GCH (South) Ltd

Brackenbridge House

Inspection report

Brackenbridge House
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced inspection of Brackenbridge House on 5, 6 and 11 September 2017.

Brackenbridge House is a residential home and is part of GCH (South) Ltd. It provides accommodation for up to 36 older people in single rooms. The home is situated within a residential area of the London Borough of Hillingdon. At the time of our visit there were 28 people using the service.

The provider transferred and re-registered Brackenbridge House under a new limited company in May 2017. The location had previously been inspected but this is the first rating for the service since the change in registration.

At the time of the inspection the service did not have a registered manager in place. The previous manager joined the service in January 2017, registered with the CQC in May 2017 and left the service in July 2017. An interim manager had been in place for three weeks before the inspection but their contract ended on the second day of the inspection. The regional manager explained the provider had arranged for a new manager, from another part of the organisation, to start working at the service shortly after the inspection and would be in post for one year.

The provider had a policy and procedure in place for the administration of medicines but this was not always followed by care workers. Records did not accurately show when medicines were administered and if people received all their medicines as prescribed.

Incident and accident records were not reviewed and actions were not identified to reduce potential risks to people using the service.

Care workers had not completed training identified as mandatory by the provider or received supervision and appraisal from their manager to support them to provide safe and appropriate care.

The provider had a policy in relation to the Mental Capacity Act 2005 but was not always working within the principles of the Act to ensure people's care was provided in their best interests and safeguards were in place if required to protect their rights.

The provider had a range of audits in place but some of them were not effective and did not provide appropriate information to enable them to identify any issues with the service and take action to make improvements.

Records relating to care and people using the service did not provide an accurate and complete picture of their support needs which meant care workers were not given accurate information regarding people's care needs.

People had access to a range of healthcare professionals but the outcomes of the referrals and instructions from the healthcare professionals were not always recorded appropriately to provide an audit trail.

People using the service felt the care workers were caring and treated them with dignity and respect while providing care.

The care plans identified the person's cultural and religious needs as well as the name they preferred the care workers to call them by. People could take part in a range of activities.

People knew how to make a complaint if they had any issues in relation to the care received but complaints had not always been dealt with in line with the provider's policy..

People using the service, relatives and care workers felt the lack of a long term registered manager had affected how the service was managed in relation to service delivery and staff support.

We found a number of breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches relate to safe care and treatment of people using the service (Regulation 12), safeguarding service users from abuse and improper treatment (Regulation 13), good governance of the service (Regulation 17) and staffing (Regulation 18). You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

The provider did not ensure medicines were managed safely

Incident and accident records were not reviewed and actions were not identified to reduce possible future risks.

The provider had a recruitment process in place to ensure care workers had the suitable skills and experience to provide appropriate care.

There were risk assessments in place in people's care folders in relation to the care being provided.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider had a policy in relation to the Mental Capacity Act 2005 but was not always working within the principles of the Act to ensure people's care was provided in their best interests and safeguards were in place if required.

Care workers had not completed training identified as mandatory by the provider or received supervision from their manager to support them to provide safe and appropriate care.

People were supported to eat their meals and to make choices from the menu by staff providing photographs of each option available.

Is the service caring?

Good

The service was caring.

People using the service felt the care workers were caring and treated them with dignity and respect while providing care.

The care plans identified people's cultural and religious needs as well as the name they preferred the care workers to call them by.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

An initial assessment was carried out before the person moved into the home to ensure the service could provide appropriate care. Care plans were developed from these assessments but these had not been regularly reviewed to ensure they reflected people's current needs.

People could take part in a range of group and individual activities at the home.

The provider had a complaints process in place but complaints had not always been dealt with in line with the provider's policy. People knew what to do if they wished to raise any concerns.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

Records relating to the care of people using the service did not provide an accurate and complete picture of their support needs as information was not consistently recorded.

The provider had a range of audits in place but some of these did not provide appropriate information to identify areas of the service requiring improvement so these could be addressed.

People using the service and relatives felt the service was well-led but there had been an impact due to the lack of a long term manager. This meant a consistent quality of service was not being provided for all the people using the service.

