Rooks (Care Homes) Limited

Bramley House

Inspection report

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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

Overall summary

This inspection took place on 2 April 2015 and was unannounced. The service provides accommodation for up to 18 older people who have age and health related care needs. There were 11 people living at the service when we visited.

At an inspection in June 2014, we highlighted concerns that the service had not been well led, with a lack of effective management. Quality monitoring of service delivery was not well developed to provide assurance that the operational management of the home and the delivery of care and support to people was safe and to a good standard. We asked the provider to take action to make improvements. The provider did not send us an action plan to tell us how they were going to make improvements. At this inspection we found that improvements had not been made, and we identified further breaches of regulations.

The Provider is also the registered 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.

The registered manager had a limited presence in the home. There was a lack of management structure. Much

Summary of findings

of the decision making and operation of the service hinged on the presence of the deputy manager who was the most experienced member of staff. Her time was spent mainly working on shift alongside a workforce that was mostly comprised of new and inexperienced staff. Important documentation to inform staff about people's needs was not always completed. Some procedures, for example recruitment, were not appropriately monitored to ensure that all required checks had been made and all necessary information gathered before staff commenced work.

People's safety was being compromised in a number of areas. Some people told us they felt safe but others felt their health care needs were not being met and this placed them at risk of becoming unwell. People's needs were not adequately assessed when they moved into the service. This placed people at risk of harm as the support people needed to manage their health needs were not known by the staff caring for them.

People's care records had not been updated to reflect important changes to people's care and support needs. Two people did not have care plans and staff did not know their support needs. This put people at risk of serious harm as their health needs were not being monitored appropriately

Staff were friendly to people, but were not always respectful when writing about people in their care records. Staff were discreet when offering personal care support so as to maintain people's privacy and dignity. Activity provision was inadequate and no provision had been made for people who chose to stay in their rooms and could become socially isolated.

The provider did not have a system to assess the number of staff needed. There were not always enough staff to meet people's needs and many staff were new and a number were new to caring. Staff induction was inadequate and did not ensure they had the basic skills needed to support people safely. The quality of staff training was not sufficient to ensure staff had the necessary competencies to support people correctly, and use equipment appropriately to ensure they did not place themselves or people in the home at risk of harm. The management of individual risks was inadequate in respect of people's health conditions and procedures for the emergency evacuation of individuals from the premises had not been developed, so that staff knew what support each person would need.

Two out of four staff spoken with, who had received safeguarding training, were unable to explain what this was, or their role and responsibilities around this or that of other agencies. There was a risk therefore that some staff may not recognise abuse if it occurred.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Whilst no-one living at the home was currently subject to a DoLS, conversations with staff and a review of records showed that the deputy manager and staff were not familiar with this legislation. No action had been taken to assess people within the home to ensure they did not meet the criteria for a DoLS authorisation referral. In addition, staff did not demonstrate a good understanding of the Mental Capacity Act 2005, and only two staff working in the home had received this training. There was a lack of capacity assessments within people's care records to ensure they were able to make every day and important decisions about their care and support.

Medicines were not managed safely and some staff administering had received minimal to do so. There were large numbers of gaps in medicine administration records and medicines prescribed by the GP to prevent recurring conditions were kept without appropriate care plans in place for their use.

People said they enjoyed the lunchtime meals they received but the quality of tea time meals was variable and for some people this was given too early. People felt confident that they would tell a staff member if they had concerns or wanted to complain but there was no complaints procedure displayed, to inform them about how their concerns should be dealt with, and a complaints log was not maintained to demonstrate how complaints and concerns were being addressed.

The Care Quality Commission had not been notified as required of deaths that had occurred in the home. The provider carried out some audits however these were not used to drive improvement, and the frequencies of audits

Summary of findings

was not made clear. Where audits had identified shortfalls there was a lack of timescales or evidence that these had been addressed. Audits were not effective and failed to identify the concerns we found.

Although the deputy manager told us people were consulted about the service, there were no records to evidence this. When we asked people if they had been asked about their views they could not recall when this had happened. Visitors to the service and people's families were asked for their views in annual questionnaires. These views were not always acted upon. For example, the most recent survey analysis completed in February 2015 showed that a lack of activities for people had been raised, but despite this we found there was a continued lack of activities for people at the service.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Summary of findings

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.

Staff did not have an understanding of safeguarding and the protection of adults from abuse. Risks to people were not assessed. Medicines were not managed safely.

There were not always enough staff on duty to meet people's needs.

Pre-employment checks and processes were not robust to ensure suitable staff were employed. Emergency contact information was in place but procedures to follow in the event of emergencies were not well documented or familiar to staff.

People had broken furniture in their rooms. Essential safety checks on some parts of the premises had not been carried out.

Is the service effective?

Inadequate

The service was not effective.

