Larchwood Care Homes (South) Limited

Brookes House

Inspection report

79-81 Western Road
Brentwood
Essex
CM14 4ST

Tel: 01277212709

Date of inspection visit:
27 June 2018

Date of publication:
01 October 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out a comprehensive inspection of this service on the 27 June 2018. Breaches of the legal requirements were found. After the inspection, the provider wrote to us to say what they would do to meet the legal requirements.

This service was placed in special measures because, at our last inspection on the 25 September and the 17 and 19 October 2017, we found the service to be inadequate in the safe domain with a number of breaches of the legal requirements under the Health and Social Care Act, 2008; 2015. Services that are in special measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection this service had failed to demonstrate that improvements had been made and continued to be in breach of the legal requirements.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to be providing inadequate care should have made significant improvements within the timeframe given. If not, enough improvement is made, so that there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating this service.

This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

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."

After the last inspection on the 25 September and the 17 and 19 October 2017, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions and take action to make improvements. This was because there was often not enough staff on duty to provide people with safe care. Staff did not always support people to move in a safe way and some people told us they were not always treated with dignity and respect. This action had not been completed.

Brookes House 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. Brookes House accommodates up to 70 people in one adapted building. At the time of the inspection there was 43 people living at the service.

A registered manager had recently left the service, and the service was being managed by a peripatetic manager and an operations manager. 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.

People told us there were not enough staff available to meet their needs. We saw that the deployment of staff in the communal lounge areas were ineffective and they did not always have time to spend with the people they supported.

We observed a number of unsafe manual handling practices. Some people were not satisfied with the personal care they received, and some people had to wait a long time to be helped to the toilet.

The provider had given staff regular training, but even though they had been given training, some staff were either not competent or were incapable of carrying out their role in a safe and dignified way.

Audits and checks were in place and completed regularly. However, these checks had failed to identify and pro-actively address the concerns we had found, specifically around staffing, medicine management and the competency of staff in relation to moving and handling. There was a lack of oversight based on the observations of the care being provided.

People did not always receive their medicines correctly and in line with the services policy and procedures. The dining experience for people was not always positive and people had to wait a long time to get their meals.

People were not always supported to have maximum choice and control over their day to day lives. Some people told us they could not have a bath when they wanted one. unless it fitted in with the staff's preferences. Other people were not offered the opportunity to sit in a chair to eat their lunch and some people were not sure if they could leave the service if they wanted to.

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

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 consistently safe.

Staff deployment did not enable people to be supported in a safe and personal way. The deployment of staff in some communal areas was insufficient.

Staff did not always move and position people in a safe way.

People were not always protected against the risks associated with the unsafe use and management of medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were given training, and the registered manager carried-out competency assessments, however this did not ensure that all staff were capable or willing to deliver care to people in an effective and personalised way.

We observed people having to wait for long periods of time for their meals. Not everyone had good access to fluids.

The registered manager and staff understood the legal requirements of the Mental Capacity Act 2005 and had made applications to deprive people of their liberty.

Is the service caring?

Inadequate

The service was not consistently caring.

People and relatives told us that staff were not always caring.

Most staff treated people with dignity and respect, but we observed some staff not talking to people in a dignified and polite way.

Is the service responsive?

Inadequate

The service was not consistently responsive.

Some people told us they could not always have a bath when they wanted to.

People were not always supported to enjoy and participate in social activities.

Care plans to inform staff about people's choices at the end of their lives were not in place.

Is the service well-led?

Inadequate

The service was not consistently well led.

A registered manager was not in post, and a number of the senior staff members had left. The service was reliant on several agency workers covering senior roles.

A quality assurance system was in place, but this was not robust enough to address the concerns we found and improve quality of the care being delivered to people.

Brookes 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 during the day of the 27 June 2018. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of caring for older people and people living with dementia. The inspection was unannounced.

The provider had completed the provider information return (PIR.) This is information we require providers to send us to give us key information about the service, what the service does well, and improvements they plan to make.

During our inspection we spoke with fourteen people who used the service, six relatives, five staff members, and the operations manager. We were told another manager was also supporting the service. We were told this person was on holiday.