Brackenbridge 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 took place on the 5, 6 and 11 September 2017 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who has used this type of care service. The expert-by-experience at this inspection had personal experience of caring for older people.

Before the 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. We also reviewed the notifications we had received from the service, records of safeguarding alerts and previous inspection reports. Registered providers need to send notifications to the CQC about certain changes, events and incidents that affect the service or the people who use it.

During the inspection we spoke with 12 people using the service and two relatives. We also spoke with the regional manager, deputy manager, activities coordinator, a senior care worker and two care workers. We also spoke with an interim manager was in post on the first day of the inspection. We reviewed the care records for six people using the service, the employment folders for five care workers, training records for all staff and records relating to the management of the service. We sent emails for feedback to 20 care workers and support staff. We received feedback from seven staff.

Requires Improvement

Is the service safe?

Our findings

The provider had a process in place for the recording and investigation of incidents and accidents but we found this had not been followed by care workers. The deputy manager explained that care workers should complete a form with information about the incident and accident with any actions taken, the form should then be reviewed and records updated.

We saw incident and accident forms completed by care workers had not always been reviewed to identify if any actions could be taken to reduce the risk of the incident or accident reoccurring. People's care plans and risk assessments had not been updated to reflect any changes in a person's care or support needs following an incident and accident. The completed forms had not been reviewed to ensure the appropriate action had been taken to reduce any risks.

During the inspection we saw accident and incident forms indicated one person had experienced six falls over May, June and July 2017 but this was not reflected in the falls risk assessment that had last been reviewed in May 2017. This meant there was no record of the action taken in response to the incident and accident in the care plan or risk assessment to ensure care workers understood what to do so the risk of reoccurrence was reduced.

A process was in place for the administration of medicines but this was not always followed by the senior care workers. On the first day of the inspection we reviewed the medicine administration record (MAR) charts for 28 people and saw the records for some people had not been completed in full. The MAR charts for nine people had at least one occasion when medicines were not recorded when administered. We looked at the same MAR charts again on the second day of the inspection during an audit and found the sections of the MAR charts that had not been completed were now filled in to indicate the medicine was administered. This meant the information may not have been accurate and could not confirm people had received their medicines as needed, as it was added after the date the medicines should have been administered.

We reviewed the medicines provided in their original packaging for eight people and we saw the stock levels of medicines for five people did not match the amount recorded as administered on the MAR chart. The stock levels of medicines recorded on MAR charts had been over written during audits so that the number of tablets matched the number in the box but did not reflect the number that had been administered. This meant it was not clear how many tablets should be in stock based on what had been administered.

A controlled drug was stored appropriately and a controlled drug book was used when administered with two senior care workers signing the book to confirm it had been administered. We saw the prescribed dosage of a pain relief patch had been amended by a person's doctor and the appropriate strength patch had been provided by the pharmacy but the staff had not amended the dosage in the controlled drugs book.

The regional manager confirmed that in August 2017 the evening medicines for some people had not been

administered for one week as they had not been recorded when delivered and placed in the medicines trolley. This included a transdermal patch for one person which had not been applied on two occasions covering a two week period. The regional manager confirmed weekly audits had been implemented when this was identified to prevent it from happening again and the GP was contacted to ensure no harm had come to the people due to missing their evening medicines.

Care workers were not recording why people had refused prescribed medicines and action was not taken if the person repeatedly refused to take a medicine to make sure they continued to receive the treatment they needed. There were no records of referrals to the GP to review the medicines prescribed to see if they would be more suitable being prescribed in other ways, such as PRN (as required).

The records relating to the application of prescribed creams did not include specific information in relation to where creams should be applied with some records not including the frequency of application as well. We saw the prescribed creams MAR chart for one person and the details of application were 'apply to areas' with no other information. This meant the care workers were not given detailed information to ensure the topical medicines were applied as prescribed by the GP.