New staff received an inadequate induction that failed to ensure they had the necessary competencies. Staff training was insufficient to provide staff with the knowledge and skills they required to undertake their role safely. Staff were not provided with regular opportunities to meet with their manager, to discuss their training and development needs and work performance.

People were supported to access routine and specialist healthcare appointments. However staff lacked an understanding of some people's health care needs and how these should be managed; this placed people at risk of inconsistent and unsafe care.

Staff lacked an understanding of mental capacity. Assessments for Deprivation of Liberty Safeguards and mental capacity assessments were not completed for people. People enjoyed their main meals but found evening meals of variable quality and for some people these were too early.

Is the service caring?

Requires improvement

The service was not always caring.

People were not involved in their care plans.

Staff showed kindness and patience in their interactions with people however this was not always reflected in information written by staff about people.

Staff demonstrated an understanding of the principles of privacy and dignity and practiced this in their everyday interactions with people.

People said their families were made welcome when they visited.

Summary of findings

Is the service responsive?

Inadequate 

The service was not responsive.

New people were assessed but important information was not gathered to inform staff about their care needs. Some people did not have care plans to inform staff about their needs and support preferences.

Care plans did not contain sufficient and up to date information about people's needs to allow staff to deliver care in a responsive and personalised way.

People said they felt confident about raising concerns with staff, but no record was kept of concerns raised and dealt with; and a complaints procedure was not displayed to inform people how to make complaints.

Is the service well-led?

Inadequate 

The service was not well led.

Action had not been taken to address previous breach of regulation we had identified. A range of audits were in place, however these were not used to make improvements to the service people received. The system used to assess and monitor quality was not effective.

There was a lack of leadership in the home. The registered manager was mostly absent from the service. The deputy manager undertook the running of the home on a day to day basis. The majority of staff were new to caring or new to the service. There was limited oversight by the registered manager to assure herself that the home was operating well and that staff and people in the service were well supported.

The provider was not notifying the Care Quality Commission of significant incidents. Relatives were consulted about the care people received through annual surveys. Comments in these surveys were not always acted upon.

Bramley House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This inspection took place on 2 April 2015 and was unannounced.

The inspection was conducted by two inspectors. Before the inspection we reviewed information we held about the service including previous inspection reports, safeguarding information, complaints and information from other sources. A Provider Information Return had been requested but this had not been returned in time for the inspection.

Before the inspection visit we reviewed the information we held about the service, including notifications. A notification is information about important events, which the provider is required to tell us about by law. Prior to the inspection we sent the provider a Provider Information Return (PIR) which we required the provider to complete and return to us before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider failed to complete this and we did not receive the PIR either before or following our inspection.

We spoke with all 11 people living at the service during the course of the inspection. We also spoke with three care staff and the deputy manager who were on duty at various times of the day.

We looked at a range of records that included four care records, four staff recruitment records, environmental risk information, staff training and induction records, menus and records of food provided, medicine administration records, accidents and incident information, operational management information including quality audits.

We have spoken to representatives of the local commissioning and safeguarding teams. We also spoke with four relatives following the inspection who raised no concerns about the service. We have contacted three health and social care professionals for feedback about the service.

Inadequate

Is the service safe?

Our findings

People told us they did not feel unsafe because the service provided them with a safe and secure place to live. They felt the presence of staff made them feel safe and that they were able to speak to them if they needed something or were concerned by anything. However, we found that people did not receive safe care or treatment at Bramley House, and were not protected from avoidable harm.

All staff spoken with told us they had completed an on line training course to understand safeguarding and the protection of vulnerable adults. Two staff who said they had completed this were unable to explain what safeguarding adults meant and their role within this. Both felt this was to do with taking action if a person had fallen or had an accident, or there was an issue with confidentiality. However both staff said that they would report concerns to their manager but in the event of this not being possible were unable to tell us what other agencies they could report concerns to.

Staff when prompted answered appropriately in regard to taking immediate action to protect a person from harm but there was a lack of understanding that this would be considered a safeguarding and should be reported through the appropriate channels. The deputy manager told us that there were policies and procedures regarding safeguarding but these could not be found at inspection and staff did not know where they were. The deputy manager was aware of contact details for social services and the local safeguarding lead and staff told us that they would report all concerns to the manager or deputy manager with the expectation that managers would escalate concerns.

The lack of a clear understanding of safeguarding responsibilities, and what abuse was could place people at risk of issues being over looked. This is a breach of Regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There was a recruitment process framework in place but this was not always adhered to. Staff told us that they had completed applications, and had attended for interview before being appointed. They knew that criminal record checks had been carried out, and character and conduct in previous employment references applied for. Recruitment records showed that a good range of personal identity was provided for each staff member and that in most cases application forms had been completed, but overall the recruitment process had not been completed thoroughly.