We reviewed eight care plans and five staff files. We also looked at the service's arrangements for the management of medicines, complaints and compliments and information relating to governance and auditing processes.

Prior to this inspection, we reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

There had been a number of safeguarding incidents which had been brought to the local authorities' attention and they had been working with the service and conducting their own investigations.

Inadequate

Is the service safe?

Our findings

At our last inspection, this key area was rated inadequate. We had found breaches of the regulations, in relation to staffing, and safe care and treatment. This was because we had concerns about low staffing levels, and saw unsafe moving and handling techniques being used by staff.

At this inspection, we found the provider had failed to improve the service sufficiently and that their response had been ineffective. We still had concerns around safe staffing levels and deployment, and some moving and handling techniques being used by staff were unsafe. We also had concerns about the way some people received their medicines.

The provider had increased staffing numbers since the last inspection, but this proved to be ineffective because it had not improved people's experience in relation to the care they received. Several shifts were being covered by new staff members or by agency staff, and this impacted on the continuity of care that people received.

We observed and people told us, that there were not enough staff to meet their needs in a safe way. Everyone and the majority of relatives we spoke with, told us they did not think that there was enough staff available to meet their needs. People said, "If I want to go to my bedroom during the day, I am not always able to. They haven't got enough staff to take me. I often feel frustrated about it." And, "Sometimes there is someone all the time, but at other times I can't seem to find anyone. When I sit in the lounge sometimes there is no-one [staff] there. I press the buzzer to go to the toilet and I can wait a long time." And, "By the time staff are available, it's too late for me. This makes me feel horrible. It's shaming." And, "I was upstairs for a long time this morning. I was left on my own. I couldn't find anyone."

The system the provider used to determine staff deployment, was not adequate to ensure people's needs were met. This was because it had been ineffective in addressing the issue. The provider had not considered the layout of the service as part of this assessment. For example, it did not consider the number of lounges the service had and how these areas would be staffed.

Observations showed that the deployment of staff was not always suitable to meet people's needs and we found that the communal lounge areas on the ground floor were frequently left without staff support. One relative when referring to a staff member entering one of the lounges said to us, "That's unusual. There is not normally any staff in here. That is because you are here."

We observed two people waiting for up to 45 minutes before they were assisted to use the toilet. One relative explained, "There is a lack of continuity with staff and there are new ones every time I come in. I have to keep telling staff about [name of person] needs." Another said, "It's impossible to find anyone when [name of person] needs help. When someone needs a wee, they need a wee now not in 10 minutes." □

Staff did not always read what was in people's care plans. This meant staff did not always know if they were caring for the person safely or in the correct way. For example, on the day of the inspection some staff did

not understand about people's care needs in relation to pressure care.

A relative said, "They do no personal care because the staff have no understanding about how to encourage. We come in and give [name of relative] a bath and shower. There is no continuity with staff so we have to keep repeating ourselves over and over again. No one has asked how to wash or shower them."

This was a breach of Regulation18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive their prescribed medicines on time and in the right way. We found there were gaps in some people's medicine administration records (MARs) and that some people had not received their medicines when they were should have done. For example, one person had missed their medicine, which helps to manage their symptoms of Parkinson's disease. Missing a dose can impact on the person's ability to function, including their speech and mobility. We found a further five incidents where people had not had their medicines on time and as prescribed. People required their medicine on a regular basis and this potentially left these people at risk of being in pain. One relative said, "Last week I had to chase for 20 minutes to get the medicine for my relative. They [staff] said they were too busy. They said they needed specific time."

Controlled drugs (CDs) were not safely managed. CDs are drugs classified under the Misuse of Drugs Act 1971 and have specific requirements in relation to the storage, administration and recording. The medicine register was not completed accurately and we found a discrepancy in the reconciliation of CDs in the register compared to stock held. Staff were recording the stock received instead of the balance. We found oral controlled medicine, which did not have a clear opening date recorded, and another bottle that had passed its shelf life.

We found evidence within the controlled drugs register that the prescriber's instructions were not being followed. For example, a transdermal patch was applied a day late. There was no investigation to find out why this had happened and subsequently the following week the patch was applied a day early. For one person, their transdermal patch had been applied a day late and then a day early. There was also a gap in administration where an applied patch had not been recorded within the controlled drugs register. For another person, we identified a gap in recording and the balance indicated that the patch had not been administered. Although we did see some evidence of checks carried out by the management team and some of the errors had been identified, we did not see any evidence of incident reports or thorough investigations being carried out in relation to these errors.