When we arrived for the inspection we found key pads had been installed on internal fire doors along the corridor on the ground floor and to access the stairs from the first floor. We asked the interim manager why these had been installed and we were told some people at the home would walk into other people's bedrooms so this meant they could not access the bedroom areas. The access code for the keypad was displayed near the keypad so people were able to open the door if they were able to use the system. People did not have risk assessments in place to identify if there was an issue with accessing other people's bedrooms. We saw that people using walking frames had difficulty in using the keypad and then opening the door whilst using the frame for support. These issues were discussed with the regional manager who confirmed the keypads on the ground floor would be removed once the fire door closure system which had been removed when the key pad was installed could be located and replaced on the door.

A bathroom located on the ground floor had been turned into a storage room but the door had not been locked which meant it could be easily accessed. The room was used to store tins of paint, cardboard boxes and mattresses. There was a risk of a person going into this room as the door still had a sign stating it was a bathroom and not being able to leave the room without support.

The provider had a range of risk assessments in place for people living at the home. Each person had risk assessments relating to moving and handling, the use of bed rails, skin integrity and access to a front door key. Other risk assessments were in place for the use of reclining chairs, falls and continence. Some of the risk assessments had not been reviewed since July 2017 with others not being updated to reflect possible changes in the person's support needs following incidents and accidents. The provider's policy was that risk assessments should be reviewed monthly with the care plan.

We saw each person had a Personal Emergency Evacuation Plan (PEEP) which identified the support they would need to leave the home if an emergency occurred. As part of the monthly review of care plans and risk assessments the person's PEEP should also have been reviewed. We looked at the PEEPs for six people and we saw these had not been reviewed monthly with two people's PEEPs last being reviewed in May 2017. This meant the PEEP documents did not provide up to date information regarding the person's support needs in case of an emergency

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

People we spoke with told us they felt safe when they received support from the care workers. The regional manager told us a new system was now in place to record the information from safeguarding investigations. We saw records included detailed information. Each person could choose to have a pendant alarm which was linked to the call bell system of the home so they could alert care workers if they required assistance.

We asked people if they felt there were enough care workers on duty at the home. The majority of people we spoke with commented that they did not feel there were enough care workers on duty. Their comments included, "At weekends there's nobody here. Definitely not enough staff and everything is pushed/rushed, you don't feel relaxed", "One more member of staff is needed to help with one to one care for some residents", "Staff should be better trained and a few more...", "Staff do get busy especially after six in the evenings. If I don't feel well enough to come down to dining room they bring my dinner up to my room" and "They haven't got enough staff. There have been lots of staff changes." During a meal one person asked the care workers for help to go to the bathroom. When this happened another person told us, "The worst thing is the time you have to wait, to be served or whatever. I think it's because there is not enough staff. I seem to want to have to go (to the toilet) quite often and it's a bit painful."

Care workers told us that sometimes there are not enough of them on duty but at other times there are. Their comments included, "I am on the nights and I believe that an extra carer is needed as it can be hectic to work with only two carers as sometimes there is a double up and when the bells are going at the same time it makes it impossible to answer, hence residents have to wait a little longer than they should", "I don't think there are enough staff especially at week days on duties, weekends are very busy and I am a very hardworking person helping people to have a bath, shaved man and changed beds", "Staffing levels vary on a day to day basis, some days we are short other days enough. Over the last few weeks the staffing levels have improved and we seem to be back on track" and "During the day and weekends yes, but I do not think there is enough staff at night but I have not witnessed a night shift so cannot comment from experience."

At the time of the inspection there were 28 people living at Brackenbridge House with one person requiring two care workers to assist with personal care. The regional manager told us there were either two senior care workers and three care workers or one senior care workers and four care workers on duty during the day. At night there was one senior care worker and two care workers on duty. During the inspection we did not see anyone waiting for an extended period of time for support and care workers responded quickly to the call bell.

During the inspection we looked at the recruitment records for five care workers and we saw all the required paperwork was in place. This included two references, notes from the interview and checks to ensure the applicant had the right to work in the United Kingdom. A Disclosure and Barring Service (DBS) check in relation to checking for criminal records was carried out before the new care worker started working in the home. This meant that checks were carried out on new care workers to ensure they had the appropriate skills to provide the care required by the people using the service. Profiles for agency care workers had been provided to the home to ensure any additional care workers had the appropriate training and checks completed.

