Blue Ocean Brookwood Limited

Brookwood Manor

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Brookwood Manor is a country manor which has been adapted into a residential care home. It provides personal care for up to 28 people, aged 65 and over and many of whom live with dementia. At the time of inspection, four people were living in the home.

People's experience of using this service and what we found
People were not always kept safe. This was because the environment was not entirely suitable for people living with dementia. The four remaining people were accommodated on the ground floor. We identified risks relating to ligatures and plastic bags. The environment was not cleaned in line with the cleaning schedules to prevent COVID-19. The garden was unsafe due to an open broken gate, stagnant water feature and loose bricks.

The wider registered environment on the first and second floor was unfit to accommodate people. It was in a state of disrepair, with some areas questionably un-safe. We asked for a schedule of works that was planned to bring this up to standard, but this had not been developed at the time of our visit.

People still did not have access to a usable shaft lift.

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

There were insufficient staff to support people. Vacancies were not filled. People were supported by a small regular staff team who had completed training to aid them in their role. Staff knew people's needs well and cared about individual's wellbeing.

Despite there being no cook meals were well presented and appetising as the interim manager had stepped in to provide a hot meal each day. The latest food hygiene rating was rated level one Major Improvement Necessary.

People did not have access to sufficient sources of meaningful engagement and were at risk of social isolation.

The provider had engaged the services of a consultant. Care plans were improved and care staff were given clear information to support people. Medicine management was generally safe with people getting their medicines as expected.

The service continues to have managers that do not remain long in post and do not register with CQC. This has led to sporadic oversight and inconsistent decision making and action to improve the service.

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

Rating at last inspection (and update)
The last rating for this service was Inadequate (published 15 June 2021).
At this inspection not enough improvement had been made and the provider was still in breach of regulations and remains Inadequate.

Why we inspected
This was a planned inspection based on the previous rating. We needed to ensure people were safe. This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvement. Please see the safe and well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We have continued to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified ongoing breaches in relation to good governance, staffing, complaints management, safe care and treatment and maintenance of the premises at this inspection.

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

Follow up
We will closely monitor this service along with our partner agencies. We will request a specific action plan relating to the environment and ensure the provider meets the terms of their registration. We want to understand what the provider will do to improve the standards of quality and safety. We will return to visit as per our re-inspection programme. If we receive any concerning information we will inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. We have taken action in line with our enforcement procedures. This means we have begun the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration. We have already placed conditions on the providers registration to prevent the admission of people to the service and to ensure the provider adequately assesses and monitors risks to the service.

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Brookwood Manor

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors conducted this site visit.

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

The service did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Prior to our inspection we reviewed information we held about the service. This included any safeguarding referrals and notifications that had been sent to us. A notification is information about important events which the service is required to send us by law.

The provider had not completed a provider information return (PIR) as we had not requested one. This is a

form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of planning we sought feedback from other agencies such as the Local Authority and we used this information to plan our inspection.

During the inspection
We spoke with all four people who used the service and observed their experience of the care provided. We spoke with seven members of staff including the outgoing and new manager appointed, care workers and maintenance.

We reviewed a range of records. This included four people's care records and their medication records. A variety of records relating to the management and maintenance of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service. We fed back our findings using 'Teams' and put this in writing to the Nominated Individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our last three inspections [8 December 2020, 2 and 9 March 2021 and 24 May 2021] the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had not been enough improvement at this inspection and the provider remained in breach of regulation 12.

- The shaft lift remained out of action. The intention was to have this repaired and not replaced as previously promised by the provider. This issue has been ongoing for a year. The impact was that people were put as risk as they would need to access the stairs and up until the week of our inspection visit people could not access bathing facilities. A shower had been installed on the ground floor.
- People were not always kept safe. There were ligature risks in peoples bedrooms in the form of roller blind cords [the blinds themselves had been removed], plastic bags were accessible to people living with dementia, a metal bracket stuck out from a wall next to a wash hand basin and posed a risk of injury.
- We inspected the whole premises to find that risks were not adequately assessed and monitored to keep people safe. Wardrobes were not all secured to the walls and therefore had the potential to fall on people. Radiator covers were not fit for purpose. Some were not attached or damaged. For example, rooms 9, 12, 20, 21, and 23 all had exposed radiators and wardrobes that were free standing. Therefore people were exposed to potential harm of scalding.
- The garden was unsafe for people to access and use. The wooden gate to keep the garden enclosed was broken and open. This led to the oil tank and maintenance shed. There were sharp tools accessible. The maintenance shed had electrical supply, petrol cans and paraffin. The roof had collapsed letting water and the elements access the electricity and fuel. This was a significant risk. We fed this back immediately. We were informed that the electrical supply had been isolated to make this area safe.
- The garden itself was unsafe. A metal grid / gate [similar to a large crowd control / perimeter fencing] had been placed in front to of three steps down into the lower garden. This had not been secured and posed a risk of falling on to people.
- The low brick wall surrounding the garden has started to crumble, leaving loose bricks. Random bits of MDF wood were laying on top of the wall. Part of the walled garden had previously been made into a water feature with a trough running along the back wall flowing into a container at the end of the wall. The water was stagnant and a fold up garden chair was in the water container. There were also plastic bottles in the

