Masterpalm Properties Limited

Brierfields

Inspection report

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Date of inspection visit:
07 February 2017
10 February 2017

Date of publication:
13 April 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

This inspection was carried out over two days on 7 and 10 February 2017. Our visit on 7 February 2017 was unannounced.

The overall rating for this service is 'Requires improvement'. However, the service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. At the last inspection and at this inspection the 'Well Led' section has been rated as 'Inadequate'.

Brierfields is a single storey care home in the Failsworth area of Oldham, registered to provide care and support for up to 37 people. At the time of our inspection there were 19 people residing at Brierfields. All bedrooms have single occupancy and ensuite toilet and sinks. There are two enclosed quadrants providing a garden area accessible to people who used the service with a ramp for wheelchairs. Car parking is available within the grounds.

At the last inspection carried out on 29 and 30 September and 3 October 2016, we rated the service as 'Inadequate', which meant the service was in 'special measures.' At that inspection we identified seven regulatory breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014, relating to person centred care, consent to treatment, safeguarding people from abuse, maintaining safe premises, dealing with complaints, staffing and good governance. We also identified two breaches of the Care Quality Commission (Registration) Regulations 2009, as the service had not notified us of incidents affecting the delivery of the service. We issued warning notices in respect of the breaches relating to person centred care; safeguarding people from abuse and good governance

Following the last inspection the provider sent us an action plan which stated the breaches would be addressed. This inspection was to check improvements had been made and to review the ratings.

When we visited the service there was a manager who had been appointed and began working as manager of Brierfields in September 2016. However this person had not registered with the Care Quality Commission. 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. At our last inspection we asked that this person seek registration but when we returned they had still not applied. This was in breach of regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) 2014

During this inspection we found that action had been taken to make improvements and the provider was meeting the requirements of seven of the regulations. However, we found that the improvements made in

relation to good governance and person centred care were still not sufficient and the service remains in breach of both regulations. You can see what action we have told the service to take at the back of this report.

There was insufficient detail in care plans to inform or guide staff when considering risk. We found that where risks had been identified the corresponding care plans did not contain enough information to consider how to overcome or mitigate the risk. We also found that care plans were task oriented, information was inconsistent or inaccurate, and did not provide a reliable way to meet assessed needs.

We saw that there was a consistent staff team who know the people who used the service well. They demonstrated a good understanding of how to protect people from harm. Where allegations of abuse had been made the service responded appropriately to ensure the allegations were followed up and investigated. We saw that the service had reviewed its recruitment procedures and all staff had received certificates from the Disclosure and Barring Service (DBS) to show that they did not have any convictions which may prevent them from working with vulnerable people.

Routine maintenance checks were carried out, and gas, electric and other appliances had been regularly serviced and tested. We saw that a small lounge had been redecorated, and we were told by a visitor that environmental improvements had led to a more relaxed atmosphere in the home. The providers recognised that the home was in need of further environmental improvement and informed us that they had begun a rolling refurbishment programme to improve the aesthetics of the home.
Looking at the training record and speaking with staff, we found improvements had been made to ensure staff were properly trained. All new starters were enrolled on the Care certificate to ensure that they were able to meet the required standards to provide care and support to people.

There were appropriate systems in place for the safe administration of people's medicines and there was good access to health care professionals.

We saw that arrangements were in place to assess whether people were able to consent to care and treatment, and staff spoken with understood the need to obtain verbal consent from people using the service before a task or care was undertaken. Where people were subject to deprivation of liberty the appropriate authorisation had been sought.

Attention was paid to people's diet and they told us that they enjoyed the food at Brierfields. One person who used the service told us, "We are really well fed. The food here is really good".

We found that there were sufficient staff and that people who used the service were treated with respect and kindness by staff who knew them well. People told us there was enough for them to do and we saw people engaged in a range of activities.

Children from the local comprehensive school visited Brierfields each week as part of their Personal Health and Social Education (PSHE) course. We saw that the people who used the service responded positively to these visits which helped to develop understanding between the generations.

To help ensure that people received safe and effective care, the manager had begun to implement systems to monitor the quality of the service provided, including response to incidents such as accidents, safeguarding concerns and complaints.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks were not always identified and care plans did not always provide guidance to minimise risks.

People told us they felt safe.

Procedures were in place to manage people's medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The general wishes of people who used the service were not always taken into consideration and we saw that staff would sometimes make decisions on behalf of people without consulting them or considering their wishes.

