Robert Owen Communities

Brimley

Inspection report

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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

The inspection took place on 17 and 26 May 2016 and was unannounced. The home had previously been inspected in January 2014 and had met all the regulations inspected.

Brimley provides accommodation with personal care for up to six people who have learning disabilities. When we visited the home, there were five men and women living there, most of whom had been resident for a number of years.

The home is located in a residential area of Exmouth, a seaside town on the south coast of Devon. It is a large bungalow style building with a parking area at the front and a garden at the rear of the building. The home provides six single bedrooms, a large lounge/diner and a large kitchen. There is also a conservatory attached to the dining area which provided additional seating and dining space.

The home has a manager, who had worked there for a number years and had been registered with the Care Quality Commission since 2014. 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.

The culture at the home reflected some of the provider's values which included being supportive and caring, treating people with dignity and respect, being passionate about people. However other values of being committed to learning and continuous improvement were not evidenced. Quality monitoring arrangements were in place, but these had not been carried out effectively. Audits had not always been carried out and where they had, there was evidence that they had not identified issues. These included audits of care records, medicines administration and equipment audits. Health and social care professionals said the home did not always implement improvements that were suggested.

Staff worked with healthcare professionals including people's GP, specialist medical staff and members of the local community mental health team. However some professionals said their advice and guidance was not always acted upon.

Staff supported people to become more independent and develop their skills, both inside and outside the home. This included increasing people's ability to travel independently and to develop household skills as well as interpersonal and social skills. People were supported to follow activities they were interested in, including meeting people in the community at coffee morning and attending art and craft sessions.

People received their medicines safely and on time. However, storage of medicines was not safe as there was a risk that locked storage cabinets could be removed by unauthorised persons. Staff had a good knowledge of people's communication, care and health needs. They also had an in-depth knowledge of their mental health and social needs.

People were treated with kindness and dignity. They were involved in and chose their preferences when supported with care. Staff respected people's rights and helped them to be as independent as possible whilst feeling safe.

Staff encouraged people to eat a well-balanced diet and make healthy eating choices. However, staff had not taken appropriate actions to support people when there were significant changes in their weight.

People's care records were not well maintained and up-to-date, although the home was in the process of revising all the records. During the inspection new care plans were being developed with each person. However, we did not find evidence that, where appropriate, those close to them, such as relatives, had been involved.

Staff received training when they started working at Brimley. However the training did not fully comply with nationally recognised standards for induction of new care staff.

Staff were supported to refresh and update specific training, such as fire safety and first aid on a regular basis. Staff were also provided training in specialist areas including epilepsy awareness and specialist communication methods. Staff received regular supervision and an annual appraisal. Staff were supported to develop their skills through undertaking nationally recognised qualifications in care. The registered manager had also received regular supervision from a senior manager and been supported to develop their management and leadership skills through a training course. The registered manager was also being supported by the provider to complete their registered manager qualification.

Staff had completed safeguarding training and knew how to recognise signs of potential abuse. Staff knew how to report any concerns they had.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity, relatives as well as health and social care professionals were consulted and involved in decision making about people in their 'best interest'.

The home was generally well maintained and comfortable. It provided spaces for people to be with others or on their own, when they preferred. Some equipment maintenance issues had not been addressed.

The provider had a written complaints policy and procedure. No formal complaints had been received. People said they would speak to the registered manager or staff about any problems and were confident the problem would be resolved.

Accidents and incidents were reported and included analysis of how to reduce the risks of a recurrence.

We found breaches of the Health and Social Care Act (2008) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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

The service was not completely safe.

Medicines were administered safely but medicines were not stored safely in lockable containers which could not be removed by unauthorised people.

Risks to individuals had not always been fully considered and addressed.

A piece of equipment in the home was not maintained properly.

There were sufficient staff to support people safely. However the home was working with the local authority to determine whether additional staff were required as people's needs increased.

Staff were recruited safely to the service.

Is the service effective?

Requires Improvement

The service was not fully effective.

Staff received training and support. However, new staff were not provided with an induction which met with national standards.