The provider had failed to ensure that staff they employed were suitable to work with people living at the service, and had failed to ensure that relevant checks and important information was obtained prior to offering staff a job at the service .We viewed five staff files. One contained no information in regard to application form, evidence of interview, references of conduct in previous employments, a criminal records check or evidence of personal identification, to provide assurance that appropriate checks had been undertaken before the staff member commenced work. Four others contained application forms but there was a lack of completion of these with no full employment histories. A lack of interview notes meant that there was no evidence that gaps in employment histories had been explored with applicants at interview. One file contained only one employment reference and a second file contained references that were addressed “To whom it may concern”, and were not directed to the registered manager in response to a reference request.

Some ISA first and Disclosure and Barring Service information (these are checks of whether the person has a criminal record or is registered on any lists barring them from working with people who use care and services) was not recorded on the files, although the deputy manager assured us this was in place. Evidence was not recorded that unsatisfactory information received about an applicant had been fully discussed with them and the judgment around how the decision to employ them was made and who by was not documented.

The failure to ensure that safe recruitment practices were followed is a breach of Regulation 19 (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises were small and homely with a pleasant dining and lounge area for people to sit in. Downstairs communal spaces and bedrooms were furnished and decorated to a good standard and people had filled these with personal possessions. People in downstairs rooms also had access out onto the patio areas outside their Patio doors. In the older part of the main house on the first floor, some bedrooms were in need of refurbishment with some broken or damaged furniture, for example drawer units

with broken drawer fronts, and water damaged worktop surrounds to sinks in some bedrooms. These could not only pose a risk of people hurting themselves on broken furniture but also pose an infection control risk with broken surfaces around areas where personal care is taking place.

Visual safety checks of fire alarm and emergency lighting equipment were undertaken by staff. Servicing of equipment including the boiler for the oil filled system had been completed by qualified contractors. We requested a copy of the electrical installation servicing certificate which was unavailable at inspection to ensure this was still in date but this had not been received. A maintenance record showing repairs and faults in equipment was maintained by staff and this showed that the majority of repairs reported by them had been addressed.

General environmental risk assessments were in place but these were undated, therefore actions identified as needed as part of risk reduction could not be tracked as to whether they had been implemented and when. For example the undated environmental risk assessment showed that a new fire alarm system was required and was to be installed because this posed a high risk. However, when we spoke with staff they were unaware of a new system having been installed, there was no timescale given for doing so and no interim risk reduction measures to minimise risks to people. The failure to ensure the premises and equipment at the service kept people safe is a breach of Regulation 15 (1) (c) (e) of the Health and Social Care Act (Regulated Activities) Regulations 2014

The environmental risk assessments did not take account of the individual risks people may have and this was not addressed within their own care records. For example there was a generic assessment of the risk to people from falls in the service's environmental risk assessment folder. There was no individual falls risk assessments within people's care plans. The service had not given consideration to the individual and specific needs people may have that could cause them to fall. Staff were unaware of the potential risks to individuals and this placed people at risk. Individualised and person specific risk assessments were completed for people with regard to moving and handling. Some people also had assessments completed in regard to their skin integrity. However preliminary assessments of risk in respect of nutrition, pressure ulcers and falls for everyone were not in place to provide assurance that people were or were not at risk, and to ensure that appropriate risk reduction measures were put in place.

Risk assessments were not in place for people with specific health conditions such as diabetes, or behaviour that challenged staff this meant that staff were unaware of the risks posed by changes in their health condition and this could place them at serious risk of harm. There was a low level of accidents and incidents, and records available of these showed that although staff had sought interventions from health professionals as necessary, the provider had not ensured that when people had had an accident or incident, that care plans were reviewed and updated to ensure people received care that was safe and met their needs, and had not implemented risk assessments to ensure future risks were managed.

Some people had pressure alarm mats in place to alert staff if they left their bedroom but a risk assessment supporting the use of this as a risk reduction measure was not in place. The deputy manager had ensured that people identified at risk of pressure ulcers were provided with pressure mattresses to reduce this risk, however, on one air mattress the setting was incorrect, and was set for someone significantly heavier than the person using the bed. Staff were unaware of what the setting should be, who was responsible for this, or that an incorrect setting could place the person at risk of damaging their skin integrity.

The failure to assess risks to individuals meant that people could be placed at risk of harm. This is a breach of Regulation 12 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have robust plans or systems in place to ensure people were safe during an emergency. A There were no arrangements for supporting people should the premises need to be evacuated. Personal emergency evacuation plans were not available in either the fire book or on individual care files, to inform staff what support each person would need to evacuate the building safely. There was no plan for staff to follow if the premises needed evacuation and what staff should do in this event. This is a breach of Regulation 12 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

Emergency contact arrangements were in place for staff to contact either the registered manager or the deputy. Emergency numbers for main services for water and electrics were made known to staff.

