Century Care Limited

# The Brambles Rest Home

## Inspection report

Park Avenue
New Longton
Preston
Lancashire
PR4 4AY

Tel: 01772614533
Website: www.thebramblesresthome.co.uk

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service
The Brambles Rest Home is a residential care home providing personal care to 23 people aged 65 and over at the time of the inspection. The service can support up to 32 people in one adapted building.

People's experience of using this service and what we found
There were inadequate processes in place to protect people from the risk of avoidable harm. Staff had not carried out effective risk assessments in relation to people they supported and the environment.

We could not be sure people always received their medicines as prescribed because medicine management practices were not consistently safe. Some staff who administered medicines were not competent to do so and this placed people at risk of harm.

Some staff did not understand how to protect people from abuse or unfair treatment. The provider failed to maintain a positive culture that promoted reporting and acting on people's concerns.

Staff were not always recruited in a safe way. Staff told us staffing levels were sufficient to meet the needs of people who lived at the service however, the provider failed to evidence how staffing numbers were decided.

Infection control processes were inadequate and placed people at risk of infection through cross-contamination. Staff did not always have access to hand washing facilities and failed to follow safe practices when handling clinical waste.

There were insufficient numbers of suitably trained and competent staff. Staff had not always received adequate induction training before being allowed to support people in an unsupervised environment. This placed people at risk of avoidable harm. Staff had not been regularly supervised or appraised.

People's physical, mental health and social needs were not consistently assessed. Staff failed to adequately risk assess and care plan the needs and preferences for people on short term or respite care. Staff did not consistently involve people in the care planning process.

The provider failed to ensure people had access to a wide range of nutritious and good quality food. Staff did not consistently support people to have choice and control at meal times. People did not have free access to snacks or fresh fruit.

People were not always supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible and in their best interests; however, the policies and systems in the service did not support this practice.

Two visiting professionals told us the registered manager and staff supported people in an effective and

responsive way. People's care records showed they were referred to specialist departments for example; dietician, speech and language and physiotherapy. However, there advice was not always included in people's care plans.

People told us they were supported by kind and respectful staff. Staff engaged with people in a kind way and had built trusting relationships. Relatives told us they were happy with the care and support people received. The provider had not asked for feedback from people and other stakeholders.

People did not always receive support in a person-centred way. People's care records were not person-centred, this meant staff did not have up to date information to guide them about how best to support people.

People's end of life needs and preferences were not always assessed in a timely way before their health needs deteriorated. This meant in the event of a sudden death staff would not always be aware of people's preferences. Relatives and external professionals provided positive feedback about how people were supported at the end of life.

The service was not well-led. The provider failed to ensure good outcomes for people and adequately quality assure the service. Some staff did not feel confident to approach or confide in the registered manager and this had a negative impact on the culture throughout the service.

The registered manager had resigned from their position but maintained their registration. The provider had taken steps to recruit a new manager, however this person had also resigned before the inspection. During the inspection the provider appointed an interim consultant management team.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 06 September 2018) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Brambles Rest Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding, consent, person-centred care, nutrition and hydration, staff training and support, governance and staff recruitment.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Details are in our safe findings below.

### Is the service effective?

**Inadequate**

The service was not effective.

Details are in our effective findings below.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Details are in our caring findings below.

### Is the service responsive?

**Inadequate**

The service was not responsive.

Details are in our responsive findings below.

### Is the service well-led?

**Inadequate**

The service was not well-led.

Details are in our well-Led findings below.

# The Brambles Rest Home

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by two inspectors and one pharmacist inspector.

Service and service type
The Brambles Rest Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, the registered manager told us they had resigned from their position and after the inspection made an application to cancel their registration.

Notice of inspection
Day one and day five of this inspection were unannounced. We gave notice on day two, three and four to ensure the registered manager and nominated individual were available for feedback.

What we did before the inspection
Before the inspection, we reviewed all the information we held about the service such as notifications. These are events that happen in the service that the provider is required to tell us about. We also sought information from the local authority's contract monitoring team and safeguarding team. We used our planning tool to collate and analyse the information before we inspected.

