.

These concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living in Brackendale House. One person said, "They [staff] are very good here, they look after us very well and make sure we're okay." Another person told us, "If I've got a problem or need someone to talk to at four in the morning they [staff] are there; I can just get up and go and talk to them. Staff and where we are make me feel safe."

The manager demonstrated that they understood what constituted abuse and told us they followed the correct reporting procedure as and when necessary. Staff also told us that they were confident with regard to recognising signs of possible abuse and said they reported anything they were concerned about straight away. We saw that safeguarding information was available for people living in the home, visitors and staff. This information included details of who to contact in the local authority's safeguarding team. The staff training records we looked at showed that staff had received training in protecting vulnerable adults, which also helped ensure they knew how to keep people safe.

Maintenance and health and safety checks were carried out regularly by designated members of staff. These checks included fire alarm tests, fire drills, safe management of water systems and Legionella. Legionella is a bacterium which can grow in water supplies and can cause people to become ill. We also noted that the service had clear evacuation plans for day time and night time. In addition, there was a business continuity plan, to ensure the service could continue to operate in the event of an emergency.

A discussion with the manager and the Provider Information Return confirmed that appropriate recruitment procedures were followed. This helped ensure that all new staff were safe to work with people who lived in the home. We were told that all staff were checked for suitability with the Disclosure and Barring Service (DBS) and appropriate references were obtained before they started working in the home.

We noted that some topical medicines, such as creams and drops, did not have the dates they had been opened. This is important, as the effectiveness of such items can deteriorate and only have a limited lifespan once opened. We raised this with the manager, who took immediate action and replaced pre-opened items with new and dated each one.

In all other areas looked at, we found that medicines were managed and administered safely in the home and people received their medicines as prescribed. We looked at the medicines storage and recording systems and saw that people's medicines were appropriately and securely stored. Some people also had lockable facilities in their rooms, for storing items such as topical creams or if they wished to self-medicate. All the records we looked at, including the medicines administration records (MAR), were clear, up to date and completed appropriately.

Is the service effective?

Our findings

People who lived in the home felt they were supported by staff who were skilled and knowledgeable in their work. One person told us, "The staff here are fantastic!" This person added that they believed staff knew exactly what they were doing and understood how to support people properly. They said, "I certainly wouldn't want their job. They have to keep on their toes, it's a real mixed bag here and no one knows how people are going to be from one minute to the next."

The manager and staff we met with during this inspection had a good knowledge of each person's individual needs and people were mostly supported by staff whom they were familiar with.

The manager explained how all new members of staff completed a full induction process, which included completing essential training courses that would be relevant to their roles. Some of the training we noted that staff had undertaken included fire safety, food safety, medication, safeguarding, nutrition, mental health, behaviours that may challenge, Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (MCA DoLS). Staff and the manager told us that supervisions and appraisals also took place on a regular basis.

All the staff we spoke with said they were happy in their work and felt supported by the manager and each other. We noted that communication between the staff team was frequent and effective. For example, information was handed over appropriately at the end of each shift and daily discussions were constant, regarding aspects of people's physical and emotional wellbeing. Formal staff meetings were also held.

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 the mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

The manager and staff told us that they understood the MCA and ensured that consent to care and treatment was sought in line with legislation and guidance. They also demonstrated that they followed the principles of the MCA when they needed to make decisions on behalf of people lacking capacity. The manager told us that capacity assessments had been completed for a number of people who lived in the home and an application for DoLS had been submitted for one person. This application had been made due to the person being unable to leave the home when they wanted to, without full staff support, and because they required close supervision and one-to-one staffing whilst in the home.

We saw that one person had been involved in putting their own 'end-of-life considerations' in place, such as do not attempt cardiopulmonary resuscitation (DNACPR). We also saw that this person had recently told staff that they wanted to write a will, which staff were supporting them to do, with help from the person's social worker.