We saw care workers used aprons and gloves when providing personal care and had access to hand washing facilities. The home was clean and tidy with no malodour present. Records indicated care workers had not completed infection control refresher training.

Requires Improvement

Is the service effective?

Our findings

During the inspection we looked at the personal records for five care workers and we saw there was no information to indicate they had completed an induction when they started to work at the home. There was also no record of them shadowing an experienced care worker or their competency in the role being assessed before they started to provide care to people on their own. The deputy manager confirmed that new care workers would complete an induction to gain an understanding of the policies in place at the home and to get to know the people living there. They also told us new care workers should shadow an experienced care worker and be assessed to ensure they had the appropriate skills for the role as part of their induction. The regional manager confirmed new care workers would complete the Care Certificate as part of their four day induction. The Care Certificate identifies specific learning outcomes, competencies and standards in relation to staff new to health and social care. During the inspection we did not see any paperwork in the care worker records we looked at indicating the care certificate had been completed.

The provider had identified a range of mandatory training courses which were completed either annually, every two years or three yearly. We looked at the training records and saw five care workers and six support staff were not up to date with the annual moving and handling refresher training. Ten care workers had not completed the annual refresher for safeguarding adults with one care worker last completing the training in 2014. The provider had identified infection control training to be completed every two years but records indicated 13 care workers had not completed the refresher training. We saw 17 care workers were not up to date with first aid training which should be completed every two years. Other training which had not been completed by care workers included health and safety and control of substances hazardous to health (COSSH). This meant care workers had not completed the training identified as mandatory by the provider to enable them to provide care in an appropriate and safe way.

The regional manager told us the expectation was that all staff should complete five supervision meetings per year. We looked at the records for supervision sessions for care workers and saw regular meetings had not been held. The regional manager confirmed that between January and August 2017 some group based supervision meetings had been held but there were limited meeting with individual care workers. The regional manager also confirmed annual appraisals had not been carried out with care workers during 2016.

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

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 so that they can receive care and treatment when this is in their

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

We asked for the records indicating when applications under DoLS had been made and authorised for people using the service. These records were not up to date but were amended during the inspection to indicate when DoLS applications had been authorised and should be renewed. The amended records showed DoLS applications for three people had been made up to six months before the inspection but the authorisations had not been received. There were no records indicating staff had contacted the local authority for an outcome of the application. This meant the three people were receiving care without DoLS authorisations in place and not within the principles of the MCA.

The records for one person indicated a DoLS application had not been authorised as the person was assessed as having capacity to make decisions but consent to the use of bed rails was signed by a relative. There was no evidence the relative had the legal authorisation to sign consent on behalf of the person.

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

People had access to a range of healthcare professionals but sometimes information following a visit was not always recorded in the person's care records. The regional manager confirmed people had regular visits from an optician if required and we saw a copy of the person's prescription for glasses was kept in their care records folder. People could go to visit a dentist or they could have an appointment at the home. They could also see a chiropodist but information relating to dentist and chiropodist visits was not recorded in the person's care records. The area manager confirmed a review of the processes in place for recording information from visiting healthcare professional and following appointments could be completed.

We asked people their views of the food and drinks provided at the home. Most of the people we spoke with were happy with the food and drinks provided. One person commented they felt there was not enough tea. Other comments we received included, "The food is not bad, nothing like home cooking but as long as it's hot", "There is a good choice, usually two dishes per day", "The food was a bit monotonous", "There was plenty of food, and the food is not bad, there are two or three choices", "Food is pretty good" and "The food is sometimes alright, sometimes not. Get a lot of minced up stuff." One person told us, "The food is horrible, not cooked."

A relative told us that her family member spent most of her time in her bedroom as it was safest for her and also that is what she preferred but the care workers always made sure she was hydrated. They also told us their relative ate all her food but they had never tasted it themselves.

We saw a list of people's food preferences with any allergies and restricted food due to religion or medical conditions, in the kitchen. Information was also provided in people's nutrition care plan to indicate the person's preference for food. Each person was asked their preference for lunch from the options on the menu during the morning. Care workers supported people to maintain a healthy diet whilst also enabling them to eat their favourite food. We saw the menu options were explained and other possible options for lunch were also offered if the person did not like what was on the menu. A picture based menu was displayed on each table in the dining room. People also had access to snacks including homemade cake during the day. We saw people could choose where they preferred to eat their meals and care workers provided support when required. During meals in the dining room people were encouraged to eat and the

interaction with care workers was positive.