People's capacity to make decisions had been assessed. Staff understood their responsibilities to work within the Mental Capacity Act (2005).

People were supported to have a healthy, well-balanced diet. However, changes to people's weight had not been addressed.

Although people were supported to access healthcare services, this was not always done in a timely way. Advice and guidance from professionals was not always followed.

Is the service caring?

Good

The service was caring.

Staff knew people well and treated them with kindness and friendliness.

Staff were aware of people's history and family and supported them to see them.

People's dignity and privacy was respected. People were supported to be as independent as possible.

People were encouraged to express their views and be actively involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

There was a complaints policy and procedure. People and their relatives said they knew how to make a complaint. No formal complaints had been received.

People were supported to follow their interests and be as independent as possible.

Is the service well-led?

Requires Improvement

The service was not always well led.

People, relatives and staff said they liked the registered manager and were able to discuss issues. However, health and social care professionals said there were times when the registered manager did not react well to the advice they were given.

Audits and checks on the service had not always been carried out.

There were links with the local community and the registered manager welcomed and encouraged friends and family to visit.

Brimley

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 checked 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 17 and 27 May 2016 and was unannounced. One inspector visited the service on both days. Prior to the inspection we reviewed information about the service. This included information we held about the service and any notifications received. A notification is information about important events, which the provider is required to tell us about by law. The registered manager had submitted a provider information return (PIR) in April 2016 to the Care Quality Commission. The PIR is a form in which we ask the provider to give us some key information about the service, what the service does well and any improvements they plan to make.

During the inspection, we were introduced to everyone living at Brimley and talked with all of them at various times during the inspection days. We met a director of the provider organisation. We also met the registered manager, their line manager and six care staff. We looked at two people's care records. We also looked at two staff records. The records included training, supervision and appraisal records. We looked at quality monitoring information such as health and safety checks, cleaning schedules and audits.

After the inspection we contacted five relatives and received one response. We also contacted nine local health and social care professionals and received five responses.

Requires Improvement

Is the service safe?

Our findings

Medicines were not stored safely. Medicines were stored in individual lockable metal boxes in an under-sink cupboard in each person's bedroom. We raised concerns about these boxes as they were able to be removed from the cupboard, which was not lockable. This meant there was a potential risk of the storage box being taken by an unauthorised person. The registered manager said they would take action to address this concern, by ordering medicine cabinets which would be fixed to the wall in people's bedrooms.

People usually received their medicines safely and on time. However where a medicine administration error had occurred, not all appropriate actions had been taken. The error involved a person having a pain relief gel to their body applied more frequently than prescribed. There was no evidence that there had been liaison with the person's GP, which would be the normal practice where a medicine administration error occurred. This meant that staff could not be sure that they had taken the most appropriate action to prevent risk of harm to the person.

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

Staff were trained and assessed to make sure they had the required skills and knowledge to support people with their medicines. Staff administered medicine to everyone who lived at Brimley. Staff completed a medication administration record (MAR) to document medicines which had been taken. We observed staff administering medicines for two people. This was done safely, ensuring the correct medicine was dispensed and the person was observed taking it, before the MAR was signed. We checked people's medicines and found that all doses were given, as prescribed, and remaining doses were present.

Risks to individuals had not always been identified, recorded and reviewed adequately. For example, one person had epilepsy. At the time of our inspection, the care record did not have a risk assessment about this condition and how staff should support the person to keep them safe. Subsequent to the inspection, a senior manager emailed a risk assessment for this condition. This was dated as having been written on the second day of inspection. This risk assessment included information about the frequency of the person having seizures and systems in place to help identify when the person had a seizure It also described the medicine used to reduce the likelihood of a seizure and referred staff to another document, the working policy document (WPD), should the person have a seizure. However, although the WPD stated that the last significant seizure had been 18 months previous, it did not adequately describe what was meant by significant. It also did not describe what staff might observe should the person have a seizure, significant or otherwise. It did not describe what actions staff should take should the person have a seizure. There was information about when an ambulance should be called, but this did provide clear instructions to staff. This meant that staff did not have sufficient information to decide when the person had had a seizure and what to do about it.