Medicines management was not always safe and this placed people at risk. Four staff were recorded as able to administer medicines but two new staff had only received one hour on line training and their competency to do so had not been observed or assessed prior to them being deemed competent to administer. Medicine Administration Records (MAR) showed that nine of the twelve people in the home had gaps in the recording of the administration of their medicines, there was no explanation for why prescribed doses had not been given, and this had not been picked up through medicine auditing.

Medicines which people might need for recurring conditions such as chest and urinary infections had been prescribed by their GP, these were only for use as and when required to help minimise the need for the people concerned to be admitted to hospital. These could only be given with the authorisation of the registered manager or deputy manager. Short term care plans were not in place to inform staff how these recurring conditions should be managed or how these medicines needed to be used in the short term. These medicines were kept in a box separate from the daily prescribed medicines, and when checked some were shown to belong to people who had since passed away; and should have been disposed of. Other medicines for a deceased person were left on a shelf in the office on the first floor and were not stored securely before disposal. Where two signatures were required for the administration of some stronger drugs, this was not always adhered to. A dose of antibiotics had been missed for one person; this meant that there was a risk that the effectiveness of a time limited course of medication such as this could be compromised by the person not receiving their medicines at the correct intervals.

The failure to ensure people received their medicines safely and at the right time are a breach of Regulation 12 (f) & (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always enough staff on duty to meet people's needs. On the day of our inspection three staff were on duty. This comprised of two care staff and the deputy manager. The rota showed that on most days three staff were on duty between 8am and 2pm, and two staff were on duty from 2pm until 8pm. From 8pm until 8am the following morning one member of staff was on duty. Between the hours of 9pm and 8am a member of staff who lived in a flat above the service was on call and although on the rota as a 'sleep in staff' member, they were not in directly in the service. There were no individual dependency assessments to ensure that the number of staff on duty was directly linked to the needs of the people being supported. This was compounded by the absence of risk assessments and care plan documents were inadequate and did not provide details of people's support needs.

People we spoke with said they thought there were enough staff to support them and the present group of people living there. However, although we observed that people's needs were met during the day of our inspection, we could not be confident that when one member of night staff was on duty for a period of 12 hours that this was sufficient to meet people's individual needs and to keep people safe. Most required support with personal care. This included one person who required the support of two staff. When the one staff member was supporting individuals with their personal care needs, there was no other staff present in the service to ensure people were safe.

On a day to day basis staff undertook most of the domestic chores in the house such as cleaning and laundry. We were told that a cleaner came in to undertake a deep clean at regular intervals, but we did not see evidence of this. In the absence of the cook due to holiday or sickness staff also undertook cooking duties. This meant that they were constantly busy with tasks, and there was only a short period in the afternoon where they had some capacity to spend time with people in the main lounge, but no planned time with those who stayed in their rooms, so there was a risk that people who did not frequent the lounge area could become isolated.

The failure to ensure that staffing levels were assessed and monitored and met people's needs is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People felt they were well cared for but some said they would like more variety in the tea time meals offered, other people felt the last meal of the day was too early and this had caused a radical change to their lifestyle. One person said they thought staff knew what they were doing but sometimes found it difficult to understand some of the overseas staff and commented "But we work it out".

The majority of staff were new to the service and to social care. A programme of training was in place which was on line training only, and there were significant numbers of gaps in the training recorded for staff with not all staff having completed basic essential training such as first aid and infection control, or specialist training to support the needs of some people in the service with Diabetes or behaviour that could be challenging. The lack of appropriate training to meet the needs of people in the service had placed people at risk of receiving inappropriate care and support. For example, people with diabetes had not received effective care or treatment when their daily blood sugar levels were raised. Although staff were taking people's blood sugars daily, they did not know what the levels meant or when they should take action.

Assessment of staff competency in regard to training they had completed was not in place to ensure staff had understood what they had learned and were able to put this into their everyday practice. We noted that several training certificates viewed had grades of D and E which did not demonstrate an acceptable level of competence, and there was no evidence to indicate that staff had been offered further support with their training or had to repeat it to improve their level of knowledge and understanding.

Records showed and staff confirmed that they had only received theory training in respect of safe moving and handling of people. Staff said they had not received practical training from a qualified trainer and had been shown by other staff how to support people correctly. No one amongst the staff or management team was qualified in moving and handling to ensure that what staff were learning from each other was either still appropriate for each person or accurate to ensure people were receiving safe moving and handling support. These shortfalls meant that people were at risk from staff that did not have the correct skills and knowledge to support them safely.

When we spoke to newer staff about their experience of induction to the service, they told us that they had been an extra person on shift on their first day, this had enabled them to familiarise themselves with household routines and the needs of some of the people. Induction is an important period for new staff which is used to ensure they have the basic skills and knowledge to support people safely, and for their competencies throughout this period to be assessed and monitored, one shift is not adequate to do this. There was no evidence of workbooks to show that new staff were working through a programme of induction units or had been signed off as competent by the registered manager.