We used the information the provider sent us in the provider information return. This is information

providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
During the inspection, we spoke with seven people who lived in the home, two relatives, ten members of staff, the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked the care records of 11 people who used the service, checked the environment and observed staff interactions with people. We spoke with two visiting professionals. We also examined a sample of records in relation to the management of the service such as staff files, quality assurance checks, staff training records and accidents and incidents.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, policies and procedures.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection the provider failed to ensure the safe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● The provider failed to ensure safe systems were in place for the management of people's medicines. Staff did not always follow safe procedures when administrating people's medicines and this placed them at risk of avoidable harm.
● For example, one person was administered double the prescribed dose of a controlled medicine because staff failed to follow safe procedures when the prescription had been changed. Controlled medicines are a drug or other substance that is tightly controlled by the government because it may be abused or cause addiction.
● The provider failed to ensure staff responsible for administrating medicines were trained and competent to do so.
● Staff did not always ensure people's medicines were stored in a secure place.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safe medicines management. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● The provider did not always undertake risk assessments to reduce incidents of harm or exposure to harm. For example, people at risk of choking had not been adequately risk assessed and the textures of food provided for them were inconsistent. Staff lacked understanding of the risk associated with choking.
● The registered manager failed to make sure people's risk assessments were updated on a regular basis and when their needs changed. Some risk assessments had been incorrectly calculated, for example an assessment for the risk of malnutrition. This meant the actual risk had not been established or managed.
● People were exposed to the risk of harm because the provider failed to adequately safeguard people from risk associated with the environment. For example, the provider did not respond in a timely manner to an

action set by the Fire Authority in August 2018. The provider did not undertake environment risk assessments.
● We could not be sure staff learnt from accidents and incidents because the registered manager did not record lessons learnt. Staff were not consistently updated when things changed. For example, two members of staff told us they had not been informed when a person had deceased. The shift handover process was poor.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not adequately protected from the risk of abuse because some staff were unaware of what constituted to abuse or how to report incidents of abuse to the local safeguarding authority.
● Whilst people told us they felt safe, the provider failed to make sure all staff had suitable training in safeguarding adults. Some staff told us they would not feel confident to blow the whistle. We discussed this with the nominated individual who assured us they would act on this information immediately.
● The registered manager was aware of how to make a safeguarding alert and evidenced they had followed the correct procedure for some incidents. However, incident records did not always show if staff or the registered manager had considered making an alert in line with the local safeguarding authorities' procedure.

We found no evidence that people had been abused however, systems were either not in place or robust enough to demonstrate effective safeguarding. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider failed to ensure safe procedures were in place for the recruitment of staff. The senior management team did not always carry out essential checks on staff in relation to their character, legal right to work and criminal record. This exposed people to the risk of abuse.

We found no evidence that people had been abused however, recruitment systems were not always safe, and this placed people at risk of abuse or improper treatment. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during the inspection. They confirmed an improved process for staff recruitment had been implemented and the shortfalls found relating to individual staff records had been checked and appropriate action taken.

● People and relatives told us they were satisfied with the numbers of staff deployed. However, a high number of staff did not have any experience of health and social care and the provider had failed to provide them with suitable training. This meant suitable numbers of qualified, competent, skilled and competent staff had not been deployed.

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

Preventing and controlling infection

● Systems and processes in place for the prevention and control of infection were not robust. The provider failed to suitably audit infection control systems and staff had not received training.

● Staff did not follow safe practices when handling clinical waste and failed to remove protective clothing before exiting the clinical area. This increased the risk of cross-contamination of infectious disease.

● Staff did not have access to suitable hand washing facilities when supporting people with personal care in their bedrooms.

● The provider failed to repair the dishwasher, at the time of the inspection staff told us the dishwasher had been out of use for four months.

● We made a referral to the infection control team, during the inspection they undertook an audit and informed us they will work with staff to improve standards.

Inadequate infection control systems and processes meant people were exposed to the risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our last inspection the provider failed to ensure staff received appropriate support and training as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● The provider failed to ensure staff received appropriate training, supervision and appraisal. They also failed to ensure staff were suitably skilled and experienced for their role. This placed people at risk of avoidable harm.
● The registered manager had undertaken an induction process with new staff. However, some staff told us the process was not thorough. We checked induction records and saw an inconsistent record keeping in relation to what support and education staff received during the induction process.

Systems were either not in place or robust enough to demonstrate how sufficient numbers of trained and competent staff were deployed. This placed people at risk of avoidable harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some staff told us they had a language barrier which prevented them understanding their role and responsibilities. The nominated individual told us they would support staff without English as their first language to access a training course to help improve their communication and writing skills.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider failed to ensure people's needs were adequately and continually assessed in line with standards and best practice guidance. People's risk assessments and care plans did not always include accurate or clear information. For example; one person's care records showed they needed a high level of monitoring due to a complex medical condition. Staff had not ascertained the exact level of monitoring and therefore, had not monitored them sufficiently. This placed the person at risk of harm.
● The registered manager failed to ensure people on respite were adequately assessed. This meant staff did not have access to sufficient care plans to guide them how best to support people.

Failure to assess people's needs effectively placed them at risk of harm. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● People were not provided with enough choice and control over their nutrition and hydration. Staff did not ensure people received a good standard of dining and we saw this impacted on people's independence. For example, there was no menu, staff did not offer people an option at meal times, staff did not encourage people to have extra portions and tables were not set with the necessary cutlery or condiments.