water feature. The lack of safety monitoring made this space unsafe for people living with dementia.

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

● Risk assessments in peoples care plans relating to falls, moving and handling, skin integrity and nutrition were all in place and up to date.

At our inspection 8 December 2020 inadequate staffing levels put people at risk of harm. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had not been enough improvement at this inspection and the provider remained in breach of regulation 18

Staffing and recruitment
● There were insufficient staff. The weekend before our visit, the evening after day one of our visit and planned on the roster were just two care staff on duty to support four people living with dementia. The needs of these people meant that for periods of time two staff were engaged with one person. Hence the other three people would have been unsupervised. In addition, these staff were required to cook, clean and access the second floor to do laundry. Suffolk Safeguarding team also shared our concern about insufficient staff.
● Each staff member we spoke with was concerned about staffing levels and those that were proposed. They believed that the provider was not listening to their concerns, despite meetings and email exchanges.

This placed people at ongoing risk of harm from insufficient staff to support them. This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The newly appointed manager's recruitment records were unavailable despite being requested more than once. This person remained four days and then resigned. No other staff had been recruited since our last visit to the service.

Preventing and controlling infection

● We were not assured that the provider was preventing visitors from catching and spreading infections. This was due to the lack of cleaning schedules being followed. These were found not filled in for several days. A cleaner was not employed each day.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. This was due to the service being rated as level 1 in food hygiene. A deep clean of the kitchen had been commissioned to address this. But this had been an issue from previous inspections and therefore we are not assured this will be monitored and maintained.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

The lack of maintaining a clean environment placed people at risk of harm. This was a breach of regulation 15 (1) (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
● There is some evidence that lessons are learnt when things go wrong, but overwhelmingly evidence shows that the provider needs to be obligated to take action. This is evidenced from actions taken by CQC, Suffolk safeguarding authority, Food Standards Agency, Anglia Water, BT and the Fire Service.

Systems and processes to safeguard people from the risk of abuse

At the inspection from 8 December 2020 people were placed at risk of continued harm with inadequate action taken to safeguard them. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● Staff had completed safeguarding e-learning to ensure they had the knowledge and competency to safely support people and highlight any concerns with the support offered.
● Incident and accidents records contained one off reports of specific behaviours that have resulted in safeguarding issues that were reported appropriately. Incident forms had appropriate detail; however, these were not always being reviewed on the reverse by the head of care to review themes and trends, e.g. appropriate equipment used. These forms showed a lack of managers review and follow up of incidents, and if safeguarding or CQC need to be notified.

Using medicines safely
● We had previously raised the best practice that when medicine administration record [MAR] are handwritten these should be double signed to ensure errors did not occur. This practice had not been adopted. One person's medicine did not reflect accurately the dose stated on the box corresponded with the dose stated on the MAR.
● Medicine stock tallied with the records and indicated that people had their medicines as prescribed.
● When required medicines were safely managed with written guidance for staff to follow.
● A new system to record any errors had been put in place that showed actions taken to prevent a reoccurrence. For example, staff received supervision or retraining.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs

- The design and adaptation of Brookwood Manor does not meet the needs of people living with dementia. Most of the home requires refurbishment and decoration throughout. A representative said, "We know the two top floors are not fit for purpose." A schedule of works was sent to us that outlined decoration, carpets and furniture required. This did not address the structure of the building, facilities such as heating and shaft lift or access to safe outside space.
- There was a lack of understanding about signage, use of colour and equipment that would enable people living with dementia to have independence and remain safe and lessen distress reactions.

The premises were not suited for the purpose they were being used. They were not properly maintained. This was a breach of regulation 15 (1) (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Brookwood Manor sets out to be a specialist facility for people living with dementia. However, we found no evidence to support this. The environment did not lend itself to best practice. The assessments and treatment and support on offer did not follow best practice. National Institute of Clinical Excellence [NICE] Guidelines such as NG97 published in 2018 was not known or used. The NICE–SCIE [Social Care Institute for Excellence] Guideline on supporting people with dementia and their carers in health and social care was also not used to support and provide the service. There was a lack of aids, adaptations and use of technology that would support people living with dementia.

