Ideal Carehomes (Number One) Limited

Brinnington Hall

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 24 and 25 October 2016 and was unannounced. This was the first time we have inspected Brinnington Hall when registered with the current provider. Our last inspection of Brinnington Hall when registered with the previous provider was June 2014, when we found the service was meeting all standards inspected.

Brinnington Hall is a residential care home providing care and support for up to 67 older people, some of whom have a diagnosis of dementia. The home is located in the Brinnington area of Stockport and is a large purpose built care home with secure gardens. All rooms are single and have en-suite facilities.

There was not a registered manager in post at the time of inspection. The former registered manager had worked at the home for around six months and had left in August 2016. The acting manager had been in post for three weeks and told us they intended to submit an application to register with CQC. 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.

Prior to our inspection we received concerns in relation to staffing levels, medicines management and respecting people's dignity. The provider had also acknowledged some shortfalls in relation to staffing levels and governance at the home. We identified breaches of seven of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to the safe management of medicines, risk management, recruitment processes, staff training and supervision, care planning and assessment, meeting the requirements of the deprivation of liberty safeguarding, dignity and respect, and good governance. We are currently considering our options in relation to enforcement and will update the section at the end of this report once any action has concluded.

We found there were sufficient numbers of staff to meet people's needs in a timely way. The provider had recently recruited staff and staff told us staffing levels had improved. Rotas showed that shifts were covered and there was decreasing use of agency staff. The provider acknowledged there had been previous staffing issues and the acting manager accepted this might have contributed to the high number of minor injuries/accidents we saw recorded in September 2016.

Prior to our inspection we were made of a substantiated safeguarding concern relating to a person who sustained an injury having fallen from bed in February 2016. One of the recommendations made was that staff should receive falls training. This training had not been provided at the time of inspection. The acting manager told us they were aware this training was required and had submitted a request to the providers' training department. We are continuing to carry out enquiries in relation to this concern.

Staff we spoke with knew how best to respond to the people they supported. People told us staff were kind

and caring in their approach and that staff respected their privacy and dignity. We observed staff had time to spend talking with people and observed many positive interactions.

People told us staff respected their privacy and dignity. However on two occasions we heard staff speaking loudly across communal areas to other staff members discussing people's personal care needs. This showed a lack of consideration for those people.

A range of activities were offered to people during our inspection. This included flower arranging, a visiting musician and an exercise group. Staff told us that since staffing levels had improved, they had found they had time to support activities and spend meaningful time with people. Trips out from the home were offered on a regular basis, and there were initiatives such as a 'pop-up restaurant' that we were told had been popular with people using the service and their relatives.

Care plans in most instances had been recently reviewed. However, we saw there had been gaps in the review of care plans in previous months and care plans were variable in their content and accuracy. Some care plans were not person-centred and contained limited information on preferences.

People told us they enjoyed the food on offer and we saw people were provided with a choice of meal. People were observed to receive the support they required to eat and drink. However, we found information about peoples' dietary requirements was not always clear.

The environment was clean, bright and spacious. There were a variety of communal areas within the home, including a recently completed cinema room, a family room and a mock bar area. Adaptations had been made to make the environment more accessible to people living with dementia, such as colour theming, pictorial signage and use of contrasting colours.

Records of medicines administration were not always accurately completed, which made it difficult to know whether people had received their medicines as prescribed. There was evidence that not all staff had followed safe procedures in the administration of medicines, which had resulted in one person not receiving one of their medicines as prescribed.

Staff received two weeks of training prior to commencing work at the home. Staff told us they found the induction to be good, although one staff member told us they would have liked to have been able to shadow more experienced staff for a longer period of time in order to further build their confidence. Staff told us they felt they received sufficient training and that training was of good quality. However, we saw a number of staff were overdue the provider's annual training refreshers. Provision of supervision had also been 'ad-hoc'.

The provider and acting manager were open and honest with the inspection team, and had identified a number of the shortfalls we also found prior to our visit. There was evidence that the provider had carried out regular support visits to help the former manager address areas of concern. The acting manager sent us an updated action plan and other evidence following the inspection that showed progress against identified actions was being made. Most actions had a completion date of the end of November 2016.

There was evidence that a staff member had commenced work at the home prior to their references and criminal record check having been returned. The acting manager told us the staff member would only have been training and not working directly with people during the period these checks were not in place.

Staff were consistently positive about the acting manager who had been in post for three weeks at the time

of our inspection. They told us they had seen improvements being made at the home since the acting manager took up post, and told us they were approachable and fair.

The acting manager told us they found staff were caring and dedicated. They gave an example of staff bringing in resources for activities in their own time out of choice. The acting manager said the provider was supportive and provided the resources they needed to manage the home effectively.

Staff had received training in dementia care, including taking part in a 'dementia experience' session, which aimed to allow staff to experience some of the impairments that dementia can cause. During the inspection we saw staff responded effectively to reassure people who could become upset or anxious.

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.

During the inspection we found there were sufficient numbers of staff on duty to meet people's needs. However, the provider acknowledged that there had been recent short-falls in staffing, which may have contributed to a high number of minor accidents that had occurred at the home.