During the course of this inspection we saw people having their lunch time meal. People told us they had enough to eat and drink and said that they enjoyed their meals. We also saw how people contributed ideas for the menus during house meetings and the quality assurance surveys. People had chicken curry for their lunch during this inspection but people told us they could have something else if they didn't like the main choice. We saw that one person chose to have a bowl of cereal for their dessert, which they were able to help themselves to.

We noted from the 2016 Quality Assurance results that out of 14 people who lived in the home, 11 people had given positive ratings for the menus and meals. We also looked at the manager's response to the survey results. This stated that a separate menu survey would be carried out to establish what people would like to have on the menu, particularly when the seasons changed.

We saw that the meal time was relaxed and people were not rushed with their meals. People also chose where they wanted to eat their meals. For example, some people ate in the lounge, whilst others chose to sit at the tables in the dining area. Staff confirmed that they understood people's individual dietary requirements and there was clear information available for staff in respect of any allergies.

We saw that staff had completed a screening tool for each person (MUST), to identify anyone who may be at risk of malnutrition. Staff and the manager explained that when these risks were identified, people's intake of food and drink was monitored and recorded. This would enable appropriate action to be taken promptly, to help ensure people stayed healthy and well.

In respect of people's general physical and mental health and wellbeing, we saw that people had regular access to relevant healthcare professionals when this was needed. For example, one person told us how they had been to the chiropodist on the morning of this inspection. The manager and staff also told us that they regularly sought and followed guidance from external healthcare professionals. This helped people to be supported and cared for effectively.

Is the service caring?

Our findings

The care records we looked at reflected people's personal histories, wants, needs and preferences. However, we concluded that staff did not consistently have the time to support people with their preferred lifestyles. For example, we saw it recorded that some people needed regular support and monitoring to keep their rooms clean and tidy. However, some of these people's rooms were in a very poor condition, particularly with regard to cleanliness. Staff told us they tried to spend time with each person individually on a weekly basis but it was evident that some people's needs for support in this area required more regular individual input.

With regard to the overall environment during this inspection, we concluded that dignity and respect was not consistently promoted. Although staff genuinely cared about the people living in the home, an evident lack of time and resources meant that people were experiencing an inferior quality of life in some areas.

Staff did not consistently encourage and promote individuals with their self-respect. For example, some people were wearing clothes that were very worn, torn and dirty. Some of the clothes people were wearing had obviously not been laundered for some time. The provider told us that these people had clean clothes available to them in their rooms but chose not to wear them. However, for one person, we saw it was recorded that they required 'all help with personal hygiene'. We acknowledged people's rights to make unwise decisions, where they had capacity, but concluded that insufficient support and encouragement was being provided in areas regarding people's personal hygiene.

We saw that the bed linen in some people's rooms was visibly dirty, missing, badly creased or in poor condition. For example, although one person's bed had been made and their room was relatively clean and tidy, we noted that their pillow case was visibly very dirty. The manager explained that this was because the person did not like to wash their hair. In addition, we noted that although this person was not a smoker, there was a cigarette burn hole in the person's duvet cover. This demonstrated that the person's dignity was being compromised. This was because the person was not enabled to change their linen on a more frequent basis, nor able to have their own linen, of a style and quality they may prefer.

On visiting the communal bathroom, with a toilet, on the first floor, we found that the door did not close properly without being lifted into place. In addition, once the door was closed, we found the lock did not work. There were no blinds or curtains at the window and there was clear visibility to and from a person's bedroom when inside this bathroom. A communal downstairs toilet also did not have and curtains or blinds at the window and the glass, although textured, could be seen through clearly. This window looked out onto a neighbouring house and was at ground level where people walked outside on the garden path. This meant that people were not assured of their privacy or dignity when using these rooms.

Following this inspection, the manager confirmed that they had addressed these issues and that the maintenance person had fixed the bathroom door and installed blinds in both rooms. The provider's action plan for improvements also showed that some of these areas were work-in-progress. However, some required actions were unacceptably slow in being completed and should have been identified and

remedied sooner.