The provider had failed to ensure that staff had effective support to enable them to carry out their roles and responsibilities. A staff member said they had received supervision (this is a regular meeting with your manager to discuss, work, training and development issues) from the registered manager sometime before Christmas, but other staff records showed that they had not received probationary or supervision meetings since commencing work. A programme of regular supervision was not in place.

The failure to ensure that people received effective care from staff who had the right knowledge, skills and support through induction, training and supervision is a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

No-one living at the home was currently subject to a Deprivation of Liberty Safeguards authorisation (DoLS) (these are decisions about depriving people of their liberty, so that they can be given the care and treatment they need, where there is no less restrictive way of achieving this). A review of records and conversations with staff showed them to be unfamiliar with how this legislation was to be implemented and their responsibilities. No action had been taken to assess whether anyone within the home met the criteria for a DoLS authorisation referral. People had mental capacity and were able to make most everyday decisions for themselves but no capacity assessments had been completed to show what they could and could not make decisions about.

People were able to give consent to everyday decisions but this was not always adhered to, and we saw that one person's rights had not been upheld; their records showed a friend without any legal authorisation to do so had signed consent for bed rails to be used, when the person

had capacity to make this decision for them self. Only two staff working at the home had received Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training. A lack of awareness and understanding amongst staff could impact on whether they ensured people's rights were appropriately upheld in regard to their care and treatment, and where they lacked capacity decisions were made in their best interest. The failure to ensure staff understood and followed the requirements of the Mental Capacity Act and the Deprivation of Liberty Safeguards, and the failure to ensure people's rights were upheld is a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people required support around the management of their diabetes. Records showed that staff were not aware of what the correct base blood sugar level range should be for each person, and records showed some people were exceeding repeatedly safe glucose levels for type one diabetes which should be less than 10 but were frequently between 20-30 which could place the people concerned as serious risk of long term harm if not addressed, and at the time of inspection there was no plan in place to reduce this down to safer levels. Staff lacked an awareness of the significance of this and the serious impact this could have on the persons concerned if this was not brought under control. Additionally attention to the care of foot and eye health for these people was not highlighted as of particular importance within their care records. Staff were aware of one person's dietary preference for cultural reasons but the specialist dietary needs of people with diabetes were not catered for. The failure to ensure people received effective healthcare which met their assessed needs was a breach of Regulation12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were examples of good practice, where the deputy manager had been proactive in seeking medical interventions, or accessing equipment for people to improve the quality of their lives. This included access to updated hearing aids, and sourcing pressure mattresses for people who needed them.

People said they generally enjoyed the main meals of the day which were at lunchtime. However, the quality of tea time meals was variable. One person told us that the quality had been particularly bad when meals were cooked by specific staff which meant on occasion they had received burnt or undercooked meals which were 'terrible'. These concerns had been relayed through surveys completed by people living at Bramley House and the deputy manager had taken action to ensure only staff who were competent in cooking now undertook cooking duties.

Several people said they had found the tea time meal at 4:30 pm to be too early, and whilst this may be suitable for some for others this had meant a complete lifestyle change for some people used to spacing their meals throughout the day over longer periods This meant that by 4:30 in the afternoon people were receiving their last meal of the day and by 6.30 pm in the evening they were given the last drink and biscuits until the following morning. No one required assistance with eating their meals. People were served with small snacks with their tea breaks and staff said they could ask for additional drinks if they wanted them. One person told us they had their own 'stash' of food which they accessed if they were hungry in the evening.

The meal times did not take account of the needs of some people with diabetes who may need to have their meals at greater intervals to try and maintain their glucose levels. People's nutrition and hydration needs were not assessed to highlight anyone who may be at risk and require additional support. We spoke with the deputy manager about whether it was possible to introduce a more flexible tea time to meet people's needs, and she said she would ask for people's views about this. The failure to assess people's nutrition and hydration needs, and the failure to ensure people had access to food and drink is a breach of Regulation 12 (1) (2) (a) (b) of the health and social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were unused to working with people displaying any type of behaviour that challenged and there was a lack of awareness about how they should be working with someone with these needs. Staff reported that a person's behaviour had deteriorated and as a result they were finding it more difficult to pacify them when they became overly anxious and became verbally aggressive to staff and others. Although there was evidence that the deputy manager was consulting with health professionals regarding the deterioration, no clear plan or guidance was available to inform staff of how to try and manage the person's anxieties in a consistent manner. Staff were unsure how to respond to the person when they were anxious and although they used some distraction techniques to divert the person they were unsure when they should do this and what they should use as distractions for the person. Other

Inadequate

Is the service effective?

people in the home were affected by the person's behaviour and chose not to spend time in the lounge because of it. This showed that staff were not managing this well and that others were at risk of becoming isolated because of it. The failure to ensure staff had appropriate skills to support people with behaviour that challenged others is a breach of Regulation 12(2) (a) (b) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

People and their relatives told us that the staff were kind and caring and that they were "Very nice girls". However, the care people received was not caring because the provider and staff did not recognise or meet people's needs. For example, Staff did not have the training or the skills to care for people with diabetes or behaviours which challenged others. People were not given any food or drink after 6.30pm until the following morning, and the provider and registered manager had not ensured that staff were trained in key areas such as medicines or moving and handling. This is despite people living at the service who required moving with a hoist and who required to take medicines for their healthcare needs.