One member of staff said that the person they were supporting did not have any teeth or dentures. When asked whether the person had been seen by a speech and language therapist so they could be assessed for

the risk of choking, the member of staff was unsure. There was no information in the person's care record about the person not having teeth. There were no risk assessments relating to the person not having teeth or recommendations about a specialist diet to reduce the risk of choking, for example a soft food diet. A senior manager said they would address this and ensure that a referral to the speech and language therapy service would be made immediately.

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

There was evidence that other risks had been considered and actions taken to reduce the risk. For example, where the risks of one person preparing food had been assessed. There was evidence that appropriate actions to reduce these risks had been put in place. These included ensuring the person was always accompanied by staff when preparing food and always washed their hands prior to the preparation.

Most areas of the home were well-maintained and comfortable. However a wet-room had a seat attached to the wall under the shower, which was badly rusted. We showed this to the registered manager who said the seat was not used by anyone in Brimley. They also said they would arrange for it to be removed. There were bars of soap and towels in communal toilets which were used by people and staff. These posed a potential cross-infection risk. The registered manager said this had been identified as an issue and liquid soap dispensers and paper towel dispensers had been purchased and were due to be installed in the next two weeks.

Prior to the inspection, safeguarding concerns had been raised about people living at Brimley. At the time of inspection, the local authority safeguarding team were undertaking an investigation into these concerns. The concerns related to whether the level of staffing was sufficient to meet people's needs. Health and social care professionals also said there were concerns about staffing levels as appointments made for people had been cancelled due to lack of staff to support people to attend them. Health professionals described how some people at Brimley needed staff to be with them at mealtimes as they were at risk of choking. They said there were occasions when staff had not been in the dining room with people when they were eating.

During the inspection we observed that people received adequate support from staff to meet their individual needs. This included during activities and at mealtimes.

The registered manager said that there was usually one member of staff on duty from 7.45am to 3.45pm, another member of staff on duty from 3.30pm to 10.15pm and a member of staff on waking night duty from 10.00pm to 8.00am. In addition to this there was another member of staff on duty for five hours during the day to support people with activities they wanted to do. They said these hours were flexible for example from 9.00am to 2.00pm or 10.00am to 3pm depending on what the activities were. In addition to these staff, the registered manager said they worked 40 hours each week and spent approximately 40% of their time (usually about 16 hours) working with people. They said the rest of their time they spent dealing with management issues. They also said that as Brimley was a small home, they were able to be flexible about how they used their time to meet people's needs. They said that there had been changes to staffing as until earlier in 2016, the staff on duty at night had been on a sleep-in basis. However, since people's needs had changed over the last year, this had been reviewed with the local authority commissioning the care. It had been agreed to change the rota so that a member of staff was awake throughout the night to support people who were awake. At night there was an emergency on-call system which provided support to night staff in an emergency.

On the first day of inspection, there were four staff on duty as well as the registered manager. The registered manager explained that two of the staff were new and were currently undergoing induction which meant they were not included in staff numbers. On the second day of inspection, staffing levels were as described on the rota.

A health professional said that appointments had been cancelled due to not enough staff being on duty at the time of the appointment. During the inspection, we discussed with the registered manager and the senior manager the staffing levels. They said they had raised concerns about the level of staffing support with the local authority. We were shown emails sent to the local authority by the senior manager over the last year which reflected these concerns. Each person's needs were being reassessed at the time of inspection by the local authority to see whether more support was needed. The emails described people's changing needs. They also stated the need for people to be reassessed so that staffing levels could be commissioned at an appropriate level. This showed that the service monitored staffing levels and responded to changes in need.

People were happy and relaxed during the inspection undertaking different activities throughout the day, both with the support of staff and independently. These included going out to coffee mornings and art classes as well as preparing and taking part in a party in the home for a person living there. Staff actively engaged with people, interacting with them to ensure their safety. People positively commented about the home and the staff. Comments included: "Staff are nice, they help me do things"; "my friends live here". A relative said their family member had "Flourished since living at Brimley."