The service had reviewed its training policy and had taken steps to ensure all staff had opportunities for growth and development, and staff received regular supervision.

People told us that they enjoyed the food on offer.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff responded to people's needs, but did not always spend time with them.

Staff treated people with compassion and kindness.

Staff showed a good understanding of people's likes and dislikes.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care files were task orientated and did not always reflect people's needs or how they would like care to be delivered.

People were supported to maintain their independence.

People told us that there were enough activities taking place to occupy them. .

Is the service well-led?

Inadequate

The service was not always well led.

There was no registered manager in post.

Systems for recording and storing records were disordered.

The manager had spent time with people who use the service and their relatives to consider their views but had not conducted a formal survey.

Brierfields

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, to follow up on warning notices issued and to provide a rating for the service under the Care Act 2014.
We last inspected the service on 29, 30 September and 3 October when we rated the service as 'Inadequate' . We issued warning notices in respect of regulations 9, 13 and 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. This inspection followed up on the warning notices issued.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe.

This inspection took place on 7 and 10 February 2017. The first day was unannounced. The inspection team consisted of two inspectors. Before this inspection, we reviewed the previous inspection report and notifications that we had received from the service. We also contacted the local authority safeguarding and quality assurance team to obtain their views about the service.

During this inspection, we spoke to three people who used the service, and relatives of two other people, and had general conversations with other people who used the service and their visitors.

We spoke with the new manager, who had recently begun to work at Brierfields, as well as the registered provider. We interviewed two senior care staff, two care staff and the cook, and spoke to two visiting professionals. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us to understand the experience of people who cannot talk with us.

We looked around all areas of the home, looked at how staff cared for and supported people, and looked at food provision.

We looked at the care records for five people, three medicine administration records and supervision and

training records for four members of staff.

Requires Improvement

Is the service safe?

Our findings

When we inspected Brierfields on 29 and 30 September and 3 October 2016 we found that risks were not always identified and when they were, lacked details of sufficient control measures to manage the risk.

At this inspection we found some improvement to the way the service managed risk, but this remained inconsistent. For example, we saw in one care file that where a person required assistance with moving and handling, a manual handling risk assessment had been completed and a referral had been made to the moving and handling team who advised using a hoist for all transfers. However, the care plan did not identify the need for a hoist. This meant that any staff unfamiliar with the needs of the person and using the care plan for guidance may not know to use the hoist, and place the person at risk. In another care file we saw a person had been identified in their mobility assessment as independently mobile, but this was not the case as they required mobility aids when walking. A risk assessment stated that the person was at high risk of falls, but there was no corresponding assessment to minimise the risk.

Moreover, risk assessments lacked analysis, for example, one care plan highlighted the person had a history of depression, but the corresponding assessment gave no thought to how this could be addressed, other than 'to manage effectively with medication'. There was no consideration of social stimulation, activity, or other actions which might reduce the risk.

This demonstrated a continuing breach of regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: good governance: systems and processes to ensure compliance were not being maintained.

At our inspection on 29 and 30 September and 3 October 2016 we found that Brierfields did not have any systems in place to ensure that people who used the service were safe from harm or abuse. The manager was unable to produce a log of safeguarding concerns or tell us how the service had investigated allegations of abuse.

At this inspection we found that the service had made improvements and was meeting the requirements of the regulations. When we spoke to staff they demonstrated a good understanding of safeguarding policy and procedures giving examples of how they had followed the guidelines, and we saw a log of all safeguarding concerns that had been sent to the local authority at the end of each month. We saw that action had been taken to minimise the risk to people who used the service and to prevent future reoccurrence.

At our inspection on 29 and 30 September and 3 October 2016 we found that records for the safe recruitment of staff were incomplete, with no evidence that checks had been made through the Disclosure and Barring Service (DBS). The DBS is a service that identifies people who may be barred from working with children and vulnerable adults and informs the service provider of any criminal convictions recorded against the applicant. These checks help the registered manager or provider to make informed decisions about a person's suitability to be employed in any role working with vulnerable people. At this inspection we saw

that checks had been made for all staff and all had an up to date certificate ensuring their suitability to work with vulnerable people.