Audits were in place which monitored medicines but the audit carried out in June 2018 had not identified the problems we found. This meant that the medicine auditing system, was ineffective. Staff had been trained in how to administer people's medicines and competency assessments were carried out, but this had failed to ensure that staff were competent to give people their medicines in the right way and at the right time.

During our inspection we found that the medication storage room was 27 degrees, whereas as safe storage temperature is between 15 and 25 degrees. Air conditioning facilities were available, but these were switched off, because the plug had been pulled away from the socket. We mentioned this and it was rectified. If medicines are not stored at the correct temperature they may not work in the way they were intended, and so pose a potential risk to the health and wellbeing of the person receiving the medicine. The temperature of storage is one of the most important factors that can affect the stability of a medicine.

One relative explained, "There was an incident regarding [name of person] being given the wrong medicine last weekend. A staff member said these are for you. It was a pot of pills. I said no, they don't have pills at this time. When the staff member checked they were for another person. If I hadn't been there, [Name of person] would have taken them."

We reported our concerns to the operations manager and Essex County Council following our inspection.

We observed how people were supported to mobilise and how staff moved people who were unable to do this for themselves. People were supported to move in an unsafe way. For example, we observed one staff member put their foot on the equipment and tell a person to pull themselves up on the frame. We also saw another staff member go to help someone to stand by pulling them up under their armpits. We noted, the senior in charge quickly advised the staff member not to do this, but we could not be assured this would have happened if we were not observing. Lifting people in this way when supporting them to stand is not a recognised technique and places them at a risk of sustaining an injury to their shoulders. When asked about what it was like to be moved, one person said, "You feel you're going to fall out of it when they move you."

We observed the same sling being used to transfer different people. This can pose a risk of cross infection and injury to people by falling through the sling if it is not the correct size for them.

Despite managers telling us that handover meetings took place twice a day, staff told us that handover meetings did not always take place. This meant that staff may not have always been given the right information to provide safe care. For example, one staff member explained, "I did not receive a full handover at the start of the shift. I received a resident list and was told what I was allocated to do. I was told everyone was fine but there were two new people, and I had to get another staff member to tell me about them and what they needed when they were administering medicines."

There was a communication book in place designed to enable staff to improve communication between them. We found this system was ineffective. For example, we found an entry that stated the district nurses had left a grey boot to be worn, but staff could not demonstrate this had been added to the persons care plan. There was no information or rationale explaining why these boots were required. We were concerned that a visiting professional had left instructions for staff which have not been escalated and followed.

Overall, most people's information in relation to risk was up to date, and it was evident that regular audits of care plans were carried out and changes were made when this was needed. However, several staff were not fully clear about the instructions within the care plan. For example, when people had pressure ulcers staff were either not aware of the person's needs or did not always know how frequently people needed repositioning to help mitigate further deterioration and promote healing. When asked how often someone was turned, staff told us that they thought staff repositioned this person twice. However, records did not demonstrate this was happening. When asked, this person said, "I'm lucky if I am turned once a day."

We looked at the care plans for people who required pressure care or who needed support to maintain their nutrition and hydration. For some people there were several gaps and omissions in the recordings. This meant that we could not always be certain that people were receiving the care they needed.

One relative said, "Most staff here don't know how to care for people. They're blinkered. They are more task orientated than people orientated."

One person was seen being taken to hospital, they had several blankets on them and were shivering. It was a hot day and staff had failed to take this person's temperature. When the paramedics turned up, we observed

them instructing staff to remove the blankets because this person had a very high temperature. The staff had not carried out adequate checks when the person became unwell and this placed the person at risk of worsening their physical condition.

This was a breach of Regulation 12 (1) (2) (b) (c) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Health and Safety and fire risk assessments were in place. At the last fire safety inspection, there had been some areas that needed to be improved. The manager was working through an action plan to address the areas that had been identified.