Staff were aware of their responsibilities in relation to safeguarding. However, the provider had not ensured all actions relating to a safeguarding case had been completed to ensure people were kept safe.

Records of medicines administered were not always accurate. There was evidence safe procedures in the administration of medicines had not been followed consistently by all staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People told us they enjoyed the food and received enough to eat and drink.

Staff received a thorough induction prior to starting work. However, there were gaps in the provision of supervision to staff, and the training matrix indicated many staff were overdue refresher training in a variety of training topics.

The environment was clean, light and spacious. Adaptations had been made to help make the environment more 'dementia friendly', and staff showed a good understanding of dementia care.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us they found staff to be caring and friendly. Staff we spoke with knew people well, although one person living at the home told us they didn't always know staff members' names.

The home had recently decreased its use of agency staff.

People told us staff respected their privacy and dignity. We observed care and support being provided by staff in a way that would help uphold people's dignity. However, we also observed two occasions where staff communicated sensitive information by talking loudly across the room in front of other people.

Staff communicated effectively with people and were aware of people's communication support needs.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans had not been consistently reviewed on a regular basis. Some care plans were not person centred and lacked details on people's needs and preferences.

A range of activities were observed during the inspection, including flower making, an exercise group and a visiting musician. There were trips out from the home arranged and other events within the home such as a pop-up restaurant.

People told us staff were on hand when they required assistance, and we saw people received support as required during the inspection. However, we found the service of breakfast and meals was not always provided promptly in accordance with people's preferences.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The acting manager had been in post for three weeks at the time of inspection. Staff were consistently positive about the new manager and improvements they could see being made.

The provider and managers carried out audits to monitor and improve the quality and safety of the service. These had not been operated consistently and effectively to ensure the home was meeting required standards.

The provider and acting manager had identified many areas of required improvement prior to our visit. We saw there were action plans in place to address these shortfalls, which the provider updated following our inspection feedback.

Brinnington Hall

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 24 and 25 October 2016 and was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed information we held about the service. This included any feedback shared about the service via our contact centre or online through 'share your experience' web-forms on the CQC website. We reviewed previous inspection reports and notifications that the provider is required to submit to us about safeguarding, serious injuries and other significant events that occur at the service. We reviewed the Provider Information Return (PIR). This is a form that the provider completed before the inspection that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We sought feedback on the service from the local authority quality assurance, safeguarding and infection control teams, and Stockport Healthwatch. We received feedback from the local authority quality assurance team who shared copies of their monitoring visits and a recent medicines audit by the CCG. We also received a copy of the home's most recent infection control audit from the local authority health protection nurse. Where relevant, we have referred to this feedback in the main body of the report.

During the inspection we viewed areas of the home including the communal lounges, the kitchen, the laundry and a selection of people's bedrooms. We spoke with 17 people who were living at Brinnington Hall and four relatives who were visiting at the time of our inspection. We spoke with one additional relative shortly after the inspection, who contacted us to provide feedback. We carried out observations of care and support provided to people in communal areas of the home throughout the inspection.

We spoke with 12 staff. This included three night care assistants, the deputy manager, the acting manager,

the regional director, two senior care assistants, three care assistants, the maintenance person and the cook. We reviewed records relating the care people received, including five care files, medication administration records (MARs) and daily records of care provided. We also reviewed records related to the running of a care home, including records of supervisions, audits, five staff personnel files and records of servicing and maintenance.

Inadequate

Is the service safe?

Our findings

Prior to our inspection we received concerns about staffing levels not being adequate to provide safe care that met people's needs. This included concerns raised specifically in relation to staffing levels at night. The provider acknowledged during previous contact with them that there had been some shortfalls in staffing that they were working on addressing. The local authority quality assurance team visited the home in August 2016 and confirmed additional staff were in the process of being recruited.

People living at Brinnington Hall told us they felt there were sufficient staff on duty. One person told us; "Yes I suppose so. I'm, not left waiting." Another person said; "If I need to use my call bell I do. The staff come. I never have to wait." During the inspection we saw there were sufficient staff to meet people's needs in a timely way. We spoke with staff working on both night and day shifts who told us staffing levels had improved, and they felt there were enough staff on duty to meet people's needs. One staff member told us; "'When I started staffing was terrible. In the last three weeks it has got much better." A second staff member said; "Staffing has got a lot better since the change of manager. We now have more time to spend with the people. In the last three week's it has felt a lot 'lighter'. We are able to engage so much more with the residents."

The night prior to our inspection we found there had been one staff member less than expected on duty. Staff told us this was an exception due to late notice from the staff member cancelling their shift, and that shifts were usually covered. We reviewed rotas, which confirmed this was the case. There was occasional use of agency staff to cover shifts at the home. The acting manager told us they aimed to stop all use of agency staff and develop their own 'bank' of staff to cover shifts when required. We saw there were seven recently recruited care staff members who were undertaking their induction training at the time of the inspection.

We saw people had risk assessments in place in relation to falls, risk of malnutrition, risk of pressure sores and other areas of risk in relation to their care. These risk assessment identified actions to help manage and reduce potential risk. We checked whether risk reduction measures such as pressure sensor mats or pressure relieving equipment were in place where required and found that they were. Although most people's risk assessments had been reviewed recently and regularly, we found one person's risk assessments had a three month gap in their review, and another person's risk assessments had not been reviewed since March 2016. This would increase the risk that changes in the person's condition or changing risks were not adequately identified so that measures to reduce risk of harm could be put in place.