New staff were recruited safely. Appropriate recruitment checks were completed to ensure staff employed were fit and proper people. The provider obtained references and Disclosure and Barring Service (DBS) checks before a new member of staff started working with people. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. Staff records showed that identity checks and evidence of previous qualifications were obtained prior to the person starting work.

People were protected because staff had a good understanding of how to keep people safe and protect them from avoidable harm. Staff had completed safeguarding training and were able to describe signs of potential abuse. Staff knew how to report concerns to the provider or registered manager, and if needed, to an external agency, such as the local authority. Two safeguarding concerns had been reported to the local safeguarding authority in the previous 12 months. The registered manager had also notified the Care Quality Commission on these occasions. Appropriate actions had been taken by the registered manager and provider to ensure people were protected from the risks associated with these safeguarding concerns.

Requires Improvement

Is the service effective?

Our findings

There was not an effective induction for new staff working at Brimley. Although staff received an induction when they first started working at Brimley, there was not a consistent approach to ensuring new staff were supported and trained effectively. The Care Certificate is a set of national standards that social care and health workers should cover as part of their induction training. However the registered manager said they were not aware of the Care Certificate and said they had developed a local induction programme. We reviewed the induction programme information, however it was unclear what the programme consisted of or how new staff received the support and training necessary to work effectively with people in Brimley. Two new staff were unclear about their induction programme although one said they felt supported by other staff if they needed help or advice. A senior manager said new staff were expected to complete the Care Certificate within the first three months of their employment. By the second day of inspection, an induction programme which covered the standards of the Care Certificate had been implemented for new staff without previous experience of care or a relevant qualification.

Concerns had been raised that people were not always supported to access health services in a timely way. There is an ongoing safeguarding process involving health and social care agencies.

At this inspection we found that although health and social care professionals had been involved by staff to support people, there was evidence that the professional's advice given was not always followed. For example, some professionals said their advice was not always accepted and put into practice. One health professional commented "recommendations were not completed." Another professional said staff gave "help and support to service users to access health care. However, …, they may not always be accessing this is in a timely manner and staff may not fully understand that a health issue needs addressing, what to do or what has happened. Some health concerns are not always being reported, monitored and service users not observed for new concerns. … Instructions from professionals are not being followed." This meant that people were not being supported to maintain good health.

There was evidence in records that appointments had been cancelled, for example an appointment for a person had been cancelled as there had not been a member of staff to accompany them. Systems had been put in place to ensure that appointments were made and people were supported to attend these.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

A GP said they had no concerns about issues relating to the level of care provided. They said "Requests for assessments are appropriate and timely. The staff appear to know and respect the clients , understanding what are frequently quite complex care needs."

People's specialist dietary requirements were not always met. For example one care worker explained how they were supporting a person to lose weight. The care worker said this had been successful over the last year and the person was continuing to lose weight. Information in the person's care plan stated the person

should be weighed every week. However, there had only been six occasions when the person had been weighed since the start of 2016. The person's weight had gone up and down from the original weight measurement, but the current weight was slightly higher than that recorded at the beginning of the year. There was no evidence that staff were working towards a target weight or had considered what the fluctuations in weight had been caused by. When asked what was done to help the person lose weight, staff gave an example how the person had always liked to have a lot of sugar on their cereal, but they had helped the person reduce the amount by making sure it was put on the cereal last so it was visible. However a health professional said "in my opinion they were not supporting [person] sufficiently."

Another person had lost a significant amount of weight (three kilograms) in five months, without any information in their care record, that this had been a planned weight loss. There was no evidence that action had been taken to identify the cause or introduce ways to prevent further weight loss, such as food supplements or additional snacks. This meant the person could have an undetected condition which was not being addressed. This person was very active and busy doing activities, however there was no evidence that this weight loss had been explored.