Good

Is the service caring?

Our findings

People using the service and relatives felt the care workers were kind, caring and treated then with dignity and respect when they provided support. Their comments included, "As far as friendliness and cheerfulness they (the staff) are excellent. Has a real family atmosphere. I felt that from the beginning and I have been here 9 years", "The staff are very good. They are very accommodating and allow me to stay up. I am happy but some people want more. I would recommend anyone to come here and live", "Staff are kind, some more than others", "The staff on the whole, they are very good", "I get the impression that because we are old, they don't care. Some of the girls are very good" and "The night staff worker had been very good."

One person when asked if the care workers were kind and supported them told us, "Because I have all my faculties I don't think I get the care and attention I should. I have asked for a bath and have to wait, keep being put off. They haven't got enough staff and there have been lots of staff changes. Sometimes they shout a bit, sometimes they haven't the patience. Some are caring."

Relatives commented "The staff are very kind. They kept me informed about my relative. The staff were fantastic" and "They are always short staffed. To be fair the staff that are here work their socks off. They are running around like headless chickens."

During the inspection we saw the care workers supported people in a kind and caring way and demonstrated they understood each person's likes, dislikes and how they wanted their care to be provided. The care workers spent time with people in a social setting as well as providing care, having a chat and the laughter could be heard around the home. People were relaxed but if they needed some quiet time the care workers identified this and made sure people were where they wanted to be in the home, be it in the lounge or their room.

We asked care workers how they supported people in maintaining their independence when they provide care. They provided a range of examples which included, "Ensure independence is not taken away so they are encouraged to walk, if they can- choose their own clothes and any other things that they can still do for themselves" and "Prompting the individuals independence is allowing them to still do things for themselves i.e. Washing what they can wash, choosing their own clothes etc. Residents are asked what they would like for meals not just given something. Let them make their own choice as best as they can."

We saw the care plans identified the person's cultural and religious needs as well as the name they preferred the care workers to call them by. Where available, information about people's personal histories was included in the care plans to provide care workers with additional information about the people they were supporting. This meant care workers had information so they were aware of people's cultural or religious needs that could affect the way care should be provided.

Requires Improvement

Is the service responsive?

Our findings

Most people we spoke with told us they knew how to make a complaint, although a few people did not. One person told us they would speak with the activities coordinator if they had any concerns and see if she could sort it out. During the inspection we saw the records for two complaints that had been responded to by the previous registered manager. These records included information from investigations but did not clearly indicate if any additional actions were required to resolve the issues raised. The regional manager confirmed two complaints had been received since July 2017 which had not been responded to in line with the provider's complaints procedure so they had dealt with these complaints directly. We were unable to review the records relating to these complaints as they were not available in the complaints folder at the time of the inspection.

Each person had a care plan folder which included a range of care plans developed from the assessments and discussions with the person and their relatives. Areas covered by the care plans included disorientation, personal care, oral care, nutrition, sleep and medication. The regional manager confirmed the care plans and risk assessments should be reviewed monthly or if there had been any changes in the person's support needs. During the inspection we looked at the care plans for six people and we saw some of the care plans had not been reviewed since July 2017. The regional manager confirmed the care plans had been audited in August 2017 but not reviewed. They confirmed the care plans would be reviewed shortly to ensure the information was accurate. We saw some of the care plans had been signed by the person using the service to show they had been involved in developing these records.

We saw a detailed assessment of support needs was completed before a person moved into the home. The assessments included mobility, social and health issues and were used to develop the care plans and risk assessments. There was also an opportunity for the person to visit the home for lunch and to meet the existing residents before they moved in. We did see the records for one person who had recently moved to the home and saw their admissions checklist had not been completed in full but they did have a full care plan in place.