At our last inspection the provider was unable to demonstrate to us that equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions, and that maintenance checks were being carried out to ensure the safety and well-being of everybody living, working and visiting the home. At this inspection they were able to produce documents to show that required servicing had been undertaken in relation to gas, electrical safety, heating maintenance, fire safety and legionella. Lifting equipment had been inspected and serviced by a competent person as required.

People told us Brierfields was safe. One person who used the service said, "I feel safe, and I'm alright here. I sometimes get scared in the night but staff come and reassure me". A visiting relative told us, "I always know my relative is safe. I don't worry about him being here I know he is safe. The staff are so patient with him".

When we toured the building we saw that it was clean, tidy and well aired with no unpleasant odours. Corridors and communal areas were kept clear of obstacles to minimise the risk of accidents. The entrance was kept locked using a secure key code lock; this ensured that unauthorised people would have difficulty entering the home, and that staff were aware of who was in the building at any time. Visitors were asked to sign in to a visitor's book. People who used the service were free to walk throughout the building and into two enclosed external quadrangles, which were well maintained.
We saw some attention was required to the maintenance of the building, for example, in one bathroom we saw wall tiles had fallen off and had not been replaced, and there was evidence of some damp around an external fire door. When we spoke to the registered provider about this they told us there is a refurbishment plan with a rolling schedule to improve and enhance the décor and structure of the building, but did not show this to us. We saw that one lounge had been redecorated since our last visit. The manager told us that people who used the service had been consulted about the colour scheme and how they wanted the room to be utilised, and their views were taken into consideration.

Most communal toilets were well equipped with soap and paper towels, but we noticed one communal toilet had run out of paper towels. We asked the domestic staff to restock this, which they did. We saw disposable aprons and hand gel were available, and used by the staff when attending to personal care tasks, administering medicines and serving food. Pedal bins with appropriate colour coded bin liners further reduced the risk of cross contamination.

We found that personal emergency evacuation plans (PEEPs) had been developed for the people who used the service. These plans explain how a person is to be evacuated from a building in the event of an emergency evacuation and take into consideration a person's individual mobility and support needs. PEEPS were stored in an accessible file by the main entrance. We saw that the fire alarms were regularly tested, and fire evacuation procedures had been reviewed since our last visit.

We asked staff if they felt there were enough staff to safely meet the needs of the people using the service and they felt there were. One person told us "there are times when we get really busy, especially in the mornings, but there are enough of us and we all muck in". Four care staff were on duty during the day with three waking night staff. In addition, the staff operated a 24 hour on call system, so if an emergency arose a member of staff would be on hand to provide additional support.

When we spoke to staff they told us that there was a high incidence of staff sickness and when we looked at the staffing rota we saw that this was the case, with sickness and absences recorded for each day over the past four weeks. The manager recognised staff absence as an issue and had taken steps to tackle this,

including return to work interviews following any period of staff absence and action plans to improve attendance.

Where issues of concern around poor work practice or absenteeism had been identified these were dealt with constructively. We saw evidence that the disciplinary process had been followed, with clear targets set and close monitoring culminating in written warnings and in one case dismissal.

We reviewed the systems in place for ordering, managing and administering medicines. The service followed a four weekly cycle for ordering medicines and would re-order for the following cycle at the start of the second week. This ensured that medicines were delivered from the pharmacy in a timely manner.

Medicines were provided using a monitored dosage system. This minimised the risk of giving the wrong dose to people and provides an efficient system of storing and accounting for medicines. Staff noted any unused medicines and tablets which they stored in a returns box for returning to the pharmacy.

A locked medicines room was used to store the medication trolley and all other medicines for the service. Refrigerator temperatures were checked daily and a record of temperatures was kept, in order to ensure medicines are stored at the correct temperature. If certain medicines are stored at the wrong temperature they can lose their potency and become ineffective. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. Controlled Drugs were stored in a further locked cabinet, and the controlled drug register was countersigned when administered.

Each person requiring medicines had a Medication Administration Record (MAR). This is a form that records the details of any medicines prescribed, when they are taken, and if they are refused. Staff recorded all newly delivered medicines on the MAR, which also included details of the medication and dose required; details of the general practitioner (GP), condition, and any known allergies. Senior care staff administered medicines. We spoke with one senior carer who informed us that they completed regular medication training and confirmed that they were happy with the training received.