Staff support: induction, training, skills and experience

- Not all staff had the appropriate skills. One staff member was in a duel role and did some care shifts, however they had not had the opportunity to attend training offered to care staff such as safeguarding and moving and handling. Care staff did not have an enhanced level of dementia care training as would be expected of a facility specifically for people living with dementia.
- Staff did have training through online e-learning. They had also had training for moving and handling, medicines administration and fire training provided face to face.
- Staff had felt supported by the interim manager who was on a fixed term contract but left shortly after our visit. One staff member said, "I have seen many managers come and go, but I love this manager, she is truly a beautiful person. Because of her we know how to care for people."

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People did not have access to a dentist for check-ups of their oral health. Oral health assessments had been completed. One person's referred to red and inflamed gums, poor hygiene and decaying teeth. This person [and one other] had only brushed their teeth on four occasions in the previous month. There was no mention or understanding of alternative methods of cleaning teeth, i.e. pineapple juice which has natural enzymes which works as a natural stain remover and plaque or chewable toothpaste.

● People were able to access healthcare from a local GP surgery. This included District Nurses and Nurse Practitioners who visited to treat people and held virtual surgeries once a week to monitor people's health.

● Staff communicated and enabled other health and social care professionals to visit and assess people's needs.

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

● People did have their nutritional needs met. We looked at peoples weight records and no one was losing significant weight. The staff were aware of who and how to refer people if they needed nutritional guidance.

● Despite not having a cook employed a hot meal was being prepared daily. On the day of our visit this was by the interim manager. People enjoyed the home cooked food that looked appetising.

● Following our visit we were made aware that the hot meal at lunchtime was being provided by an outside caterer who was able to deliver hot meals and knew how to cater for adapted diets.

● The Food Hygiene rating was level one. Actions were being taken to address the short falls found.

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Applications had been made to the local authority for DoLS. Assessors had recently visited.

● Records relating to the decision-making processes were appropriate and followed the principles of the MCA.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People were not consistently well treated and cared for. Staffing levels were not consistently adequate to ensure respectful support and treatment. The lack of a safe and clean environment shows that people have not been treated as well as they could have been.
- Care staff employed were found to have the best interests of people through their actions and deeds. Staff have worked and supported people in situations that have been difficult due to a lack of facilities. Staff were seen to be kind to people.

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

- People and their representatives were not routinely involved in decision making about their care. An example of this was the change from in-house catering to hot meals being brought in. People were given the choice on the day about what food they would like to eat, but consultation about the change did not take place. Similarly, a relative found out from the media that the care home was on the market and for sale. People and their representatives were not involved or informed on a regular basis.

Respecting and promoting people's privacy, dignity and independence

- People's privacy was respected to a degree with staff showing consideration to people spending time alone in their rooms. The new shower room however had a large hole in the door that eroded any privacy whilst showering.
- People's dignity was much improved with the installation of the new shower room on the ground floor. People had been able to have a whole-body wash and had their hair washed. Some had their hair styled by staff.
- People's independence was respected to a degree and people were able to self-determine where they spent their day within Brookwood Manor on the ground floor. Independence was not promoted through partaking in everyday activities such as laundry, setting tables, light housework and daily living tasks.

The lack of dignity and respect afforded to people with regards privacy, involvement and independence was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns
- There was little evidence of driving improvements through learning from complaints. There were two complaint/grievances in the file and neither of these had been dealt with in line with a complaints policy of acknowledgement, timescale and response or apology.
- Two complaints that we had been made aware of from neighbours had been long running and had not been resolved.

This lack of investigation and failure to act was a breach of regulation 16 (Receiving and acting on Complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
- Staff were spending more time with people than previously seen. However, there was a lack of engagement with people and more a role to observe and intervene if the person was unsafe.
- There was a lack of meaningful activities that were relevant and personalised.
- People were able to have visitors in line with government guidelines and two people had this in place.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
- Care plans had been developed from the same template and had other people's names used in their care plans. This error needed to be actioned and was also reported as a concern by Suffolk Safeguarding.
- Care plans had a form to chart and record distressed behaviour. Where the forms were used these were not being completed properly to understand the actual behaviour and what happened afterwards. Additionally, there did not appear to be any monitoring of these charts to understand and better respond to the distressed behaviour.
- Care planning had improved. Staff were guided by much more comprehensive and up to date plans than previously seen. These include good plans about people's specific health conditions with pictorial diagrams of the parts of the body affected to aid staff understanding, i.e. Asthma has a diagram of the lungs and how asthma effects the airways.