The décor in some areas of the service was tired and some of the doors had chipped paintwork. This had not changed since our last inspection. Two relatives told us that the bedroom their family member lived in had damage to the walls that had not been rectified. One person showed us a hole in the ceiling above the toilet caused from a leak above. They could not recall how long ago this had occurred, but said, "They [the management] know about it. It was meant to have been done. I don't know if they have a maintenance person here."

Everybody we spoke with, except for two people told us they felt safe living at Brookes House. Staff had received appropriate safeguarding training and knew how to recognise and report any recognisable suspicions of abuse. Staff knew how to whistle blow and told us they would contact the CQC if they had concerns that people were not being cared for in a safe way.

Systems and processes were in place for the safe recruitment of suitable staff. Information inspected on the recruitment files for five members of staff showed they had completed an application form, provided a full employment history and eligibility to work in the United Kingdom was checked. The registered manager (when in post) had undertaken a Disclosure and Baring Service Check (DBS) on all staff before they had started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal records and whether they are barred from working with people who use health and social care services.

Accidents and incidents had been recorded. Each report recorded the details of the person who had the accident, and where and when it had occurred.

At the time of the inspection, the service was clean. Staff had been trained in the control of infection and food hygiene and we saw they had access to appropriate personal protective equipment [PPE] such as gloves and aprons.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, this key area was rated requires improvement because the registered manager had not checked to make sure that staff were competent to carry out their role.

At this inspection, staff had been trained in core subjects, and assessments of their competence had been carried out. However, we observed and people told us that staff were insufficiently skilled to support them, in an effective way, which enabled them to have a good quality of life. For example, staff had been trained and competency assessments had been carried out in relation to medicines, moving and handling and dignity and respect, but what the provider had put in place to make improvements since the last inspection, had been ineffective to improve the quality of care being delivered to people.

Newly employed staff received an induction which included an 'in-house' orientation, but this had failed to equip staff with the knowledge they needed to care for people in a personalised way. Whilst records were in place, the induction was not effective enough to ensure that all staff were fully competent and capable to carry out their role, because some of the new staff were not clear about how to meet people's care needs. Staff confirmed they received regular supervision and appraisals. Records we reviewed confirmed this.

We observed the meal time experience and found this needed to improve. We saw people waiting for up to 45 minutes, before being given their meal, once they had been sat at the dining table. People told us that it was not unusual, for them to be made to wait for up to an hour, before their food was served. Typical comments made were, "They leave us too long in there [the dining room] though. I get fed up with that. We all get fed up with that." And, "They keep us sitting there for ages. It's not right." And, "They take us in there too early. We have to sit and wait and wait." And, "I'm not given a choice. They just take me to the dining room and I'm put at a table. No one checks if I want this."

We noted, that most people sat in wheelchairs when eating, and staff did not offer people a choice between sitting in a seat for lunch or in a wheelchair. We were told that this was the 'normal' practice. We observed that one person could sit in a chair, so we asked their visitor why they thought they were sat in a wheelchair during lunch. They said, "It's always like that. It's easier for the staff to take the wheelchair, rather than transfer them." Later, we saw a relative washing a wheelchair, they explained, "Some of the wheelchairs here have enough food on them to make a sandwich."

Staff did not always consider people's needs at meal times. For example, we observed one person calling out to attract a staff members attention. We noted, they had to repeat themselves, because no one responded. When a staff member did attend to them they asked them to cut their food up. We found this was because they had restricted use of both hands. We spoke with this person, and they said, "I am paralysed down one side. I can't do it [cut the food] myself. I have to remind staff every time." One person explained, "The staff don't always bother to take notice of what you like. I prefer a specific snack for a pudding. I've told them often enough. When I ask for one I don't get it. I would think they would know by now. It's not offered, I'm ignored." Another person said, "Some of them [staff] do know what they're doing, but some don't have a clue."

We received mixed feedback about the quality of the food. Some people were not enthused. Typical comments were, "It's eatable, but it's not the best. I don't get enough fruit. I've asked but it just gets ignored or forgotten." And, "I'll pass on the food. It's not the best. Some meals are quite good though." A relative explained, "The quality of the food varies depending on who the staff member is."