We observed one medication round during our visit. The senior carer giving out medicines wore a lilac tabard to indicate that they were giving out medication. This meant that they would not be disturbed whilst handling medicines. Hand-wash and a paper towel dispenser were available on the medication trolley along with gloves and protective aprons. We saw that the care worker checked the MAR chart to ensure that they were giving out the correct medicines, and passed the medicines to the person to whom they were prescribed in a disposable cup, and provided a drink to help wash the tablets down. Once they were sure that the medicine had been taken, they recorded in the MAR chart that the medicine had been administered.

Where creams and ointments had been prescribed these were stored in the person's room. We saw in one room that two tubes of the same cream had been opened and had been there for some time. There is a risk that when opened, medicines and creams can lose their potency and become ineffective. We asked the registered manager to check and dispose of the oldest tube of cream, as it may have lost its effectiveness.

Requires Improvement

Is the service effective?

Our findings

At our inspection on 29 and 30 September and 3 October 2016 we found that the staff at Brierfields did not always seek the consent of people who used the service before taking any action. During this inspection we found some improvement, for example, people were given choices about times of rising and retiring or what clothes they wished to wear. We saw that when staff needed to provide assistance they would generally ask the person for permission, for example, we saw a member of staff knock on a person's door and wait for a response before entering, and staff would ask people if they required assistance with washing and dressing. However, the general wishes of people who used the service were not always taken into consideration and we saw that staff would sometimes make decisions on behalf of people without consulting them or considering their wishes. For example, people were not asked which television channel they would like to watch, or if they wanted the television on at all. At one point we observed four people sitting in the lounge. The television was on. A member of staff, talking to another person who used the service asked if he would like to listen to some music. They put on a music compact disc (CD) and went over to switch off the television without first checking if anyone was watching the programme. We were told that if people wanted to watch a specific programme, such as a football match, this would be put on for them in a smaller lounge.

The people who used the service we spoke with and their visitors believed the staff were knowledgeable. One visitor told us, "They know [my friend's] needs and can sometimes anticipate when he needs help. He doesn't need to ask, they are there for him and they know what they're doing". Another visitor told us, "I won't have a bad word to say about this place. When it's my turn I want to be looked after here. They are all well looked after by people who know how to do their job".

When we inspected Brierfields on 29 and 30 September and 3 October 2016 we found that staff had not received sufficient training to ensure that they had the knowledge and skills to meet people's needs, and were not receiving appropriate and regular supervision.

At this inspection we found that the service had reviewed its training policy and had taken steps to ensure all staff had opportunities for growth and development. The manager showed us a supervision timetable where all staff received supervision every twelve weeks, and informed us that, "Professional development is important for personal growth and for the development of the service. I am looking for opportunities for staff to develop their knowledge, and also looking at people's interests so that they can lead in specific areas, such as activities, dementia awareness or end of life care".

We looked at the training matrix, which is a record showing where each member of staff has received training in specific subjects. Most staff had completed or received updated training in essential areas, such as moving and handling, basic food hygiene, health and safety, infection control, and safeguarding vulnerable adults. We saw that all new staff had either completed or begun the Care Certificate. This is a professional qualification which aims to equip health and social care staff with the knowledge and skills which they need to provide safe and compassionate care. In addition thirteen staff had been enrolled on a National Vocational Qualification (NVQ) level 2 in care. We spoke to the external assessor for this course who told us, "The home has shown a keen interest in learning. I have seen a big improvement and raised

standards over the past two months". This person also told us that the service had commissioned a further twelve courses for face to face training in such issues as mental capacity, end of life care, and working with dementia, and the manager of the home confirmed this.

We saw the manager had also reviewed the induction process. All new staff would be enrolled on either the Care Certificate or NVQ depending on their experience, and spend a week shadowing more experienced staff to learn the daily routines of the home and the needs and wishes of the people who used the service. Staff would not commence employment until all pre-employment checks had been satisfactorily completed.

We talked with staff about their supervision and all the staff we spoke believed that supervision was beneficial. One person told us, "I get very good supervision. The manager is supportive and allows me to express my concerns in a positive fashion. It has helped me to consider my strengths and I think I am better for it". We looked at three supervision records and saw that notes reflected two way discussions. Training needs were identified and there was discussion about how learning had been applied in practice. Issues around poor work practice were dealt with constructively with clear improvement action plans in place.

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (MCA). The 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. 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.

We saw the manager had a register of applications for DoLS. This helped to make sure that people who were not able to make decisions for themselves were protected. It showed that seven applications had been made, two of which had been authorised by the local authority and the other five were awaiting authorisation. We saw copies of applications and capacity assessments to determine why people might have needed a DoLS authorisation.