● Some people told us they were dissatisfied at meal times, "The mugs are so stained, I have been given this (breakfast) without a knife and fork", "The meals are bland, we had fish fingers the other day and they were cold" and "The food is ok, we never know what we are getting."

● Staff had not received training in nutrition or swallowing despite there being 16 people on special diets or at risk of weight loss.

● Staff had not always accurately assessed people for the risk of malnutrition and care records showed conflicting information which meant people were at risk of not receiving the correct nutritional support.

● We observed meal time service and what was available for people to eat and drink in-between meals. Across two days of the inspection we saw people were served the main meal of the day without any vegetables. Meals were not always nutritious or fortified for people at risk of malnutrition. People did not have access to self-serve fruit or fluids and we did not see staff offer fruit at snack times.

Systems were either not in place or robust enough to ensure people's nutritional and hydration needs were met. This placed people at risk of avoidable harm. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● The provider and staff were not consistently working within the principles of the MCA. Staff undertook assessments of people's mental capacity and failed to evidence clear information about what was discussed before a decision was made.

● Staff consistently told us they did not know who was subject to a DoLS or what this meant for the individual.

● The provider failed to ensure staff were suitably trained to make sure they understood their responsibilities in relation to principles of the MCA.

Systems and processes were not robust to ensure people were supported by staff who understood their responsibilities in line with the MCA and DoLS. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff asked for people's consent before they supported them. When people declined support, we saw staff discussed this with the registered manager and their decision was respected.

Adapting service, design, decoration to meet people's needs
● Some aspects of the environment did not meet the needs of people with cognitive and visual impairment because signage was not designed to effectively promote people's independence.
● People had access to ensuite bathrooms and their bedroom layout had been considered in line with their preferences and needs.
● Bathrooms were adapted to aid people with reduced mobility.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The registered manager had built positive relationships with external health and social care professionals. People were referred to specialist professionals for support and guidance. However, care records showed inconsistencies in care planning following their advice. For example, one person had been assessed by the dietician and they recommended a 'pureed' diet, the diet sheet staff followed stated the person could have a 'soft diet and soft filling sandwiches'. This placed them at risk of choking.
● Staff supported people to attend hospital appointments. The registered manager did not make sure people had anticipatory records, such as a hospital passport, prepared in case of an emergency transfer.

Requires Improvement

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People were not consistently supported to maintain their independence because staff did not always support people in a person-centred way. For example, staff did not provide people with choice and control at meal times and some staff told us people were assisted to bed early "to make it easier for night staff".
- People told us, and family members confirmed, they were treated with respect and staff were kind. Comments included, "The staff are really nice", "I have found staff very understanding" and "Staff are genuinely nice".
- Staff had built trusting relationships with people and their relatives.
- Staff respected people's dignity. They knocked on doors before they entered and people's privacy whilst with their friends and family was respected.

Supporting people to express their views and be involved in making decisions about their care

- The provider did not actively seek people's feedback. People told us they could approach the registered manager and inform them of any concerns or ideas. However, we received feedback from people and relatives that they had not been informed the new manager had left.
- People had been given the opportunity to share information about their life history, likes, dislikes and preferences. However, this information was not consistently followed. For example, we observed one person was served a food they did not like despite this being mentioned in their care plan and on the kitchen notification sheet.

Inadequate

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People were at risk of not achieving good outcomes because the provider failed to ensure they received consistent person-centred care. Staff did not always know people's individual needs in relation to choking, hydration and nutrition. This placed them at risk of avoidable harm.
- People's care needs were not regularly reviewed. Their care plans were out of date and did not sufficiently guide staff on their current care, treatment and support needs.
- People were not always involved in the care planning process. One person had experienced significant deterioration in their mental health, their care plan for 'mental state and cognition' had not been updated to show current risk or emotional impact.
- The registered manager did not always undertake risk assessments and care plans for people when they were admitted for respite. This meant staff had limited information about how to support people in the best way.
- Staff told us people had gone for long periods without a bath or shower. We checked care records and saw people had mainly received 'bed baths'. The registered manager told us a new 'bath list' had been started and this meant people were offered support to bathe once a week. This was not person-centred.

Failure to assess people's needs effectively and provide person-centred support placed them at risk of harm. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs; Improving care quality in response to complaints or concerns

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The provider had not taken sufficient steps to comply with the Accessible Information Standard to identify, record, flag, share and meet the information and communication needs of people with a disability or sensory loss.
- Staff were not aware of the AIS and had not received training in promoting effective communication. We saw staff supported people to wear their communication aids.
- People and relatives told us they felt confident to complain and said their concerns were taken seriously.