These concerns constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the staff in the service were caring. One person said, "Yes, I think they actually do care about us here. They [staff] are always very kind and nice to us."

All the staff on duty during our inspection had a good knowledge and understanding of each person. Discussions with the manager and staff, plus our observations of staff interactions, confirmed this. We saw that staff interacted well with people in a warm and friendly manner and observed mutual joviality and light hearted conversations during our inspection. People were comfortable in the presence of the staff who were supporting them. We also saw that staff gave their full attention when people spoke to them and noted that people were listened to properly.

People who lived in the home had been involved in planning their care, as much as they wanted to. This was evident from the information we looked at in people's care records, observations and discussions with people who used the service.

Visitors were welcome without restrictions and, where possible, people had regular contact with family members or friends. For example, we noted that one person had a friend who visited on a daily basis and stayed for lunch with them. If people did not have any family, we noted that they were supported to access an independent advocate if they wished.

Is the service responsive?

Our findings

A discussion with the manager and information in people's care records showed that each person participated in an assessment, prior to their admission to the home, to help ensure their needs could be met. We saw that these pre-admission assessments were used to form the basis of people's care plans and risk assessments.

We saw that people had been involved in planning their care, to help enable care and support to be provided that was individual to their needs. However, we noted that although staff were quick to respond to any requests for assistance, there was little time for staff to be proactive with regard to consistently supporting people in a person centred way. Although staff's approach with people was individualised, the lack of resources meant that staff were inevitably task orientated.

The contents of people's care plans were personalised and gave a full description of need, relevant for each person as a unique individual. The information we saw included people's preferred routines, things that were important to or for the person, hobbies and interests. In addition, we saw information that explained how each person needed to be supported with their physical and mental health and wellbeing. People's care records also included risk assessments, which we saw were reviewed and updated on a regular basis. However, our observations and discussions confirmed that staff were not always able to act in accordance with people's care plans, due to time constraints.

We saw that people living in the home mostly made decisions for themselves on a daily basis in respect of what they wanted to do and how or where they wished to spend their time. During this inspection we saw some people spending time in their own rooms, while some spent time in the communal areas within the home. Some people accessed the community independently and some spent time outside in the garden.

We saw the home had a communal games room, which was equipped with items such as musical instruments and board games. However, we did not see anyone using this room during our inspection. When we asked one person about the activities in the home they told us, "I do a lot on my own. It's nice when they [staff] can do something with people but they don't always have enough staff for that." A member of staff told us that they tried to spread their jobs out, so they could spend more quality time with people and said, "We do try our best but time is very restricted." They added that making sure everyone was safe was the most important thing.

The results from the 2016 quality assurance survey showed that nine people out of 14 had responded positively when rating the activities and events in the home. However, five people had provided negative responses. The manager had stated that they would establish what people would like to do, that was meaningful to them, to occupy their time and include this information in the care plans. The manager also told us that significant improvements would be made when the increases in staffing levels and resources were implemented in November 2016.

People told us that they could make a complaint if they needed to. One person said, "Oh I'd soon say if I

wasn't happy about something. [Name] is my keyworker but I talk to them all." Other people said they could raise any concerns at any time with the manager or staff and felt they would be listened to properly.

Is the service well-led?

Our findings

The provider's nominated individual visited the service on 5 October 2016 to provide oversight for the home. A further visit was scheduled for 19 October 2016. The visit report showed that the nominated individual had reviewed the progress of the required improvement works. As a result of this visit, we saw that the nominated individual had authorised additional refurbishment work to be carried out.

Although we saw 'work in progress' for a number of required improvements that had been identified, some actions were not completed in a timely fashion. For example, one person's window had been badly cracked for some weeks prior to our inspection. We saw that this had been made safe by a covering of protective film but was not scheduled to be replaced until the time at which other windows and frames in the home were due to be done. We were told that these works had begun to be carried out with effect from 10 October 2016 and were expected to take four to six weeks to complete. However, as all the work had not yet been completed, we were unable to determine the overall impact at the time of this inspection.