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

● We saw an example of a pictorial format with the use of photographs of food to show people what was for dinner. Peoples preferred communication styles were documented in care plans, which included the use of facial expression and body language.
● Care plans reviewed were documented in the same format. This would make it difficult for some people to have input or an awareness that this document related to them or that it was in place.

End of life care and support
● The purpose of end of life planning is to ensure people have a pain free death that is respectful and involves the person and their family. People had their wishes known about resuscitation and next of kin was known but, other wishes and plans were not recorded and therefore arrangements would be left until a person was actively dying. Staff had a reasonable knowledge of end of life care and were willing to learn more.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At our last inspection CQC were not notified of significant events. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

At this inspection enough improvement had been made and the provider was no longer in breach of regulation 18

At our last inspections we found a lack of assessing and monitoring quality and safety. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement was made and the provider remains in breach of regulation 17.

- The provider has not been open and honest with people, relatives and staff about the situation and plans for Brookwood Manor.
- Appropriate and timely action had not been taken as a result of our last inspections at this service, and the same areas highlighted are still a concern. December 2020 the service went into special measures and was rated inadequate. Six months have past and very little has changed for the people and staff of Brookwood Manor.
- This service remains without a registered manager. There has been no registered manager since 2019. Since the new provider took over in September 2020, we have been made aware of seven different managers that have been in day to day control. This lack of appropriate and consistent leadership has led to the confusion and a lack of timely actions taken.
- In a bid to understand this further CQC have repeatedly asked for information such as who is the decision makers and scheme of delegations. There has been a lack of oversight of the journey this service has been on, We at CQC have been told several times by representatives of the provider, "I do not know anything about that. It was before I started." Accountability and responsibility within the provider/management group has been sidestepped because of multiple changes in personnel and a lack of handover.
- Active quality monitoring on behalf of the provider has been sporadic. We have seen a couple of reports and minutes of meetings, but these fell short of capturing the real issues and prioritising action and ensuring

these are met and then reviewed to move the service forward quickly. An example of this was people were still sleeping in bedding that was stained. There had been confusion about ordering new sheets and managers thought others had actioned this. Others reported that payment had not been made therefore the order did not materialise.

● Care staff at the service feel they have been blamed for the situation and held responsible for failings. All staff we spoke with said that they were looking for new jobs. One staff member said that the provider, "It is shocking what has happened, they have abused everyone." Staff told us that they had not been informed about what was happening and felt that a lack of honest communication was leading to poor staff morale. There was a lack of mutual respect between staff and provider management.

● CQC placed conditions upon the registration of this service. The provider has failed to comply with these. When asked at the inspection there was a lack of ownership and responsibility for sending information to CQC. This has still not been received.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Working in partnership with others has been inconsistent. We appreciate that negative feedback can be difficult, but professional judgements have not always been respected. There have been times when managers and staff have engaged well that has brought about positive benefits for the people living at Brookwood Manor. However, we are also aware that some staff have been advised not to share and disclose information with CQC and Suffolk Safeguarding.

● We have repeatedly been contacted by members of the public as they were unable to resolve disputes through the complaints process at the service. One person had received a bill for the service with their address. This matter had gone so far as to being allocated to a debt recovery company and therefore the person was concerned they would be liable and their credit history marred. Another person contacted us with concerns relating to a broken water supply/metre and thousands of litres of water had been discharged on to their land. We were informed that water bills were not paid and the necessary repairs made.

● The payment of services rendered to Brookwood Manor was a common theme told to us from tradesman and staff. When questioned if finance was a concern, we were informed by the Nominated Individual that this was not the case. There had however been a systems change to get invoices paid and this had caused delays.

● People and staff at Brookwood Manor have not been invested in the changes at Brookwood Manor. The new provider has not surveyed or consulted to seek feedback or a benchmark from which to develop. No allowances were made for equality characteristics of people to play a part and being involved with the running of their own home, care and support.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not afforded dignity and respect with regards privacy, involvement and independence.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The lack of maintaining a clean environment placed people at risk of harm. The premises were not suitable nor maintained to a safe standard

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The lack of investigation and failure to act on complaints led to a lack of improvements.

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

personal care	governance There was a lack of oversight, assessing and monitoring quality and safety that led to people being placed at risk

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Inadequate staffing levels put people at risk of harm.