There were processes in place to monitor falls and accidents and to help with the identification of any trends such as in relation to the time or location of falls. The acting manager had also taken recent action to improve these systems by putting in place individual falls logs. We found appropriate actions had been taken when people had fallen, or experienced unplanned weight-loss such as updating the care plan and carrying out post-incident observations following accidents to help ensure any potential injuries were identified. We also found staff had made referrals to specialists such as the falls team, dieticians and physiotherapists via the GP when required, although this information was not always easily identified in the care plans.

In July 2016 CQC received minutes from the local authority safeguarding team relating to a person who had fallen from bed in February 2016 and sustained a serious injury. The safeguarding case was found to be substantiated and raised concerns around record keeping, and measures taken to reduce falls risk. One of the recommendations made was that specific falls training was carried out with the staff team. We checked and found this training had not yet been provided. The acting manager told us they were aware of the recommendation made prior to them taking up post at the home, and said they had requested this training via the provider's training department.

Despite finding appropriate actions had been taken in response to falls and other accidents, we saw from the provider's audits of accidents occurring in September 2016 that there had been a relatively high number of minor accidents. The acting manager acknowledged that previous staffing levels may have contributed to the seeming high number of incidents at this time. Records of falls also showed a number of unobserved falls, including one person who had sustained three unobserved falls despite an identified risk reduction measure of ensuring the lounge was always covered by staff when they were in that area. We spoke with this person's relative, who, although happy with the care their relative was provided with, told us they had previously raised a complaint about staff supporting their family member to bed early due to their falls risk. This was an inappropriate response to managing risk in this instance.

The provider had failed to ensure care and support was consistently provided in a safe way, and adequate, proportionate actions to reduce risk were not always taken. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff we spoke with told us they had received training in safeguarding. Staff were able to tell us how they would identify and report any safeguarding concerns, although none of the staff we spoke with told us they had had to do this. Staff said they felt confident to raise any concerns they might have with the acting manager or the regional director if needed.

The local authority had identified that the previous manager was not aware of local safeguarding procedures in relation to the reporting of safeguarding concerns of different severities. The acting manager told us they had been due to attend this training on the day of our inspection and would re-arrange this training as they had not previously worked within the Stockport local authority area.
We found the provider kept a log of safeguarding referrals made to the local authority, and could see that they had undertaken appropriate investigation when requested to do so by the safeguarding team. Appropriate actions had been taken to help ensure people were protected from harm, including taking disciplinary action against staff when required. However, we found that not all safeguarding concerns were reflected on the home's safeguarding log. Two safeguarding referrals made to the local authority safeguarding team were not recorded in documentation kept at the home and had also not been reported to CQC as required. These safeguarding referrals had been made by an interim manager at the home. However, as they had not been appropriately recorded, the current acting manager had not been aware of them.

People told us they received their medicines regularly and on time. One person said; "My medication is in a pod and I get it on time. It's very organised." Senior staff administered medicines and confirmed they had received training and had their competency to administer medicines checked. We saw medicines were kept safely in locked medicines trolleys that were kept in locked treatment rooms when not in use. The treatment rooms were air conditioned and the temperature of the room and medicines fridges were monitored to ensure medicines were kept at the required temperature. However, we found thickening agent used to thicken drinks had been left unsecured in one person's room. NHS England issued a patient safety alert in February 2015 in relation to risk of asphyxiation through accidental ingestion of thickening agents. Staff told

us they were unsure why the thickener was in this person's room as drinks were normally prepared in the kitchen area and the thickener locked away in the cupboard afterwards. Staff removed the thickener when we made them aware.

Prior to our inspection we viewed the findings of an external audit of medicines at Brinnington Hall, conducted in September 2016 by the clinical commissioning group (CCG). This raised concerns that staff had signed medication administration records (MARs) to indicate medicines had been given, despite the medicines still being present in the monitored dosage system (MDS), indicating they had in fact not been administered. The MDS in use meant that the majority of people's medicines that were required to be administered at particular times of the day were contained within one 'pod'. However, not all medicines were suitable to be contained in the pods and if medicines were prescribed outside the normal monthly cycle, these could be received separately. It is therefore important that staff administering medicines follow the usual safe procedures of checking the medicines administration records (MARs) to ensure people are administered all their prescribed medicines at the correct time.

We found evidence that not all staff had consistently followed such safe procedures. We found that none of the medicines recorded on the MARs for people living on the first and second floors of the home had been signed for on the last day of the previous cycle of medicines. The provider checked records of returns and spoke with the staff member responsible and informed us the medicines had been administered from the MDS, but that the staff member had not signed to indicate this. We also found that this had resulted in one person not being administered their medicine as required, which was likely to be due to this medicine not being contained the MDS and the staff member not having checked the MAR. The provider addressed these concerns appropriately with the staff member. We found the recording of the application of cream medicines was inconsistent. The MARs did not always contain adequate information for staff to follow in relation to when creams should be applied. We also found multiple examples when records did not demonstrate that creams had been applied as frequently as directed by the prescriber.