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

People were encouraged and supported to have food and drink of their choice. Menu planning was done with the people and took account of their preferences. People were supported to get involved in the preparation and cooking of meals and drinks. Hot and cold drinks were available throughout the day and we saw people being offered drinks by staff regularly if they were unable to get their own.

Staff had completed training to support them in their roles. This included mandatory training in areas including fire safety, emergency first aid, health and safety and medicine administration. In addition staff had completed training to support specific needs for the people living at Brimley, for example epilepsy awareness, person centred planning and for Makaton. Makaton is a system which uses signs and symbols to help people communicate.

Staff said they received regular supervision from the registered manager. They said they found this helpful. Staff records confirmed this.

Staff supported people to be as independent as possible. Staff recognised that people did not always have capacity to make some decisions for themselves. They understood that family and health and social care professionals should be involved to determine what should be done in a person's best interests.

For example, one person had said they wanted to be able to travel on a bus on their own. Staff had assessed whether the person would be safe to do this and had supported the person to travel on particular journeys. Once the person had been assessed as confident to be able to do the journey on their own, staff had stopped travelling with them.

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

Staff had undertaken training on the Mental Capacity Act 2005 (MCA) and demonstrated an understanding

of how this applied to their practice. People's capacity to make decisions had been assessed and where they were deemed not to have capacity to make a particular decision, a best interest meeting had been held to involve people, such as health professionals and family, who knew the person well.

Staff described what was meant by a person not having the capacity to make a particular decision, such as going out on their own. They also understood that the person had the capacity to make other decisions, for example what time the person chose to get up and what activities they got involved in. One health and social care profession said staff "understand the Mental Capacity Act and have facilitated resident inclusion using total communication. They are also able to recognise the role of an advocate or purpose of a best interest meeting."

Staff supported people to make choices about day to day support and decision making, including making choices about what they wanted to do each day. Care records described in each person's care and support plan what people preferred.

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). These safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. The home had applied for DoLS authorisations for all the people living at Brimley, although at the time of inspection, they were waiting for these to be assessed.

Good

Is the service caring?

Our findings

People were relaxed and happy at Brimley, supported by staff who knew them well and treated them with kindness. Many of the staff had worked at Brimley for a number of years and had developed positive relationships with people. One person said staff were "nice, they help me do things." Another person when asked whether they liked staff said they thought staff were supportive and kind. A relative commented about care workers say they "are very friendly and we get on with all the staff. There are some new staff recently who we are still getting to know, but all the old staff were very good."

A health and social care professional commented "The staff are all caring." They also said "Brimley has a community feeling about it and the residents call it 'home.'" Another professional commented "The staff appear to know and respect the clients."

On the first day of inspection, staff helped people prepare for a party for one of the people living at the home, who had a birthday to celebrate. Staff, not on duty, had come into help with preparations and attend the party, which was also attended by everyone in the home as well as friends from elsewhere. Throughout the morning and the party, there was evident enjoyment for people and staff who were clearly comfortable in each other's company.

People were supported to express their views about decisions which affected them and about the home. For example, two people had expressed that they would like to eat together, separate from others in the home for some meals. Staff had arranged that they had a private space in which they could have meals together when they wanted to.

People were involved in deciding about their care. For example, one person had expressed a wish that they travelled on their own on public transport. Staff had worked with them to develop specific travel plans which they had introduced over a period of time. Once the person and staff were confident they were able travel on their own, regular arrangements were put in place for this to occur.

People were treated with dignity and respect. For example, we observed people being supported by staff with personal care needs, such as going to the toilet in a discreet and dignified manner.

A visiting professional commented about observations they had made during a visit, "All residents were spoken to with dignity and respect by all staff". Another professional said that staff "respect the clients" and another said "Personal care is prompted or supported in a dignified manner"

Requires Improvement

Is the service responsive?

Our findings

Most people had lived at Brimley for a number of years and the registered manager and long-serving staff knew them well. This included knowing information about their family, background and personal history. However there were a number of new staff who had been employed by the home, who did not have this level of knowledge.