The failure to ensure that people's needs were understood and met by staff is a breach of Regulation12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection staff were seen to be constantly busy undertaking task based activities for people. Interactions were relaxed and although staff were busy, they engaged with people in patient and friendly ways. Although staff understood the principles of privacy and dignity when they provided support and ensured doors were closed when delivering personal care, staff did not always talk about people in a respectful or dignified way: The quality of daily reporting about individual people was variable, some entries written by staff whose first language was not English were not always detailed to show that staff were fully aware of the persons wellbeing each day with brief sentences as to whether someone had 'slept well' or was in a 'good mood, sometimes the content of entries was not appropriate with staff sometimes using terms which are not acceptable to describe people. For example: 'the person is like a baby' (this was written about a person who needed support with their continence). This was discussed with the deputy manager who agreed this was an area of training and development for some staff.

The failure to ensure that people are treated with respect is a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was some evidence that people and their relatives had been consulted to develop life histories, but there was no evidence to demonstrate that people or their relatives had been involved in the development of their care and treatment plans. One person we spoke with said this was the first time they had seen their care plan and could not recall being involved in developing it.

People were not consulted about the way in which the service was run. The deputy manager told us that resident meetings had taken place. However, when we asked people about these meetings they could not recall them, or recall being asked for their views. We did not see and were not shown these minutes. Relatives and visitors were consulted annually through quality assurance questionnaires. They received feedback about the surveys and actions to be taken in response to some comments. The analysis of people's feedback showed that they were happy with the number of staff and staff attitudes, and they thought the communication they received from the home was good.

Relatives commented that they felt they were kept informed. This was supported in conversations we had with relatives following the inspection, who told us they felt they were kept informed of any matters relating to their relative. However when people surveyed had made negative comments, these were not included in the analysis and feedback. For example, the questionnaires showed dissatisfaction with the lack of activities at the service and the quality of the food.

The failure to ensure people were involved in making decisions about their care is a breach of Regulation 9 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported and encouraged to personalise their own rooms and these were filled with memorabilia from their lives which gave each room an individual and homely look.

Staff engaged warmly with people and people responded in a like manner. Choices were offered to people around meals and drinks and activities. We saw some examples of when staff interacted with people in a caring manner. For example a staff member spent time explaining something to someone that was making them anxious, and then provided a distraction by offering them an activity they enjoyed.

Requires improvement

Is the service caring?

People told us that their families and friends were made welcome. Relatives we have contacted after the inspection have told us that they find staff friendly and kind and were always made to feel welcome, and were offered refreshments.

Inadequate

Is the service responsive?

Our findings

People and relatives told us that if they had any concerns they felt confident of raising these and that they would be dealt with. However, people did not get the care they needed, did not have access to a complaints procedure, and when people did make complaints, these were not recorded.

Two people had recently been admitted to the service and an assessment of their needs had been undertaken by the registered manager These assessments lacked the information necessary to inform staff about their support and health needs for example management of people's specific conditions like diabetes and mental health needs; to ensure these were managed appropriately and safely. Transition information received from a previous home for one person was poor and as a consequence staff were not provided with a clear understanding of the person's health care needs and how these impacted on them; and would not recognise when this was not being managed appropriately.

The lack of appropriate transitional information had not been pursued with that service to gain more information and ensure that the support provided by staff at Bramley House was appropriate and safe. An interim care plan for staff to refer to had not been completed and there was a risk that staff could be providing an inconsistent level of care and support and the persons health needs may not be appropriately monitored or managed. There was no care plan in place for another person who was staying for a short period; staff were not provided with any documented information about the persons support and care needs, so as to ensure the care staff delivered was in keeping with the persons assessed needs, their preferences and was appropriate and safe. Staff were not made aware of any risks associated with the care and support of either person, so potential risks they might be subject to in regard to health or safety risks could be overlooked.