People were not supported to make daily choices from the menu. Their options were taken the day before. People were not routinely offered a 'second helping' if they wanted more. We observed staff did not offer people a choice of drinks and did not consider if people would like an alternative to the juice flavour on offer. People's snack preferences were not taken into consideration. For example, one person told us they preferred a savoury snack and had told staff but were never given an alternative.

Some people did not always have enough to snack on. One person explained, "They provide some snacks for us. If we want more, we have to bring in our own. I have asked for more food, but I haven't had any. Families provide extras for people, we keep them in our rooms." This person pointed to a bowl of crisps in the lounge and said, "You could have them, but you have to be able to get up and ask for them, and if you can't speak, you can't ask anyone."

We observed that there was some fruit which had been cut up and left in the lounge. We observed it was in a bowl, under cling film at 9:55 am. At 11:45 am we found the room was very warm and the fruit had gone soggy.

This was a breach of Regulation 14 (1) (4) (d) 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 mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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. Whilst we found that some people felt that they did not have enough control over their day to day lives the correct records were in place.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people were deprived of their liberty, the provider had made appropriate applications to the Local Authority for DoLS assessments to be considered for approval.

Care plans had people's health needs recorded and people told us that their healthcare needs were managed. However, some relatives said they were not always kept informed when their relative's needs had changed or the outcome of appointments. One relative said, "No one informs us if [name] isn't so well." Another said, "Communication could be better."

Inadequate

Is the service caring?

Our findings

At our last inspection, this key area was rated requires improvement because comments about caring nature of staff were mixed. Some people and their relatives reported very high levels of satisfaction, but this experience was not shared by everyone who lived at the service.

At this inspection, this had not improved. People's experience of being consistently supported by kind and compassionate staff was still not shared by everyone who lived at the service.

We found that staff did not know people sufficiently to provide care to them in a kind and personal way. For example, one person was upset because it was their birthday. They told us no one had wished them a happy birthday and indicated that no one knew or cared. We asked staff and they confirmed that they did not know it was this person's birthday and they had not planned to celebrate this occasion in any way.

Another person said that staff did not always call them by the correct name. They said, "The staff mostly know us." However, they went on to explain that throughout their life, they had been called by the first four letters of their surname, rather than by their first name. They said, "Some staff use it, others don't bother. Some staff haven't bothered to look at what I've said and they don't ask what I prefer to be called." Another said, "There have been lots of changes. I don't think they've had time to get to know us." Another said, "They are very jolly. They chat and talk to us, but they don't have the time to sit down and join us to chat. That would be nice. They are always so busy."

Some staff needed to improve how they interacted with people. For example, we observed a person calling out for help. A staff member asked if they were alright, but their tone and demeanour was not friendly, it was impatient. We saw the person say they were alright. At this the staff member walked away and said, "If you say so."

Some staff acted in an unkind way with people at lunchtime. For example, some people had an apron put on them to keep their clothes clean. The staff member did not ask if people were okay or if they wanted one. They said, "Here is your apron" and proceeded to put it on. After the meal time, staff were offering people drinks. One person asked for apple juice. The staff member responded by saying, "We will see." We noted that this person did get a drink of apple juice.

We observed staff delivering care in a rushed and hurried way, and not noticing what was going on around them. For example, we saw a staff member knock a wheelchair as they passed. At the same time, another staff member was giving eye drops to this person. The staff member who knocked the wheelchair, did not appear to notice, until the staff member giving the eye drops mentioned it to them.

This was a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not everyone we spoke with had been involved in the review of their care. For example, one person said,

"No-one sits and speaks to me about my healthcare. I haven't got a clue what this plan might say about me." Another person said, "I don't know what that [the care plan] is." They then went on to tell us that they didn't feel involved in their own care. We asked who they thought made decisions about their care. They said "I am not sure. It's not me." Another said, "I haven't seen it if I have. I don't think I've been involved. I don't mind though." Another said, "What is a care plan." Once it was explained, they said, "I don't think I have one of those." A relative said, "I have never seen it. They don't involve the relatives. I've got Power of Attorney. I am never asked anything."

Most people could not recall being asked about which gender staff member they would prefer to support them with their personal care.