People told us that they enjoyed the food at Brierfields. One person who used the service told us, "We are really well fed. The food here is really good". A visiting relative told us, "[My relative] is a really fussy eater but the chef always gives him something he likes".

We saw that the chef spent time with people who used the service discussing their likes, dislikes and preferences and he showed us a list of people's likes and dislikes. He informed us that he always tried to accommodate their preferences when planning the weekly menu. Meals were varied and imaginative, and we noticed they smelled and looked appetising and were well presented on the plate. On the day of our inspection there was a choice of main meal between Hunters Chicken and bacon carbonara. The chef told us, "I will not serve anything I would not want to eat myself". All food was prepared from fresh and cooked in the kitchen which had received a five star rating from the Food Standards Agency.

The chef showed a good understanding of the dietary needs of older people in general, for example the risk of choking or digestive problems associated with some foods such as pasta or pastry. He also showed awareness of the specific needs for cultural or health related diets of the people who used the service, such

as low sugar, calorific needs or soft and pureed diets. In addition he was aware of the appetites of people who used the service. Each meal was plated individually for each person, and second helpings were available. Where people's routines did not fit with regular mealtimes meals would be provided as required, for example, one person slept late in the mornings so was served lunch later in the afternoon.

Where people's food and drink was being monitored to minimise the risk of malnutrition or dehydration we saw that charts were kept to track the amounts people would eat and drink.

People could choose a cooked breakfast, cereal and toast. . Throughout the day, people who used the service were offered a range of drinks with support and encouragement to take regular fluids. Snacks, including fresh fruit, were always available and a supper was provided, consisting of cakes or a light snack.

All the people who used the service that we spoke with felt their health needs were being managed and monitored by staff, and when we spoke to them, they confirmed that they had easy access to both doctors and nurses when required.

We saw from handover notes that regular appointments with healthcare professionals were kept, and if a health need was identified, this was recorded in the person's daily notes with a record to show that the care staff had made the appropriate referral, for example to a dietician, falls co-ordinator or continence advisor. In the case files we reviewed, we saw evidence of dental and optical checks.

Requires Improvement

Is the service caring?

Our findings

People told us that they were well cared for. One person who used the service told us "They look after me all the time, and make sure I am clean, presentable and well dressed." This person then showed us their hands, and said, "Look, they've even varnished my nails for me. They are so kind".
At our last inspection we saw that people were sometimes left for long periods, and staff would generally stay in the main lounge leaving people unsupervised in other areas.

On this inspection we saw there had been some improvement and a greater level of supervision with staff monitoring the whereabouts of people. Constructive use of space, for example, using a smaller lounge for some general activities, allowed for improved interaction with people who used the service on an individual level and Where communal rooms were in use, there was a staff presence. A visiting relative told us, "Staff don't leave people on their own, they go and attend".

However, we saw that staff would still congregate together in groups rather than spend time sitting with the people who used the service. When we observed people in the main lounge we saw that staff would often be sitting together in a group away from the residents, and did not spend time with people who used the service.

There were no restrictions on people's movement within the home, and people were free to walk about the building or spend time in their own rooms if they wished. A number of people spent much of their day in their own rooms, and staff told us they would check on them at regular intervals. However, we noticed that the home was not full and one person's room was isolated from the main part of the building leaving them at risk of social isolation. Care notes did not indicate if this person preferred their own company or how much time care staff would spend with them. We raised this with the manager who agreed to speak to the person about moving to a more central part of the home.

Many of the staff had worked at Brierfields for a long time and understood how best to respond to people's needs. When we looked at the staff rota we saw that gaps were covered mostly by regular staff working extra hours. This meant that people who used the service were supported by people who knew them. Where this was not available, support was provided by staff from Brierfields' sister homes which provided a level of consistency to staff.

We saw some good interaction between people who used the service and staff. Staff treated people with compassion and kindness, for example we saw a care assistant ask a person if they would like a cup of tea. When they brought it over they knelt by the chair, and talked quietly to them, giving undivided attention listening to what they were saying. All the while they gently stroked the person's hand. Before moving on to complete a task they involved another person in the conversation and ensured the person was comfortable and relaxed. Communication was natural and relaxed, and we observed staff chatting and sharing jokes with people who used the service. We also saw people had developed their own friendship groups, for example we saw a group of men having a game of dominoes together.