We found medicines prescribed to be administered on a 'when required' (PRN) basis were not always managed effectively. There was no protocol in place to inform staff when to administer one person's PRN medicine, and other protocols were limited in detail, for example, stating 'pain' as the reason why a pain relief medicine would need to be administered. We found one person had a PRN protocol in place for a pain relief medicine and also found this medicine was in stock. However, this medicine was not recorded on the MARs, which meant it was not clear whether this medicine was currently prescribed or would be required.

The provider had not ensured medicines were managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked whether the provider followed safe processes in relation to the recruitment of staff. All staff had a disclosure and barring service check in place (DBS). DBS checks inform the employer whether an applicant has any noted police record or is barred from working with vulnerable people. This helps employers make safer decisions when recruiting staff. Staff files contained other required checks such as proof of identity and application forms had been completed. Providers are required to obtain a full employment history from potential staff. We saw two people's application forms only requested a five year employment history. For one person their employment history did not go back further than five years as they had been in education prior to the listed employment. However, in the second staff member's file, there was a gap in their work history that was unaccounted for. This meant the provider had not carried out adequate checks to ensure the staff member was suitable to work with vulnerable people. The regional director told us the application form had been amended to ask for a full employment history following a CQC inspection at one of the provider's other locations. They told us they would ensure any copies of the old format application form

were deleted.

Staff we spoke with told us they received an interview as part of the recruitment process. However, there were no interview notes in the files of two staff members. In two staff personnel files it was also unclear who had provided the employment references, and in one case the date the applicants start date was prior to the date of return of the references and DBS check. The acting manager told us this person would have been undertaking induction training during this period and would not have worked unsupervised with people.

These gaps indicated systems were not operated effectively to ensure people employed were of good character. This was a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The environment at Brinnington Hall was clean and tidy. Relatives and people living at the home also commented positively on cleanliness of the home. There were no malodours present at the home and we could see most of the carpets had been recently replaced. The home was in the process of replacing furniture, and we saw one of the older sofas due replacement had a torn cover. The acting manager said this was due to be replaced in the near future. We saw peoples had their own named slings when they required assistance using a hoist. This is good practice in relation to the prevention of spread of infection.

Staff told us there were always adequate supplies of personal protective equipment (PPE) such as gloves and aprons to use when supporting people for example, with personal care. The local authority's health protection team had conducted an infection control audit at the home in June 2016. This audit identified several areas where actions and 'urgent actions' were required to meet relevant infection control standards. The acting manager was able to show us evidence of actions taken to make improvements, which included purchasing new cleaning supplies.
A food hygiene inspection had taken place in June 2016 where the home received the highest possible rating of five/very good.

There were routine checks in place to help ensure the safety of equipment and the building. These included checks by a competent person of lifting equipment, gas safety, window restrictors, wheelchairs, the fire alarm and the electrical system. The home employed a maintenance person who also completed regular checks in relation to fire safety and the water system to ensure water temperatures were within a safe range and to reduce the risks of legionella.

We asked to see the home's emergency or contingency plan. This details what actions staff should take to ensure the safety and wellbeing of people using the service in the event of incidents such as fire, flood or loss of utilities. We saw an emergency plan was in place; however review of this plan had been due in March 2014, and there was no evidence this had been done. There was an up-to-date fire risk assessment in place. However, personal emergency evacuation plans (PEEPs) were limited in the detail they provided about the support people would need to evacuate in the event of an emergency. The acting manager told us they would ensure the PEEPs were reviewed.

The provider had not taken all reasonably practicable steps to reduce the risks in relation to emergency evacuation of people living at the home. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's care plans contained capacity assessments where required, and screening tools to determine whether a DoLS was needed. We looked at the home's DoLS records, which showed there were four authorised DoLS and that there had been 28 further applications made, which were awaiting authorisation. The acting manager had audited the DoLS folder when they took up post and told us they were unable to determine for whom applications had been made, or if they had been authorised. They had contacted the local authority DoLS team to try and determine the status of any applications made. As a result they had produced an updated matrix that showed there were a further 21 people who required a DoLS, but there was no record of an application having been made.

Staff also informed us of one person who could actively try to leave the home and was prevented from doing so. There was no record that a DoLS application had been submitted for this person. This meant the service was potentially depriving this person, and others, of their liberty without the appropriate legal authorisation. The acting manager told us they would submit an urgent DoLS application in respect of this person. They also told us they were in the process of writing to families to inform them they may be invited to take part in best-interests meetings ahead of making DoLS applications for the remaining people who required a DoLS application.

Most staff were aware of the reason a DoLS may be required. For example, staff said a DoLS would be required if a person was unable to make their own decisions about leaving the home. Three staff members we spoke with were not aware of which people living at the home had an authorised DoLS in place. It is important staff are aware of such details to ensure care provided is both legal and meeting that person's needs.