People told us that staff were often hurried and rushed. They said staff did not have time to spend to sit and talk with them. One person said, "They [the staff] chat as they pass." Another said, "Time would be a fine thing. They're always rushing here and there." They pointed to two staff members who walked passed. This person pointed to them and said, "Like that. They rush past." A relative said, "I think this is the role of family. It's just as well they have got us. Staff don't have time to sit and chat. I've not seen them do it anyway."

This was a breach of Regulation 9 (1) (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

At our last inspection, this key area was rated requires improvement, because the systems in place, did not encourage staff to provide people with personalised care.

At this inspection, the care and treatment provided by the service was task-centred rather than in response to people's individual needs and preferences. We observed and people told us, that established routines were in place, and that did not allow people to have control over their day to day lives. People told us that could not always make choices, as they would like. For example, some people told us, they could not always choose when they had a bath, when they got up, or, when they went to bed, or, where they sat.

People told us they did not always have choice and control over when they had a bath. Most people told us that bath time was at the weekend. One person explained, "It's down to the staff when they take me to the bathroom. We are only allowed a bath once a week. Staff will come and tell me when they can bath me." We asked what might happen if they asked for a bath now and they said, "I doubt they would let me, it is down to the staff when we have one." Another person told us that they went out last Saturday with their relatives, which meant they had missed their bath and had to wait a whole week to have one. A relative explained, "[Name] does not seem to be having a bath. After three weeks I said to the manager, but the following week, they still hadn't had a bath."

People did not have maximum choice and control over where they were sat. One relative told us that their relative was often put in a convenient place for the staff instead of where they wanted to sit. They finished their discussion with us by saying, "Until it was raised, [name of person] was invisible."
Some people did not have maximum choice and control over where they got up or went to bed. They told us that this was because they needed two members of staff to assist them and they were not always available. One person said, "They haven't got enough staff to take me. It's frustrating. I often feel frustrated about it."

Some people weren't sure if staff asked their consent. Two people were clear that this did not happen very often. One person said, "Not really. We just get on with things like washing and dressing." We asked people if they understood that they could leave if they wanted to and most people said they were unsure if they were able to.

Information surrounding people's preferences at the end of their life was not always recorded. This meant that clear guidance for staff to know what to do, and people's preferences when they are near to the end of their life, was not always available. Some care plans had information about decisions people had made on hospitalisation and where, appropriate a Do Not Attempt Cardio Pulmonary Resuscitation [DNCPR] was in place. A DNACPR is a way of recording the decision a person, or others on their behalf had made, that they were not to be resuscitated in the event of a sudden cardiac collapse.

From 31 July 2016, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. This means people's sensory and communication needs should be assessed and supported. The service was not actively identifying the information and communication needs

of people with a disability or sensory loss, and no one had been trained in the accessible communication standards.

Providers have a duty under information accessible standards to ensure that they identify people with communication difficulties and support them to be actively involved in their care and daily living. Staff lack of knowledge and understanding of this person's needs could result in the person becoming isolated, increasingly confused and have a negative impact on their mental well-being.

We observed a relative explaining to staff about how to support their family member with their hearing aids. One relative explained they had introduced a booklet which showed when new batteries in their hearing aid needed to be inserted. They said, "The staff don't notice the batteries need changing even with this. [Name of person] does not have capacity to tell them that they can't hear."

This was a breach of Regulation 9 (1) (2) (3)(4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that staff did not always respond to people in a responsive way. For example, one person told a staff member they were cold and that their fingers hurt. The staff members response, was to tell the person that they shouldn't be cold on a hot day like this. They did not offer an extra cardigan or blanket or look at ways they could make this person more comfortable.

A programme of activities was planned each week, but some people told us that these activities were not meaningful or stimulating for them. For example, one person explained "Sometimes I feel bored, because I can't see and so I can't read. I am a great one for reading. I miss it. There really aren't enough staff around to read to me regularly."

Staff did not always treat people in a dignified way. For example, during one conversation, a staff member continuously interrupted us to remind this person of what they had done. The staff member reminded them that they liked doing exercises. The staff member demonstrated by moving their arms to the side and up, saying, "We did these this morning."

One person explained how living at Brookes House felt for them. They said, "I have tried to have it different. I would like to choose when I have a bath. Sometimes it's not convenient for the staff. It makes you feel like a child. It's like being treated like a child and it isn't very dignified."