● The provider failed to implement a complaints procedure in accessible formats for example in different languages or for people with cognitive or visual impairment.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Staff supported people to carry out activities and encouraged them to maintain hobbies and interests.

● People told us they were satisfied with the level of stimulation provided. We saw people enjoy time with their visitors.

End of life care and support

● End of life care and support was inconsistent. Staff did not always undertake a person-centred approach to end of life care planning. Staff were reactive rather than pro-active and this meant people had not always been asked for their preferences in relation to end of life before their health deteriorated.

● People's relatives provided positive feedback in thank you cards about the care and support their relative received from staff when at the end of their life. Comments included, '[Name] spent many years at The Brambles contented and happy, she left the world with dignity and peace. Thank you also for always making the family feel welcome', 'Thanks so much for the care you gave our mother in her final days. You are a wonderful team' and '[Name] died peacefully, without fear or anxiety, safe in your care. The staff at The Brambles were her guardian angels'.

● We received positive feedback from a visiting professional who told us "There is good end of life support for people here".

Inadequate

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection the provider failed to effectively lead and quality assure the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The service was not well-led. The provider failed to ensure people received high quality care to achieve positive outcomes. The provider failed to quality assure the service.
● Shortfalls found at this inspection had not been identified by the provider or registered manager.
● The provider failed to embed good systems to reduce the risk to people, visitors and staff of avoidable harm. We have outlined out findings in the safe domain of this report.
● The registered manager had previously resigned from their position but maintained their registration. A new manager was recruited in May 2019 however, before the inspection the new manager had resigned, and the registered manager had taken over full responsibility for the service again.
● Some staff told us they did not feel supported by the registered manager and they were unhappy at work. The culture was poor, staff did not always understand their role and responsibilities. This meant people did consistently receive safe and person-centred support.
● The registered manager failed to maintain a positive culture that promoted staff to report their concerns or share ideas for improvement.
● The registered manager did not effectively include people, relatives and staff in the running of the service. There had been a staff meeting in August 2019 and staff told us this was a positive experience. However, because the new manager had resigned, actions agreed with staff had not been carried out. People and relatives were not asked for their feedback.
● People and relatives provided positive feedback about the registered manager and told us they were, "approachable" and "[the manager] knows [name] backwards."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The nominated individual and registered manager failed to fully understand their role in line with regulatory requirements. The nominated individual told us they would seek training to make sure they improved their understanding.
● The registered manager told us there had been uncertainty between them and the new manager in relation to what their role and responsibilities were.
● After the inspection the registered manager informed us they had resigned from their position and no longer acted in a management role. They applied to cancel their registration.

Systems were either not in place or robust enough to demonstrate the service was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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<br><br>The provider failed to ensure people were supported in a person-centred way.<br><br>Regulation 9 (1) (2) (3) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider failed to ensure people were consistently supported in line with principles of the Mental Capacity Act.<br><br>Regulation 11 (1) |

| 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<br><br>The provider failed to ensure robust safeguarding procedures were in place.<br><br>Regulation 13 (1) (2) (3) (4) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>The provider failed to ensure people received good nutritional support. |

Regulation 14 (1) (4)

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider failed to ensure robust recruitment processes to check staff were fit and proper for employment.<br><br>Regulation 19 (1) |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had failed to ensure that risks to receiving care and treatment were identified and managed robustly.<br><br>The provider had failed to ensure the safe use of medicines.<br><br>The provider had failed to operate effective systems for the prevention and control of infections.<br><br>Regulation 12(2) (a) |

**The enforcement action we took:**

Enforcement action was taken by the Care Quality Commission in light of the significant risks identified in the home. We added a condition to the service providers' registration. The registered provider must not admit service users to The Brambles Rest Home without prior written permission from the Care Quality Commission.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to ensure governance systems were robust and systems or processes were not established and operated effectively to ensure compliance.<br><br>Regulation 17 (1) (2)(a)(c) |

**The enforcement action we took:**

Enforcement action was taken by the Care Quality Commission in light of the significant risks identified in the home. We added a condition to the service providers' registration. The registered provider must not admit service users to The Brambles Rest Home without prior written permission from the Care Quality Commission.

| Regulated activity | Regulation |
|---|---|

| | |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had failed to ensure that staff received such appropriate support, training, professional development, as is necessary to enable them to carry out the duties they are employed to perform.<br><br>Regulation 18 (2) (a) |

**The enforcement action we took:**

Enforcement action was taken by the Care Quality Commission in light of the significant risks identified in the home. We added a condition to the service providers' registration. The registered provider must not admit service users to The Brambles Rest Home without prior written permission from the Care Quality Commission.