The provider had failed to ensure they were acting in accordance with the MCA, and that people were not deprived of their liberty without lawful authority. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff members had a variable degree of understanding in relation to the principles of the MCA and DoLS. Staff we spoke with told us they would support people to make their own decisions whenever possible and were aware that decisions taken on someone's behalf should be in their best interests. One staff member

demonstrated a good understanding about decision making processes in accordance with the MCA and the need to hold best interests meetings for certain important decisions. People living at Brinnington Hall told us, and we saw that staff always asked for their consent before providing any care or support.

We received positive feedback from people about the food provided and people told us they always received sufficient amounts to eat and drink. One person told us the food was 'very good' and when asked if they received enough to eat and drink, replied 'without a doubt'. Another person commented; "These sausages are lovely, very tasty," whilst eating their meal. We observed that the meal times were relaxed and people received the support they required to eat and drink. The chef told us they worked on a four week menu cycle, but that this was adaptable. There were two choices for the main meal, which on the first day of our inspection was stewing steak or fish cakes with vegetables. There were photo menus to help people make a choice of meal, and we also observed staff presenting both options to people when serving the meals to support them to make a choice. The chef told us there was always sufficient stock and staff said if people wanted an alternative the chef would always accommodate requests if possible.

We saw risk assessments were used to assess people's risk of malnutrition. The provider was in the process of changing the risk assessment tool used, which they said had been at the request of other health professionals involved with the service. Where people had been identified as being at risk of malnutrition we saw their weights and intake of food and drink were monitored. There was evidence that staff had contacted health professionals such as GPs where people had experienced unplanned weight loss, and plans for managing weight loss had been put in place. We noted that records of intake were limited in detail, for example just recording a meal had been eaten, but not stating what meal this was or documenting quantities of food/fluids. Following the inspection the acting manager sent us a new food and fluid intake recording form that they planned to introduce.

People told us they were supported to see a GP or nurse if they had any health concerns. One person told us; "I can see a doctor when I want if needed and my medication is given to me regularly." However, one relative told us the procedures in place in relation to the management of medical appointments appeared 'disorganised', such as staff not knowing why a referral had been made and resulting in appointments having to be re-arranged. There was evidence that health professionals including GPs, physiotherapists and district nurses had been involved in people's care, although the outcomes of such appointments were not always easy to follow in the care plans and related records.

We saw information was displayed in kitchen and in a locked cupboard in the satellite kitchens to inform staff and the chef of any special dietary requirements a person may have. However, this information, and the information in care plans was not always clear about requirements to modify meals to a particular texture/consistency for people who may have difficulties swallowing. The information in the kitchens stated 'soft option' for several people and staff told us this could mean meals needed to be pureed or that they should just be soft. We saw one person was provided with a pureed meal and staff said they would be provided with either soft or pureed food dependent on the food type and whether they were struggling with certain food at that time. The care plan was not clear about the texture of meal this person required. The acting manager told us they would ensure this person's care plan was re-written to ensure it was accurate in the information it provided. They also made a referral for this person to be seen by a speech and language therapist (SALT) to advise on any required adaptations to this person's meals due to possible swallowing difficulties. We also spoke with a relative who told us staff had stated their family member received a pureed meal, and that when they queried this there had been no mention of this in the care plan.

This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as the provider had not adequately assessed people's needs in relation to their dietary requirements.

Brinnington Hall Care Home is a modern, purpose built care home based on three floors. The environment was spacious and light and there were communal lounge areas on each floor. The home had recently converted one of the smaller communal lounges into a 'cinema room', another was used as a 'family room' and there was also a mock bar area. The corridors were wide and would be easy for people using wheelchairs or other mobility aids to access. Adaptations had been made to make the environment more dementia friendly. This included the use of sensor lights, themed areas, directional and pictorial signage, people's photos on their bedroom doors and contrasting colour grab rails in the corridors and bathrooms. Such adaptations would help people move around the environment safely and independently. Other adaptations included the provision of 'rummage boxes' and provision of items that might interest some people living with dementia. During our inspection we saw people moved freely around the home, receiving support from staff to mobilise when required.

Staff told us they had received training in dementia, and some staff told us they had also taken part in a dementia experience session. This was a session that aimed to simulate some of the ways dementia can affect people's sensory experience. The provider informed us in their provider information return (PIR) that this session had been provided twice in the previous six months. During our inspection we saw staff responded effectively to people to provide reassurance and distraction when they showed signed of anxiety or becoming upset.

Staff told us they thought the training and induction provided was useful to assist them in their roles. One staff member told us they thought the training was 'outstanding' compared to that they had received with care providers they had previously worked for. Staff told us they undertook a range of training, including training in moving and handling, infection control, safeguarding, MCA/DoLS, food hygiene, basic life support and end of life care. The home's records of training indicated some gaps in training provision. Of the 24 care staff working at the home (discounting staff on long-term leave and undertaking induction training) the training matrix indicated less than half of the staff had completed safeguarding training; and around one quarter had completed MCA/DoLS; moving and handling; fire and health and safety training. A larger proportion of staff were shown to have completed recent training in first aid and dementia care. We saw a higher number of staff had completed these training courses in the past three years, but the provider's annual required refresh dates for many of these courses had passed. The acting manager told us many of these training courses were also covered during staff induction, but were not identified on the training matrix. Staff we spoke with confirmed induction training covered a range of these topics including moving and handling, dementia and safeguarding. They told us the provider was moving the majority of training, other than medicines training and moving and handling training to a new e-learning system, which meant other recent training was not currently reflected on the training matrix. The provider sent an updated training matrix following the inspection that showed progress had been made in ensuring staff completed refresher training in key areas including the MCA and moving and handling.