The care workers we spoke with showed a good knowledge of the people who used the service, their lives, likes and past histories. One care worker told us for example, how they responded to one person who used the service. They told us this person can be quite difficult at times, but explained that by working with the person they had got to know the triggers to their behaviour and how to best meet their needs, telling us, "We have to respect them, and that this is their home, so we try to make it as homely as possible. It's not for me to dictate, so we have to offer alternatives, if they want another cup of tea, or to stay in bed longer, it's their choice. Sometimes we have to leave them a while, and sometimes stay with them". Another person told us that they will often share jokes with the people who live there and their relatives. This person spoke of the importance of understanding facial expressions and hand movements, especially with people living with dementia, and of sharing knowledge with other care staff.

People were supported to maintain relationships with family and friends. Feedback from visitors was positive about the care provided, and the relatives we spoke with had no issues about the quality of care. There were no restrictions on visiting and those visitors we spoke with told us that they were always welcomed and supported when they visit. They informed us, and we saw that staff knew them and greeted them by name. A relative told us that the staff were always available, friendly and knowledgeable.

A visiting health professional told us that staff responded to people in a person centred way and provided consistent and caring support. This had reduced the reliance on anti-psychotic medicines which help to calm people, and we were told that nobody who lived at Brierfields relied on this type of medicine. A visiting relative told us, "[My relative] can be difficult but they all go out of their way to accommodate [their] wishes, and they are ever so patient."

All the people in the home were clean and well presented. Care was taken to support people with personal needs. People told us that the staff take time to ensure they are well groomed and that they thought the care staff made an effort to get to know them. A visiting relative informed us, "[My relative] is always kept clean. If he makes a mess or spills food down his front they don't leave it and will change him immediately". The staff we spoke with had a good understanding of culture and diversity issues and gave examples of how they would respect people's individual beliefs, culture and background.

At the time of our visit nobody was on end of life care. There was no evidence in the care files we looked at that people's wishes had been considered for end of life care. Some records we reviewed included a 'Do not attempt resuscitation (DNAR) form. This is a document issued and signed by a doctor, which advises medical teams not to attempt cardiopulmonary resuscitation (CPR). We asked staff how they would support a person who was nearing the end of their life and they were able to explain how they might consider their needs, but acknowledged that they would like further training in this aspect of care. Further training in this area will support staff to deliver high quality end of life care in a compassionate and understanding manner.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 29 and 30 September and 3 October 2016 we found that care plans did not reflect the character of the person or identify their specific needs. They were not person- centred and had been written without reference, consultation or involvement of the person concerned.

At this inspection we looked at five care files. We saw some improvement in that care plans had been revised and people told us that they had been asked about their care when plans had been reviewed. We saw that people were consulted on various aspects of their support needs, for example we saw the chef discussing meal choice, tastes and preferences with one person who used the service and their visitor. However, we found that care plans still did not reflect the person's needs, wishes and preferences. Care plans had been broken down into eighteen sections covering all aspects of daily living or key tasks, but did not build a coherent picture of how the person wanted care to be delivered. Without cross referencing the separate components the plans were task orientated, inconsistent and conflicting. For example, when we reviewed one care file we read a very basic 'life story' which indicated that the person had poor hearing in one ear, and advised face to face communication to aid understanding. When we looked at the section in the care plan relating to communication this information was not included, simply stating "communicates well even though has a diagnosis of dementia. Can express needs very well". There was no indication of how the person would like to be communicated with, which could lead to a risk of exclusion.

Another care plan made inconsistent references to continence; a bowel chart stated the person was self-caring with personal hygiene, but the care plan noted that this was not the case and the person was doubly incontinent. This person's care plan had recently been reviewed, but the anomaly was not picked up.

This demonstrated a continuing breach of regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Person Centred Care. Care and treatment of service users must be appropriate, meet their needs and reflect their preferences.

We saw that routine checks were made as necessary on people's health and care needs, for example, food intake charts, skin integrity checks and records of vital signs such as weight and body mass. However, when we tried to review these we found that there appeared to be gaps in the records. There were two files for each person; one was ostensibly intended to hold essential information which may be required for general information about the person, whilst the second recorded daily interventions. However, the staff were not clear what each was for or where to record information. We found, for example that monthly weight charts and nutritional screening records for some months had been stored in one file, and for other months in the other file. This meant that the process for monitoring and checking for any changes was made difficult for any staff or visiting health professionals to audit or check for trends and patterns.