People did not receive personalised care that was responsive to their needs. We looked at four care plans. Each care record provided an overview of the person as a pen profile; two contained detailed life histories and had been compiled with the help of the person or their relatives. The care plans all had a record of people's specific needs regarding personal care and preferred support for the person in this area. However, there were no care plans in place to ensure people's health needs or mental health needs were met. For people who required moving with a hoist there was no guidance for staff to inform them how to do this safely. People who had a diagnosis of diabetes had no care plans in place to ensure their needs were met and there was no guidance for staff about how to monitor complications associated with this health condition. For one person with mental health needs who was also displaying behaviours which were challenging to others there were no assessments, care plans or guidance in place to support them or to inform staff about how to respond to their needs. When people's needs changed care plans had not been updated to reflect this. For example, one person's mobility had reduced significantly. But their care plan did not reflect this change or what extra support the person now required. Another person had lost weight and the deputy manager told us this was part of a weight reduction plan in agreement with the GP. However this was not reflected in the person's care records.

The failure to ensure people had care plans in place, and the failure to ensure care plans were updated to reflect changes in people's support needs and risks are a breach of Regulation 12 (1)(2) (a) (b) of the Health and Social care Act 2008, Regulated Activities Regulations 2014.

Seasonal activities, for example a summer fete and an Easter raffle were held at the service. There were no other activities for people in the service to participate in. On the day of our inspection we observed that two people were playing a game of dominoes and everyone else was either in their rooms or sitting in the lounge. Apart from a television being on in the lounge, there was no stimulation or activities available. Minutes from a staff meeting held in August 2014 stated that people had been asked about their interests, and the most recent resident's survey showed that people felt there was a lack of activities. We observed that staff were busy and task orientated during the inspection. They did not have time to engage with people in a meaningful way.

Some people were at risk of becoming socially isolated as they did not leave their bedrooms. There was no system in place to ensure people were not isolated, and although people in their rooms had some contact with staff, this was brief and usually was when they were given a drink or had support with personal care. One person told us they had stopped using the lounge as they were upset about one

Inadequate

Is the service responsive?

person's challenging behaviour. There were no plans in place to address this persons worries or their isolation. The lack of activity provisions meant people in the service had nothing to do every day. People had been consulted about activities, but their views had not been listened to and people's needs in this area continued to be unmet. This is a breach of Regulation 9 (3) (a) of the Health and Social care Act 2008, Regulated Activities Regulations 2014.

There was no information or guidance for people about how to raise a complaint or a concern. The provider did not have any system in place to inform people how to make a complaint, or to tell them what the process was when they had done so. The deputy manager told us that any issues raised with her were dealt with immediately, but these were not recorded and there was no log kept of concerns or complaints received on an informal or formal basis. We were unable to establish if any learning opportunities had come from complaints, or if there was a pattern of issues which might suggest reflective learning from complaints had not taken place.

People said that if they had any concerns they would talk to the deputy manager or talk to other staff or their own families. People were not aware that if they were not satisfied with the outcome of their complaint they could raise this with other agencies, for example an ombudsman. Some relatives we spoke with said they had raised issues previously and these had always been dealt with promptly, but also told us that they were strong and persistent in ensuring action was taken. Relatives said they did feel listened to. One relative gave a recent example of the service listening to their concerns and taking action to accommodate their relative in a better room.

The failure to ensure an effective and accessible system for identifying, receiving, recording, handling and responding to complaints from people and others is a breach of Regulation 16 (2) of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At a previous inspection in June 2014 we identified the service was not well led and was in breach of the regulation regarding the management of the service and the monitoring of the quality of the service people received. We issued a compliance action requiring the provider to take action to address the issues we had raised and identified. Despite being required to do so, the provider failed to send an action plan to the Commission outlining how they were going to address the issues raised.

The failure of the provider to send to the Commission a written report and plan detailing how they would improve the standard of the management of the service and the monitoring of the quality of the service people received is a breach of Regulation 17 (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider had not addressed the areas of concern raised at the previous inspection. In addition we found 21 further breaches of Regulations. This demonstrated that the service was not well led and had significantly deteriorated since our last inspection. The impact this had on people living at Bramley House placed them at daily risk of receiving care which was unsafe and inadequate.

At our inspection in June 2014 we found the provider had not informed the Commission when people living at the service had died. This is a legal requirement. At this inspection we saw that since December 2014 five people had died. The Commission had not been notified of these deaths as required by legislation. This is a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

At our inspection in June 2014 we found that although the provider had audit systems in place to monitor the quality of the service people received, these audits were not effective because when shortfalls were identified, there was no action plan in place to make improvements. At this inspection auditing systems and records we looked at showed the provider had not addressed these issues. In addition, we found further concerns relating to the quality of monitoring the care people received, and this placed people at risk of harm. A range of audits were undertaken at various times, but these were not robust and there was no clear frequency to when these happened. For example an environmental audit had been conducted once in the past year, this had only checked that call bells were in working order, that cleaning had been undertaken and bath and basin water temperatures were being recorded. No other room checks had been made within this to identify the condition of bedrooms, bathrooms or communal area furnishings, fittings or lighting.