There had been a high turnover of staff at the home, and many of the care staff we spoke with had been in post around six months or less. New staff undertook two weeks induction training prior to starting work. Staff told us they thought the induction training prepared them sufficiently for their role, although one staff member told us they had only been given opportunity to shadow other more experienced staff for two days before being required to work independently. They told us they would have liked opportunity to shadow for longer to gain more confidence, but understood this was not possible due to staffing pressures at the time. Induction training was designed to cover the standards of the care certificate.The care certificate is a set of minimum standards that should be covered for any new care workers to ensure they have the required competence to care for people safely and effectively. We saw there was a structured six month probation period in which key competencies were developed and assessed, as well as tasks being set for staff members such as reviewing policies and procedures.

The services supervision matrix indicated there were large gaps in the provision of supervision to staff. This indicated there had been 15 supervisions held in the previous ten months for 37 staff shown on the matrix. When we asked to see records of staff supervision we were provided with copies of nine loose records. Staff indicated that the provision of supervision had been ad-hoc, and one staff member told us they had received a recent supervision, but prior to this had not received supervision for around 18 months. The acting manager acknowledged that supervision of staff did appear to have lapsed prior to their arrival. They told us they were working on implementing regular supervision again, with an emphasis on supervisory staff recognising good work undertaken by staff and not just using supervision to address areas of concern. The acting manager sent us an update following the inspection that showed progress had been made in ensuring staff had received recent supervision.

The provider had failed to ensure staff received appropriate training, support and supervision. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us they found staff to be kind and caring. Comments made included; "Staff are very good, wouldn't grumble," "They look after you," and "Staff are lovely, very kind." One relative told us; "Ninety percent are caring and helpful people, but they are restricted by staffing levels and resources." During our inspection, we observed warm and friendly interactions between staff and people living at the home. For example we saw staff sitting with people and providing comfort to them if they had become anxious or upset. Staff communicated with people in a natural manner, discussing topics of mutual interests.

From our discussions with staff members it was clear that staff had got to know people they cared for well. For example, one staff member told us; "[Person] likes having their hair done and likes you to sit and talk with her. We go through the newspaper with her." Staff told us they worked across all three floors at the home. They told us this although this meant they did not get to know people as well as they otherwise might, they felt this approach worked as they got to know more people living at the home. This would help ensure consistent care was provided when staff cover was required.

We asked people whether they knew the staff who provided support to them. Most people told us they usually knew the staff on duty, although one person commented; "I like to know their names [staff members] so I don't have to say 'hey you.' You don't always get a name." One relative we spoke with also noted there had been a recent high turnover of staff at the home, and the provider acknowledged this was the case. Agency staff had been used to cover shortfalls in the rotas, although the acting manager told us the use of agency staff had recently greatly reduced. The rotas indicated there had usually been at least one agency staff member on the night shift and up to three agency staff members on the day shifts. The provider told us that they expected the regular use of agency staff to reduce following recent recruitment.

We asked people whether they felt their privacy and dignity was respected by staff. One person replied; "I suppose so, yes. They do their best for you." Another person told us they felt staff did respect their privacy but added that they found staff only knocked 'casually' before entering their room. We saw staff were in most instances mindful of respecting people's privacy and dignity. For example, we saw staff communicated clearly with one person when supporting them using a hoist. They were also careful to assist this person to re-arrange their clothing whilst they were lifted. Another staff member discreetly asked and then supported a person to go and change their clothing after they had spilled some food on their top during the mealtime.

However, we also observed two instances where communication was less discreet and respectful. We heard one staff member saying loudly in the lounge area; "I'll take [Person] to the toilet," and another staff member was heard to loudly say to another; "I am going to put [Person] in the chair now." One relative told us they had found their family member's support with oral care and other aspects of personal hygiene had on occasions not been adequate, although they said this seemed to have recently improved. They also said they had previously found their family member to have faeces under their finger nails. We also observed some people who appeared to have unclean nails. We discussed this with the acting manager who said they would highlight this area for improvement with the staff team.

These issues in relation to upholding peoples' dignity and treating them with respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw staff communicated clearly and effectively with people. Peoples' care plans contained information on their communication needs and topics of interest to them that staff could use as conversation starters. Information on any communication aids the person used such as hearing aids or glasses were included in the care plans we reviewed. Staff demonstrated an awareness of how to communicate effectively with people who could find it hard to communicate verbally or understand what was being said to them. For example, we saw staff presenting options of meals to people visually. One member of staff talked about a non-verbal gesture a person used that indicated they had 'had enough' and didn't want staff to continue sitting or interacting with them.

The acting manager told us they found the staff to be very committed and caring. They told us that staff had come into the home on their days off to support activities for example. They told us staff had not done this with the intention of wanting to be paid, but because they did care about people living at the home. We asked three staff if they would be happy for a friend or family member who might need residential care to live at Brinnington Hall. All three staff responded positively to this question. One staff member said; "Yes, and I'd live here," and another said; "Yes, definitely. It's a lovely home."