This was a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they liked the atmosphere of the home, but, one person said, "I do like the home but it's been all change recently. There have been lots of managers and staff changing. It feels a bit awkward sometimes." Another person said, "It's alright. Some days are calmer than others."

Before people were admitted to the service a pre-admission assessment was completed and this information had been used to develop a care plan. Despite people not being aware of their care plan, we found these had been regularly reviewed. Each person's care record contained a social profile, whereby information had been collected with the person and their family. It gave details about the person's life history spiritual needs and previous lifestyle choices. Information contained details of people's individual daily needs such as mobility, personal hygiene, nutrition and health needs.

Policies and procedures were in place to ensure complaints were recorded and investigated. The policy included details of how a person could escalate their complaint to the correct agencies if they needed to. Several complaints about the service had been made and these had been recorded and investigated.

Inadequate

Is the service well-led?

Our findings

At our last inspection, this key area was rated requires improvement. This was because a number of audits and checks were in place, but these had failed to address the concerns. Specifically, relating to staffing numbers and the competency of staff in relation to manual handling.

At this inspection, we found the governance and oversight systems had not improved, because the care being delivered to people was not always consistent or safe. Not enough had been done by the provider to address the concerns we found at our last inspection. For example, the provider had failed to address our concerns in relation to staffing levels, competency and deployment.

Quality assurance systems were in place to identify areas for improvement and audits had been completed which looked at a number of key areas.

Since the last inspection, the provider had sent us an action plan to address how they would deliver better care for people. They were also working with the local authority to look at ways they could improve, but the providers systems continued to fail. This was because improvements to people's experience of care, had not been made, and whilst we found that a system of auditing was in place, this remained completely ineffective to address the persistent issues. There was a lack of effective oversight based on observations of the care being provided.

Since our last inspection, the registered manager had left and at the time of this inspection, there was no registered manager in post. A registered manager is a person who has been registered with the Care Quality Commission to manage the service. The management function was being covered by a covering manager and the operations manager.

The previous inspection, found that task focused care had been encouraged. This had promoted poor staff behaviour and did not benefit people. At this inspection, we found that routine and task focused care was still present. No progress had been made by the provider. They had failed to ensure that people received personalised care, which allowed them to have day to day control over their lives and enabled them to make their own choices.

The provider had carried out a survey. We were told by the manager that they had carried out surveys to obtain feedback about the service being offered to people, to continuously improve the service. The records we were provided, showed that no people were asked their views, making this survey ineffective.

One person told us they could recall being asked about their views of the service, but then told us that the staff had filled it in on their behalf. When asked about completing a survey, typical comments from people and their relatives were; "Not that I know of." And, "I don't think I have, no."

During the inspection we found that the provider had not always complied with the General Data Protection Regulation. We saw people's records had been left out in communal access. These had not been retained

securely. We advised the manager of this immediately.

At our last inspection we reported that some handwritten information in some people's care plans, were illegible. At this inspection we found no significant improvement had been made.

The registered manager had not reviewed the information being recorded to make sure that handwritten information was legible enough, for staff to understand people's daily physical, emotional, health and mental health needs.

This was a breach of Regulation 17 (2) (a) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service. At our last inspection the provider had not been reporting all important events to us. At this inspection the manager was now reporting to CQC about events that had happened.

There was no credible statement of what the vision and values were and staff were not aware of them and could not explain what they were. This is important to help teams to work together using a shared ethos.

Regular meetings were held with people who used the service, their relatives and staff. Minutes of recent meetings showed that where concerns had been raised, these had been discussed. Not everyone was confident that these meeting led to an improvement. One relative said, "I think they are useful. We tell them what we think. I am not sure anything has improved as a result."

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 People were not always given in care in a personalised and responsive way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always given care in dignified and respectful manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People preferences around meal times were not always.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance structures in place did not ensure that people received safe and effective care.

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 People did not always receive their medicines on time and in a safe way. People were not moved and positioned correctly.

The enforcement action we took:

Notice of Decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to meet people's need in a safe way.

The enforcement action we took:

Notice of Decision to restrict admissions.