A health professional had described care plans as "They are incomplete, inaccurate, unclear and are not being updated consistently. Care plans are not in place for some specific health conditions; as a result of this staff may not know the care and support service users require and what they need to be monitoring and reporting." This meant that new staff might not be fully informed about people's care when reading care plans and might not provide the care necessary to meet people's risks and needs.

The service had identified prior to the inspection that care plans required improvement and had started the process. Care records were being rewritten by a senior manager and the registered manager with involvement of the person concerned. This was because the previous care plans did not accurately reflect all the information needed to support people given their current needs.

The senior manager said they were still working on updating the care plans. However, there was no evidence that everyone involved in the person's care, such as their family, health and social care professionals had contributed to developing the plans.

Treatment escalation plans (TEPs) are forms which describe whether resuscitation of the person should be undertaken in the event of a potentially life-threatening situation. They are usually completed by a person's GP who will determine whether a person has the capacity to make a choice. Where the person is identified as not having capacity, the GP should ensure they discuss with people who know the person well, what is in the person's best interests. One care record contained a Treatment Escalation Plan (TEP) dated 2012. A member of staff said that the TEP was no longer appropriate as it described that the person should not be resuscitated. However the staff member said the person's health had improved since 2012 and therefore they believed there should be a new TEP for this person. This meant that if the person became acutely unwell, staff could take actions that were no longer valid in an emergency situation. A health professional stated they had discussed the TEP for this person with the registered manager prior to the inspection. They stated they had advised the registered manager to remove the TEP from the person's care records to avoid confusion. A senior manager said that they would take actions to address this immediately.

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

We discussed the TEP with a senior manager during the inspection. They said they would ensure that the TEP was labelled as out of date and arrange that a new TEP form was completed by the person's GP taking into account the changes to their health.

There were systems in place for people and their relatives to raise concerns and complaints. A relative said they had "Never had to complain as such but I know how to, if needed'. They described how they could always talk to staff or the registered manager who was "very approachable." They also described how they had, on some occasions, found that staff were not always very good at communicating with each other, which had created some problems for them. They said there had been times when they had phoned the home and made an arrangement, which staff had said would be communicated to other staff. They added they had found this had not happened which meant that the arrangements had been upset. However, they said they had not raised this formally as a complaint, although they had discussed it with staff. They also said they had found the same problem had happened again. This meant that informal complaints and concerns were not always addressed to ensure a satisfactory conclusion.

One person said "No, I like everything" when asked whether they had ever had to complain, although another person said they did not like it when other people shouted and argued. When asked what happened if this occurred, they said that staff intervened and stopped it carrying on.

People said they got involved in activities and interests that they enjoyed and were encouraged to do. A daily planner showed that people attended a number of different activities outside the home. The included drama, cookery, art and craft and pamper sessions run by other organisations during the day. For example, on the first day of inspection, one person had chosen to attend a coffee morning in the local town and had been picked up by taxi which took them there. Another person described how they had enjoyed doing an art session and added that staff supported them to "do what I want to do." People also attended a social club in the evening on one night each week, although staff said some people chose not to go on occasions. Group trips out were also organised to attractions and events.

A relative said that there were times when there were not sufficient staff to ensure people were able to undertake their preferred activity outside the home, although they added that staff tried to be as flexible as possible. Staff said they worked with people to support them, wherever possible, to undertake activities of their choice. They said some people were able to go to activities outside the home without staff support. They described how these people were enabled to do this by the systems that had been put in place. These included using a taxi service that knew the people well and good communications with outside activity coordinators. For example, one person had been assessed as able to go out independently. Safeguards had been put in place to ensure they were able to be supported when away from the home on their own. This included the person taking a taxi organised by staff for the person to get to the planned activity. A phone call system between the home and the activity organisers had also been arranged. If the person did not arrive at the venue, a phone call by the organisers would be made to the home. The person had been provided with a mobile phone with the Brimley number pre-programmed in it. The person had been shown how they could use the phone in an emergency.

Requires Improvement

Is the service well-led?