We asked staff how they would support people's independence. Staff told us they got to know people and what they were able to do. They said they would encourage people to do things for themselves such as getting dressed or making choices where they were able to do so independently or with support. We saw staff made sure people who had mobility aids such as walking frames, had these pieces of equipment nearby. This would help ensure people were able to mobilise safely and independently around the home.

People told us their relatives and friends were able to visit without restrictions, and there were areas throughout the home where people could sit and talk with relatives or visitors in private should they wish. We saw evidence of family member's having been involved in the development of people's care plans where this was appropriate. One relative told us they were confident that the home would contact them if they had any concerns regarding their family member's well-being. We heard staff talking with a relative and offering reassurances that they could ring later for an update on how their family member was due to them having been agitated earlier in the day.

Requires Improvement

Is the service responsive?

Our findings

Care plans and pre-admission assessments were variable in relation to the level of detail they contained about people's support needs and preferences. Some care plans contained information such as social histories and information on preferences about how care should be provided. However, this information was not present in all care plans. We saw one person's care plans had not been reviewed since March 2016. Although staff had carried out recent reviews of the other care plans we looked at, we saw there had been gaps in the monthly reviews, particularly between June and September 2016. The most recent reviews in October 2016 lacked detail and often stated the care plan had been reviewed with no changes required. Such statements had been made even where we found information in the care plans to be out of date or contradictory, such as in relation to the support people required in relation to eating and drinking and discussed in the effective section of this report. We found relevant information difficult to locate in many of the care plans. It is important relevant information about people's needs is easy to locate by both staff and other professionals who may require information about people's care needs. Two staff we spoke with acknowledged they did not regularly look at care plans. One staff member commented they had started looking at care plans when they picked up some night shifts, and said they had only then found out about a mental health condition one of the people they supported had. Another staff member was not able to tell us about a person's social history and commented that it would be useful for such information to be recorded somewhere. The acting manager acknowledged that care plans required review, and we saw they had produced a tracker to monitor progress in relation to this.

We asked people whether they were able to make day to day choices around aspects of their support, such as the time they were supported to get up from bed and when they were assisted with washing and bathing. Most people confirmed they were able to make such choices. One person told us; "They [the staff] ask what I want and when I want it." A second person told us they would like an extra half hour in bed in the morning, but said they hadn't made staff aware of their request at that time. Staff told us they were not under any pressure to try and support people to get up or go to bed at any particular time. One staff member told us; "If you don't give people a choice, you are taking away a basic right." During the inspection we heard staff offering people choices such as what they wanted for their meals and where they wanted to eat. We heard one person tell staff they wanted a wash that morning. The staff member discussed this person's preferences around this, including whether they wanted a shower or a wash in their chair. However, we found people sometimes had to wait to receive their meals. On the morning of the first day of our inspection at 8:30am, one person asked a member of the inspection team to pass them a packet of crisps that was available on the table as they had had no breakfast. They told us breakfast was not served until 9:30am and that they found this a long time to wait after getting up. A second person told us that they had to wait longer than they would like to receive their breakfast and a cup of tea in the morning. They said they understood that this was due to staff being busy assisting people in the morning.

These gaps in the assessment and provision of care to meet people's needs and preferences outlined in the previous two paragraphs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
During the inspection we noticed call bells were sounding for a lot of time. This was in part due to the

sounder operating on all three floors of the home, irrespective of where the call was placed. We timed some of the response times to call bells, which were around five minutes. On one occasion we observed a staff member walk past a room where the person had activated the call bell. Although they were busy with another task, we discussed this with the acting manager who agreed the staff member should have acknowledged the call and provided brief re-assurance that other staff would attend. We checked one person's room and found although there was a senor mat in place, there was no call bell. Staff told us the person would be able to use the call-bell and were unsure why it was not in place. They told us they would ensure a call-bell was put in place before this person came back to their room.

The provider operated a model whereby regional activity co-ordinators supported activities across a number of homes. We discussed the provision of activities with the regional activity co-ordinator who was present during their inspection. They demonstrated enthusiasm and an in-depth knowledge about effective practice in this area, and the associated benefits of an effective programme of meaningful activities. Staff were expected to provide day to day support for activities in addition to the support provided by the regional activity co-ordinator. We asked staff whether they had time available to provide this support, which they confirmed they found they now did, since staffing levels had improved. One staff member told us; "We do a lot of activities like a knitting circle, videos, music. There's an exercise guy who comes in. [Person] likes having her hair done and for you to sit and talk to her with the newspaper." Another staff member said; "We are able to engage so much more with the residents [since staffing had increased]. I now plan things at home to bring into work like different activities and ideas." Trips out from the home were organised on a regular basis, which were provided at cost price to people.