There were a number of systems in place in order to ensure the quality of the service provided was regularly monitored. For example, we saw records of a weekly action plan that the manager completed. This showed aspects of work that had been completed such as interviews for new staff, arranging funding reviews for people who lived in the home and completing inductions with new care staff.

The manager also completed a regular 'work session record' with their line manager. This was an audit tool that enabled checks on the progress of various required works, as well as confirming when work had been completed. We saw from the records for September and October 2016 that some areas still required action, which had been ongoing since May 2016. For example, the infection control action plan still needed to be completed.

Care plans and people's individual assessments in respect of risk, were audited, reviewed and updated regularly. The manager and designated staff also carried out regular audits covering areas such as health and safety, medicines, falls, accidents and incidents. However, these were not always effective. For example, we were concerned that the health and safety audits had not identified that the risks in respect of the extension leads were not being sufficiently managed or reduced.

We looked at the food and drink records for three people who were currently being monitored. We saw that these were not always being fully completed, with gaps on a number of days. We also noted that one person regularly refused food and drink that was offered by the service and frequently declined to be weighed. Although staff explained that the person often preferred to buy their own food and drink, there was no system in place to confirm when this was the case. There were also no guidelines in place to determine whether the person was losing weight or when a referral to the GP or a dietician may be necessary. These omissions in people's records had not been identified during the audits that were undertaken.

We concluded that when audits of the home identified any negative trends, the risks were not always being mitigated in a timely way. For example, a fire officer from Norfolk Fire and Rescue Service completed a

follow up visit at Brackendale House on 27 October 2016. This person confirmed that the outstanding fire safety works had been completed and that no further intervention by the fire department was currently planned. However, the fire officer also stated that there did appear to be undue delay between defects being identified and works being carried out.

These concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that the manager and staff managed Brackendale House well on a day to day basis. The staff we spoke with said they enjoyed their work and were passionate about their responsibilities. One member of staff said their job was, "very rewarding" and told us how they had been given more opportunities in recent months to act as a senior.

There was a registered manager in post, who understood their responsibilities and reported notifiable incidents to CQC as required. The manager was responsible for both Brackendale House and another nearby service, also owned by the provider. Although divided between the two locations, we saw that the manager had an open door policy and was clearly visible within the home.

We noted that people living in the home had opportunities to provide feedback regarding the quality of the service provided, by way of daily discussions, quality assurance surveys and 'residents' meetings. The manager told us that, where possible, suggestions for improvements were listened to and action taken, with the involvement and inclusion of the relevant people. For example, we saw comments in the minutes from a 'residents' meeting that people were concerned about the rear garden being uneven and a trip hazard. We saw that a new decking area had been installed to rectify this issue. One person told us, "It's so much better now with this new decking, it was very uneven before and you couldn't walk round here without tripping over."

Communication between the manager and the staff team was noted to be frequent and effective, with daily discussions and formal staff meetings. The staff meetings covered aspects such as training, housekeeping and other service specific topics. On changing shifts, staff handed over information to each other and discussed the health and wellbeing of people living in the home. Any concerns, issues or requirements were highlighted at this point, to ensure people had continuity of care. We also noted that the staff team as a whole regularly took note of people's comments, thoughts and feelings to help try and ensure they could have a good quality of life.

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	<p>Regulation 10 HSCA RA Regulations 2014 Dignity and respect</p> <p>People who use services were not protected against the risks associated with a lack of dignity and respect in relation to the environment they lived in.</p> <p>Regulation 10(1)(2)(a)</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>People who use services were not protected against the risks associated with untimely and inadequate action to reduce identified risks.</p> <p>Regulation 12 (1)(2)(b)</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>People who use services were not sufficiently protected because the provider did not take timely action to mitigate identified risks.</p> <p>Regulation 17(1)(2)(a)(b)</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>People who use services were not protected against the risks associated with insufficient</p>

staffing levels to fully support people, as well as maintain the environment appropriately.

Regulation 18 (1)