At our last inspection on 29 and 30 September and 3 October 2016 we found that the service did not have a system in place to record any action taken to respond to complaints received, or to record, track and investigate issues of concern, and to determine any trends or actions which would prevent a reoccurrence. At this inspection we asked what action the service had taken, and were shown a complaints file which had

been set up to respond to any complaints received. At the time of our inspection the service had not received any complaints. One person who used the service told us, "I have nothing to complain about, everything here is good", and a visiting relative said, "I have no complaints, there is nothing I would change, nothing I'm not happy with". When we spoke with care staff they told us that in supervisions they were encouraged to raise issues of concern and reminded of the whistleblowing policy.

When we asked, people who use the service told us they were supported to meet their own needs wherever possible. A number of people who used the service were independent with their personal care tasks and they told us that this was encouraged.

People told us that there was enough for them to do. The manager told us they no longer have an activities co-ordinator at Brierfields, so the responsibility has been placed on all care staff to consider activities and stimulation for people either on a one to one basis or in groups. On the second morning of our inspection a care worker had taken some people into a small lounge to watch an old musical. We saw that they were attentive and involved in discussion about the film and other roles played by the actors. We saw one care assistant found an audio tape that they were taking to a person who was blind. When the care assistant realised the recorder was broken they selected a number of books from the small library to allow the person to choose one which the care worker then began reading to them.

The service had also liaised with the Personal Health and Social Education (PSHE) department at a local school, and arranged for pupils in years 10 and 11 to visit the home on a weekly basis. We noticed that the atmosphere within the home lifted on the first day of our inspection when the children arrived, and people told us that they really looked forward to and enjoyed these visits. One person told us, "I love it when the children come; they are interested in us and want to know about our lives. They get us up dancing sometimes, and they helped us to decorate the Christmas tree. It was lovely." This view was reciprocated; when we talked to some of the visiting children they told us that their visits were a highlight of the week, and were able to tell us how they had learnt about the people who lived at Brierfields. Their teachers told us that the children had got to know each person in the home, what their needs are and how they were being cared for, and this had helped nurture intergenerational understanding. They informed us that the children who visited were much further ahead in their academic studies as a result of these consistent visits. The children had invited people who used the service back into the school, and a number had attended the department's Christmas party. A care assistant told us, "The kids are great; they've built up a strong rapport with some of the residents. [The visits] lift the residents, we've seen them in a whole new light, and learnt a lot about their character".

Inadequate

Is the service well-led?

Our findings

It is a requirement under The Health and Social Care Act that the manager of a service is registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. At the time of this inspection, however, there had been no registered manager in place since May 2016.A manager been appointed by the service provider, and had been working at the home for over four months. The manager informed us that they had not yet applied to register with the CQC.

This was in breach of regulation 7 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014: requirements relating to registered managers.

The manager was present throughout our inspection.

At our last inspection on 29 and 30 September and 3 October 2016 we found that the systems in place to monitor and improve the quality and safety of the services were not operated effectively, so the risks relating to the health, safety and welfare of people who used the service could not be properly addressed.

At this inspection we found improvements had been made, although the manager recognised that there was still work to be done to improve standards. Following our last inspection the service had drawn up an action plan to outline steps to meet the requirements of the Health and Social Care Act 2008. We reviewed this action plan and saw that whilst some actions had been completed there were still outstanding and on-going issues to be addressed, particularly around care plans, risk assessments and training. For example, all care plans had been re-written, and more closely reflected the needs of the people who used the service. but we found inconsistencies and contradictory information in individual's care plans. Moreover there was a lack of clarity about where to store information held about people who used the service,

We were shown a copy of the Local Authority Quality Monitoring Team action plan which identified seven areas of concern similar to the concerns identified at our last inspection. We saw that two of these actions had been completed but the manager acknowledged that more work was required to complete all the actions.

We found evidence of poor and unprofessional record keeping. Examples included charts which did not record the person's full name, so identifying to whom they referred was difficult or impossible to determine, especially if two people shared the same first name; undated or untitled records, so it was not clear what, or which time period they related to, and unsigned records meaning there was no accountability. We saw that there were templates available for all charts, but once these had been filled, rather than collecting a new blank template staff would write on the back of the completed template or use loose sheets. For example, when we looked at the nightly check and turning charts for two people, we found that the information was inconsistent, sometimes illegible and did not follow a chronological order.