During our inspection we saw staff, including the acting manager, had time to spend interacting with people and supporting a range of activities. Activities included flower arranging sessions, a reminiscence group and staff supporting people whilst they tried on different hats. We saw people were engaged and smiling and laughing with the staff during these sessions. There was also a visiting jazz musician and an exercise group held during our inspection. One person who we saw had showed signs of anxiety earlier in the day joined in singing and dancing with the jazz groups' songs and commented; "I've needed this for a long while." The regional activity co-ordinator had introduced the provision of a 'pop-up restaurant' within this home and other's owned by the provider. They told us staff acted as waiters and waitresses and that meals were provided in a separate dining area and based on varying themes. Family member's and visitors were able to join their relative at these meals for a small contribution. The regional activity co-ordinator discussed instances where both people and their relatives had found these events very beneficial and enjoyable, particularly in instances where the person would have been reluctant or unable to eat a meal at a restaurant outside the home.

People we spoke with told us they would feel confident raising a complaint if they felt this was required. Comments included; "I know how to complain, yes I do," and; "If I've got a problem, I know I can talk to someone." One relative we spoke with told us a family member had raised a complaint and that they had been satisfied with the outcome of their complaint. We looked at records of complaints, which showed that complaints had been investigated, and a response and corrective actions taken if required. We saw one complaint raised in September did not have any outcome or actions recorded against it. We discussed this with the acting manager who told us they had provided a verbal response to the person raising the complaint and that they had been satisfied with the acting manager's response. They told us they would update the records to ensure this was reflected. One staff member told us there had been a lot of complaints in the past in relation to the non-return of clothing and some complaints about meals. They told us in response to this the chef had come in and had discussions with people around their preferences. The provider told us in their PIR that they had increased staffing hours in the laundry to attempt to resolve issues identified in relation to this aspect of service provision. We saw feedback had been sought from people

living at Brinnington Hall, and this was displayed in a 'you said, we did' document displayed on each floor. There was also a resident's committee group, and we saw their suggestions, such as the suggestion to purchase a cards table had been acted on.

Requires Improvement

Is the service well-led?

Our findings

There was not a registered manager in post at the time of our inspection. The former registered manager had been in post for approximately six months prior to them leaving the service in August 2016. The acting manager had been in post for three weeks and told us they intended to submit an application to CQC to register as the manager for the service.

The provider had been open and honest with CQC and had contacted us prior to the inspection to inform us of some shortfalls they had identified in relation to the running of the service. This included lapses in the completion of audits and following proper recruitment processes. We looked at records of audits and other visits by the provider and regional director, which demonstrated that they had provided regular support to the former manager and other staff at the home to address issues the provider had identified. This included the production of action plans, and we saw these were still in progress at the time of the inspection.

The acting manager demonstrated a good awareness of the areas of the service that required work to develop them and bring them up to standard. For instance, we saw they had carried out a thorough audit of the DoLS file and identified short-falls. We could see the acting manager was taking action to address this concern. The acting manager had also produced a tracker to monitor review and updates of the care plans. There were systems of audit in place, covering a range of areas of service provision to help monitor and improve the quality and safety of service provision. This included audits of accidents, falls, weights, pressure sores, bed rails and medicines. However, we saw the medicines audit was incomplete and the system of audits and quality checks had not been implemented effectively and consistently to ensure standards were maintained at the home.

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

Staff we spoke with were consistently positive about the acting manager, and told us they had seen improvements in the home during the short period the acting manager had been in post. One staff member told us; "[Regional Director] has come in. Staff have coped with the changes in management okay. There did need to be change and I think the new manager can do it." Another staff member said; "The home is now being managed well by the new manager. [The manager] comes to each floor throughout the day and has time to speak with both residents and staff. They are really approachable and they ask for your opinion about things."

The acting manager had previously managed a similar size residential care home for a different provider. They told us they found Ideal Care Homes to be resident led and they told us; "What residents say matters." They told us the provider was supportive and provided adequate resources to manage and improve the home, such as providing finance to develop the new cinema room.

Staff told us they got on well as a staff team and felt valued for the work they did. One staff member said; "I was thinking of leaving previously, but not now… The new management are approachable and there's more

support." The acting manager told us a lot of staff had left prior to them starting at the home, but that they found the current staff group to be committed and caring. Staff were well organised during the inspection and clear about their areas of responsibility. We saw records of care provided were updated throughout our visit. Although most records had been completed consistently, we saw night staff had not maintained regular records of repositioning for one person.

The provider had not submitted all required notifications to CQC in relation to safeguarding incidents, although they had taken other appropriate actions such as informing the local authority. This omission had occurred during changeover of management and we found other notifications had been submitted as required. It is important, and a legal requirement, that notifications are submitted to CQC to enable the effective monitoring of services. We are dealing with this matter outside of the inspection process and will consider taking further action if we find other instances where the provider has not submitted notifications as required in the future.

The acting manager was responsive to our feedback and sent us a copy of their updated action plan shortly after the inspection. This documented progress made since the inspection and other actions that the acting manager had identified to make improvements within the service. The plan indicated the majority of identified actions were due to be completed by the end of November 2016.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not carried out adequate assessment of needs and preferences. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff did not consistently work in ways that upheld peoples' dignity. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider was depriving people of their liberty without lawful authority. Regulation 13(1)(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems of governance were not operated effectively to ensure the service was meeting the requirements of the regulations and that the safety and quality of the service was

effectively monitored and improved.

Regulation 17(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not consistently operated safe processes when recruiting staff. Regulation 19(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff were provided with regular supervision and training. Regulation 18(2)