Most of the people we spoke with told us they enjoyed the activities provided but one person commented they felt they were a "bit babyish" and they would prefer more activities which would "stretch their mind." Another person told us they had been told there would be more outings but in the last four months there had only been any outing. We saw information about activities was displayed on the wall outside the lounge and included photographs of recent events.
The activities coordinator had a very good relationship with all the people living in the home and provided activities with enthusiasm and actively encouraged people to take part. During the morning we saw people in the lounge area were given pages from newspapers and were involved in a group discussion about the news stories of the day.

There was a range of activities throughout the day including identifying famous actors and discussing their films as well as name that tune which involved people singing the songs. The conservatory area had been changed into a space for people to do gardening and a bistro seating area. We asked the activities

coordinator how they supported people and they told us "I discuss the options with them so they can make their own choices. I talk to each resident about what makes them happy for example going to shops to choose their own lipstick. Or to buy present for grandchild then we work together so that they can do it. I also remind residents that the activities don't have to always be group activities and if there is anything they want to do on their own that's alright to."

Requires Improvement

Is the service well-led?

Our findings

The provider had a range of audits in place but they were not effective and comprehensive enough to identify areas of concern and where improvements could be made. Weekly audits were carried out on MAR charts but these did not identify that the administration of medicines was not always recorded and the noted stock levels of medicines did not always reflect actual levels. The log sheet used to record when a complaint was received and what it related to had not been completed since May 2017. This meant complaints could not be monitored to ensure they had been responded to and to identify any trends. The previous registered manager had completed a daily audit around the home to monitor the environment and to ensure safe care was being provided to people. This daily check had not been completed since the registered manager had left in June 2017. The weekly kitchen and dining experience audit had been completed up until the 7 August 2017 and the actions identified had not been recorded as completed. An audit of the care plans had been carried out during August 2017 which identified where information needed to be updated or included but no actions had been taken to address the improvements that were needed.

The dependency assessment for another person was completed and reviewed on the same day shortly after they moved to the home three month before the inspection so this did not provide a current assessment of the level of support required by the person. The records relating to the choices of the person and their social interests were not completed in full as only the front page had been included in their care folder. Therefore care workers could not access some of the information relating to the person.

The nutrition care plan for one person stated that their weight was stable but this was not accurate as care workers had been unable to record the weight of the person for a number of months. The records for this person relating to skin integrity did not provide up to date information relating to a pressure ulcer identified the previous month. This meant the information was not consistent across the records and did not provide care workers with accurate information.

The records relating to visits from healthcare professionals were not always recorded in a consistent location in the care records or GP book. This meant other healthcare professional and care workers could not ensure they were accessing up to date information. When a GP visited the information about the people they saw and any changes to their prescribed medicines or care was not always recorded consistently. The information would be recorded in the GP book or on a multidisciplinary log sheet but there was no consistency in how this was done. The information was not transferred into the persons care plan's or risk assessments. We saw the multidisciplinary log sheet for one person provided information from the GP in relation to how to care for a wound but this information was not transferred to the care plan. The deputy manager told us that an out of hours GP had been called out for another person but did not access information recorded following a previous GP visit as they had not used the same document to record the outcome of their visits.

The care plan describing the morning routine for another person stated they preferred to have their breakfast in the dining room after their personal care has been completed. The nutrition care plan stated the person preferred to have their breakfast in their bedroom. Both documents had been reviewed on the

same date in July 2017 but there was an inconsistency in the information recorded.

During the inspection we saw the records relating to personal care provided, food and fluid intake and continence records had not been completed for 12 people for more than five hours during that day. An agency care worker was responsible for completing these records but these had not been checked by senior staff to ensure the information was being recorded as care was provided. This meant the records of care were not accurate or contemporaneous.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During the inspection it was identified that some statutory notifications relating to injuries and deaths of people using the service had not been submitted during August 2017. Statutory notifications are for certain changes, events and incidents affecting the service or the people who use the service that providers are required to notify us about. The regional manager reviewed the information and it was found that these notifications had been submitted using the wrong identification code for Brackenbridge House. These notifications were resent and the information corrected.

The regional manager explained a range of audits had recently been introduced including accidents and incidents, housekeeping, pressure ulcer care and medicines. Information from the various audits would be recorded on a central system which would be used to identify any trends and ensure any actions were completed.