Medicines audits were meant to be undertaken monthly but the frequency of these was nearer to two monthly. Medicine audits covered a number of areas for example; storage and administration, and records showed areas for improvement in these areas had been identified. However, there was a lack of timescales for implementing improvements, and the audits were not sufficiently in depth to identify the shortfalls we found with medicines management.

Accident and incident audits were undertaken at intervals to identify any trends or patterns, and showed that remedial actions were taken to minimise the risk of further occurrences such as pressure mats in people's bedrooms. However, no risk assessments to demonstrate how risks could be managed safely were in place. There was a lack of records audits to ensure all required documentation for every person living in the service was in place, accurate and kept updated.

Safe procedures had not been followed in regards to the assessment and admission of new people into the home to ensure their needs could be met safely. There was a lack of good practice in regard to the assessment and management of risk to people and staff, the recruitment of staff, and the safe management of medicine. Guidance and policies and procedures were not readily available to staff. Staff demonstrated a lack of awareness in regard to relevant legislation that impacted on the care and support they provided. People's care records failed to reflect changes in need or detail how specific health conditions were to be managed, all these shortfalls placed people in the service at risk of receiving unsafe care.

The provider's programme of induction and training to provide staff with the necessary skills and knowledge to support people safely was of poor quality. There was no evidence that staff competency assessments were undertaken following training to ensure they had understood what they had learned and could put this into

practice safely. Records showed and feedback from staff indicated that they were not in receipt of regular supervision to discuss their training and development or work performance.

The failure to ensure that accurate records were maintained and that robust quality assurance systems were in place and were used to drive continuous improvement put people at risk of receiving care and treatment that was unsafe. This is a continued breach of Regulation 17 (1)(2) (a) (b)(c)(d)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in June 2014 we found that the provider had not spent a lot of time in the service, and had not ensured a registered manager was in post. The provider had delegated the day to day management of Bramley House to an acting manager, and had not monitored the effectiveness of this arrangement. We learnt at the inspection in June 2014 that the acting manager had left the service. The provider informed us at the inspection in June 2014 that she had assumed day to day management of the service and was based at Bramley House full time. This included living on site in a flat above the service. Since the inspection in June 2014 the provider had registered with the Commission as the registered manager of the service. At this inspection when we spoke with people using the service some people had never met the registered manager, others had met them only once, and some newer staff had only met the registered manager on one or two occasions. We checked a sign in sheet for the registered manager and deputy manager; this showed that from 28 July to 26 November 2014 the registered manager was on site at the home on only 28 days out of 122 days. The sheets had been discontinued as the deputy manager was the only management figure present on a day to day basis after November 2014.

There was a lack of a staff structure to provide staff with support from an experienced senior in the absence of the deputy manager and registered manager and comments from newer staff and people admitted to the service would indicate that there was no evidence of regular oversight of the service by the registered manager. In a recent staff meeting, the minutes of the meeting recorded instructions for staff regarding access to the registered manager. The minutes stated, 'Phone calls for (the named registered manager) are to be ignored and we have permission to explain to the person on the other end of the phone that if the registered manager wants to get in contact with them then she will ring'. At inspection we witnessed a call from a staff member wishing to reach the registered manager urgently but they had been unsuccessful on numerous occasions throughout the day and calls had not been returned. This showed that the registered manager was not accessible.

The registered manager had appointed a deputy manager to manage the service when she was not available. This had become a full time role for the deputy who was the most experienced staff member in the home. Much of the recent and planned improvements were as a result of the deputy manager's input.

The provider did not have a system in place to ensure effective communication with the Commission. The provider had failed to return a key document to the Commission prior to inspection: the Provider Information Return. In addition, despite having written several letters to the provider over in relation to concerns the Commission had regarding Bramley House, the provider did not respond to any correspondence and has continually failed to engage with the Commission.

The continued failure of the provider to be present in the service, and their lack of contact with staff who worked at the service meant they were unable to ensure that their audit and governance systems remained effective. This is a breach of Regulation 17 (2) (f) 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 legal requirements 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 did not take formal enforcement action at this stage. 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 **The registered person had failed to ensure that people were involved in making decisions about their care. 9 (1) (c)** **The lack of activity provisions meant people in the service had nothing to do every day. People had been consulted about activities, but their views had not been listened to and people's needs in this area continued to be unmet.9 (3) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered person had not ensured that people are treated with respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The provider had not ensured that the premises and equipment used was suitable for the purpose it was being used and properly maintained 15(1) (c) (e)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had not ensured that people were protected from the risk of abuse because staff lacked an understanding of safeguarding and their role and responsibilities within this. Regulation 13 (1) (2)
	The registered person had failed to ensure that there was an effective and accessible system for identifying, receiving, recording, handling and responding to complaints from people and others.16 (2)