This was in breach of regulation 17 (1) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014: good governance.

The manager had begun to develop systems to monitor the service, such as weekly cleaning checks which had identified areas requiring deep clean and regular maintenance checks. Where issues had been identified action taken to remedy the issue had been recorded before actions signed off as completed. The manager informed us that she would tour the premises each morning and note any issues needing addressing, but she did not compile a log or record of this. She informed us that she had completed an audit of all rooms, which included clearing out and replacing old or battered furniture from unoccupied bedrooms. We saw one lounge had been redecorated and furniture in other communal areas had been reorganised to give the place a more homely feel and encourage people to make better use of the space available. A visiting health professional remarked to us that environmental improvements and better use of space had led to a more relaxed and homely atmosphere.

We looked at a medicine audit, which showed that where issues were identified these had been followed up, for example, unused or out of date medicines were returned to the pharmacist appropriately for destruction.

The manager had sought feedback from stakeholders about the service. She informed us that she had spent time with each person who used the service to understand their views about how they would like the service to be developed. She had arranged a relatives meeting, but informed us that only one person had attended. However, she told us that she had spoken to relatives when they visited, and we saw notices by the entrance encouraging visitors to meet with her to discuss the service. At the time of our inspection the service had consulted staff for their views but had not conducted any surveys or questionnaires about service delivery with people who used the service.

When we last inspected Brierfields we saw that there was a lack of clarity amongst staff as to their roles and responsibilities. At this inspection the manager told us that questioning staff and changing staff attitudes and practices had been a challenge as they had become accustomed to working in a specific way. She said, "It's a work in progress. I'm told things like, 'I've been here over ten years and we've always done it that way'. It is hard to change staff attitudes but I'm trying to show them better and more consistent ways to get things done. Sometimes it's a battle with them". By example, she told us that staff had been using four different handover books to record information at the start of each shift. This had led to inconsistencies in the way services were – or were not – delivered. The staff we spoke with told us that the handovers were now used more productively, and people were delegated specific tasks and specific areas to work in throughout their shift. This allowed greater responsibility and accountability to ensure that people's needs were met.

People we spoke with recognised that the service was undergoing a period of change. When we asked what was different since our last inspection one care assistant told us, "We had been left without proper support and were drifting, but we are in a better place now." A visiting professional shared this view, telling us, "I have seen a big improvement in the quality of care over the past two months and the staff I have spoken to are happy with the changes". Others were more wary. Another visitor told us, "Staff are well supported and they are getting better, but they need to understand their responsibilities and not be complacent. They need to be challenged, there is still a long way to go!" and a senior care worker said, "Things are a lot better, staff don't sit about as much and we know what we need to do. Staff morale has improved". This person told us that they had seen some positive changes, but felt that the manager was not always getting the support needed.

When we asked people about the manager they were positive. One person who used the service told us, "We see a lot of her; she's always in and out, but has time to sit and talk to us, finding out about our lives and

what we want to change". Staff talked of the positive impact she had made, telling us that training was much better; people were made accountable for their actions, and the need for good recording was being reinforced. They told us that supervision was good, and that staff were beginning to understand their duty of care. She explained that this meant that staff were becoming more diligent, and taking a greater responsibility for their actions whist recognising that they needed to "pull together and work as a team; the future of the service is down to all of us".

When we spoke to staff and visitors they told us that Brierfields is seen as an intrinsic part of the community. We saw that the home had established strong links with the local high school and were collaborating with them to enhance intergenerational understanding. All the people talked with knew that the service was facing a number of difficulties but were keen to see these overcome. We saw that the service was working closely with the local authority commissioning and safeguarding teams, and with the health service commissioning team to improve standards. We were shown copies of the local authority support and improvement plan which showed on-going progress to meet targets.

At our last inspection we saw that the service did not inform us of any notifiable incidents such as police incidents, deaths and other serious incidents as required under the Care Quality Commission (registration) Regulations 2009. Before this inspection we checked our records and saw that the service had told us of incidents which affected service delivery.

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 care and treatment of service users must be appropriate, meet their needs and reflect their preferences. 9 (1) (a) (b) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance systems and processes to ensure compliance were not being operated effectively. (17) (2) templates and forms were not being completed correctly 17 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers no registered manager in place