We asked people and relatives of people living at the home if they felt the home was well led. Most people felt it was but the lack of a consistent registered manager was an ongoing concern. Their comments included, "On the whole, no. Can't put my finger on it. The staff keep changing and they haven't got a settled manager. Am I happy? Some things I'm not quite happy with – think it's because they are short of staff. Everyone's rushing around", "It is well run", "Yes it is well run. We've changed managers. Staff are very kind", "Not bad, not perfect", "Runs pretty well" and "Could be a lot better. The two ladies that run it have got families and they are not here enough. They need to spend more time in the home." A relative commented, "They've had their ups and downs. The staff are fantastic but I am aware they have management issues. In the last three to four years they have had a high turnover of managers. Not helpful for the staff. The deputy manager keeps them together but they need a manager overall."

Care workers comments identified the lack of regular manager as an issue in relation to how well-led the service is. Their comments included, "I believe if Brackenbridge got the right manager to be in charge of the home, it could be one of the most outstanding places of care for the elderly", "Working at Brackenbridge has a lovely homely feel to it making it a nice place to work. The team we have is a good working team, we just need a manager that's long term to support the home and the different departments within" and "Unfortunately the managers change too frequently."

At the time of the inspection the service did not have a registered manager in place. The previous manager joined the service in January 2017, registered with the CQC in May 2017 and left the service in July 2017. An interim manager had been in place for three weeks before the inspection but their contract ended on the second day of the inspection. The regional manager explained the provider had arranged for a new manager to start working at the service shortly after the inspection and would be in post for one year.

The regional manager explained that following the registered manager leaving the deputy manager had taken on the running of the home with support from a senior care worker and regional manager. The deputy

manager had not been offered the providers induction course for new deputy managers or any other additional training. The regional manager confirmed that the deputy manager would now be supported to complete the relevant training for people new to the post as well as being supported by registered managers at other homes. The aim of this was to provide consistency in the management of the home. A senior care worker would also be provided with level four training in relation to medicines management to support a more robust monitoring of the administration of medicines in the home.

The lack of a long term registered manager and the deputy manager providing cover without appropriate training had resulted in an inconsistency in the management of the service. This was identified by care workers as an issue in receiving support. Their comments included, "The staff are brilliant. We try to work together as a team as much we humanly possible can. The atmosphere is quite good", "Managers are not there long enough for you to get to know [them]. The deputy manager is whom I speak to should I have any urgent matters. She is very efficient, she made herself available whether she is at work or not", "I haven't had a manager that's stayed long enough within the year to be supported" and "Each home manager has supported the work I do to a different degree."

The regional manager confirmed residents' meetings were held monthly and the activities coordinator supported people to take part. A meeting for relatives should be held quarterly. During the inspection we saw the minutes from the both resident and relative meetings held in January 2017 but the records of other meetings could not be located. The regional manager stated these meeting were held but was unable to confirm if the notes from the meetings had been circulated to people using the service and relatives.

The regional manager told us questionnaires had been sent to relatives in July 2017 for feedback on the quality of the service. When the completed forms were received they would be analysed by staff in head office. We saw completed questionnaires were on file but these were not dated so we were unable to confirm when they were completed. The regional manager was also unable to confirm when people were supported to complete the questionnaires.

A daily meeting was held with senior staff at the home to identify any issues, check for maintenance concerns and review any changes in the support needs of people using the service. The meetings also reviewed the number of care workers on duty and how many agency staff were on site that day. This meant senior staff from all areas of the home were aware of any issues or concerns identified each day.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care was provided in a safe way for service users. Regulation 12 (1) The registered person did not ensure that the premises used by the service user are safe for their intended purpose and are used in a safe way. Regulation 12 (2) (e) The registered person did not ensure the proper and safe management of medicines. Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not ensure service users were not deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

	The registered person did not have a system in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those service) Regulation 17 (2) (a) The registered person did not have a process in place to assess the specific risks to the health and safety of services users and do all that is reasonably practicable to mitigate any such risks. Regulation 17 (2) (b) The registered person did not have a system in place to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (2) (c)
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not ensure person's employed in the provision of a regulated activity received such appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (1) (2) (a)