Our findings

Before the inspection, we had received concerns about the management and leadership of the home. During our inspection, we found some evidence to support this. For example, there was evidence that the service did not always work in partnership with other agencies, including health and social care professionals. Some professionals described how there were times when the registered manager was defensive about concerns they raised. One health professional commented "My colleague and myself tried on numerous occasions to support the home with their recording systems and highlight the needs for accuracy, this proved difficult and we met with resistance with the home manager. I also know that the home has not followed recommendations from the best practice support group around one resident's care."

However, another health professional said that there were other times when the registered manager was approachable and extremely helpful. One health professional said that the registered manager and the provider "always" worked together with them to "meet the needs of residents."

There was a lack of audits and checks to ensure the home was delivering high quality care.
Although some checks and audits in the home had taken place, these had not always identified concerns. For example the checks on the building and equipment had not identified the poor state of repair of wet-room equipment. Audits of care records had not identified that some information was out of date, missing or inaccurate.

Although the registered manager had completed a quarterly report which was sent to a senior manager, there was no evidence that actions to address issues identified had been undertaken. A senior manager and a director both acknowledged that there had been oversights in terms of monitoring the quality assurance systems in the home. They both acknowledged there had been, over the previous year, gaps in the systems which meant they had not had the reassurance about the health and safety of people living in Brimley. The responsible individual said usually services had a "check every six months, but Brimley was missed." A senior manager commented that there had not been a regular programme of quality assurance at the home in the last year.

A senior manager described how they had started to complete an audit in April 2016, but had not finished it as they had found so many concerns, they had decided to focus on the first problems they had identified. This meant there was a risk that the provider did not fully understand all the issues and had not developed an action plan to address all the concerns.

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

The responsible individual, the senior manager and the registered manager described remedial actions that were being undertaken to address the concerns. These included a review of all care plans, the introduction of new management systems to support staff and closer involvement of senior managers and directors to support the registered manager. During the inspection we were shown the new management systems

which included a daily planner. The planner was based upon a format used by another home run by the provider. The planner not only described what each person was doing in terms of activities, but also provided checks for staff to ensure specific tasks to support people and ensure the safety of the home were undertaken. Brimley staff had been introduced to this and said they had helped to customise it to the needs of the home. Staff had started to use these systems and said they found them helpful.

There was evidence that where incidents happened, these were reported and action was taken to address the causes.

People in the home clearly knew the registered manager well and felt comfortable with her. Throughout the inspection we observed interactions by the registered manager with people living in the home and friends who had come to visit which clearly showed a positive relationship. A relative said "the manager is 'very approachable' and manages very well."

All the staff we spoke with said the registered manager and other senior managers were approachable and would always offer support and guidance when needed. A social care professional commented "A positive aspect of the leadership is that all staff are confident in the management."

The provider's website described the philosophy of the organisation as "believes all people with a learning disability should have the chance and the support to be able to do what they want to do. ROC will work towards making this happen."

Their values included being supportive and caring, treating people with dignity and respect, being passionate about people and committed to learning and continuous improvement.

There was evidence that these values were understood by the registered manager and the staff at Brimley. People were encouraged to be as independent as possible and the registered manager encouraged staff to support people in a very positive way. The registered manager had developed positive links with the local community and helped people to access local groups and activities.

There was evidence that staff from the provider organisation had tried to engage with people to get involved in a services committee which included representatives from all the provider's services. However, people at Brimley had chosen not to get involved despite repeated encouragement from staff. Actions were being taken to find ways to engage with the people living at Brimley, including discussing with them what their preferences were.

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 9 HSCA RA Regulations 2014 Person-centred care Staff did not always ensure that people's access to health care professionals was timely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Where a medicine error had occurred there was not always evidence that staff had discussed this with the person's GP to determine what action should be taken. Medicine were not stored safely in lockable cabinets which were fixed to a wall. Risk assessments had not been fully completed and not all risks to the person had been assessed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional needs were not always met. Staff had not taken action where there had been an unexplained weight loss for a person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Care records were not up to date and did not fully describe the person's risks and needs and

how these should be addressed. Quality assurance systems had not been fully completed.