Bronte Regency Healthcare Limited

Bronte Park Residential Home

Inspection report

Bronte Park
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Haworth
West Yorkshire
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08 May 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Bronte Park Residential Home on 27 April and 8 May 2017 and the visits were unannounced.

Bronte Park Residential Home is a large detached converted property. It provides accommodation and personal care to a maximum of 28 people. Accommodation is provided in double and single rooms on two floors. There is a lounge and dining room on the ground floor, car parking to the front and a garden.

At the time of the inspection there were 24 people using the service.

There was a registered manager in post. 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.

When we inspected the service in February 2016 we identified one breach of regulation in relation to staff training and the overall quality rating for the service was requires improvement. On this inspection found the service had declined significantly.

Staff were not being recruited safely and there were not enough care staff on duty to keep people safe or to meet their needs in a timely way. We saw staff had received training, however, some of the poor practices we saw regarding moving and handling and privacy and dignity made us question the quality of this training.

In their direct dealings with people we saw staff were kind and caring. However, we found practices in the home which showed a lack of respect for the people who lived there. People were not receiving person centred care which met their needs or preferences and there was a lack of activities to keep people occupied.

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

Although staff were able to describe how they would keep people safe, they were not always following their safeguarding policy and reporting incidents to CQC or the safeguarding team. The registered manager was holding money for safekeeping, however, the finance policy was not being followed which left people at risk of financial abuse.

People's healthcare needs were mostly being met, however, there were some concerns about the management of people's nutrition and hydration needs. Medicines were being managed safely.

People's views about the meals were mixed and the meal time experience was very poor for some people.

Risks associated with the building were poorly managed, leaving people at risk. Repairs were not being completed in a timely way and information which would be required in an emergency was not readily available. We also saw not enough was being done to mitigate risks to people who used the service who were at risk of falling or had swallowing difficulties.

A complaints procedure was in place, however, concerns were not always fully investigated and no analysis was being done to look at any common themes or trends so further complaints of the same nature could be eliminated.

We did not find an open and honest culture at the service. Staff found it difficult to answer direct questions or were not honest in their answers.

We found there was a lack of effective management and leadership which coupled with ineffective quality assurance systems meant issues were not identified or resolved. We found shortfalls in the care and service provided to people.

We identified eight breaches in regulations – regulation 18 (staffing), regulation 19 (fit and proper persons employed), regulation 12 (safe care and treatment), regulation 13 (safeguarding), regulation 10 (dignity and respect), regulation 9 (person-centred care), regulation 11 (Need for consent), and regulation 17 (good governance). The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff were not being recruited safely and there were not enough staff to meet people's needs.

Risk management was poor both in relation to the premises and to individuals who used the service.

Systems for keeping people safe were not robust and left people at risk of abuse.

Medicines were managed safely.

Is the service effective?

Inadequate

The service was not effective.

Staff were being provided with training, however, we found this was not always suitable or reflected in their practice.

The service was not meeting the requirements of the Mental Capacity Act or enacting conditions attached to Deprivation of Liberty Safeguard authorisations.

People's health care needs were mostly being met, however, there were some concerns about the management of people's nutrition and hydration needs.

Most people told us they were satisfied with the food.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw people were not always treated with dignity and respect.

Visitors were made to feel welcome.

Is the service responsive?

Inadequate

The service was not responsive.

People were not receiving person centred care which met their needs or preferences and some practices were very institutionalised.

There were not enough activities on offer to keep people occupied.

There was a complaints procedure in place; however, the one on display was out of date.

Is the service well-led?

Inadequate

The service was not well -led.

A registered manager was in post. Records were not readily available and up to date information was difficult to find.

We did not find an open and honest culture in the home; staff found it difficult to answer some direct questions and were not always honest with their answers.

Effective quality assurance systems were not in place to assess, monitor and improve the quality of the service. We identified eight regulatory breaches during our visits.

Bronte Park Residential Home

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 27 April and 8 May 2017. The inspection was carried out, on the first day, by two adult social care inspectors and one 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. Two adult social care inspectors returned on the second day to conclude the inspection.

Before the inspection we reviewed the information we held about the service. This included notifications from the provider and speaking with the local authority contracts and safeguarding teams. We also asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The registered provider returned the PIR and we took this into account when we made judgements in this report.

We spent time observing care in the lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We looked around some areas of the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included eight people's care records, three staff files and records relating to the management of the service.

We spoke with 10 people who lived at Bronte Park Residential Home, five relatives, three care workers (days), two care workers (nights), the cook, the registered manager, the providers, one community matron,

two district nurses and one mental health community liaison nurse.

Inadequate

Is the service safe?

Our findings

We asked people who used the service if they thought there were enough staff on duty to support them. One person told us, "At night I do ring the buzzer- they do not come quickly- I think they are short staffed." A visitor told us, "My relative does complain about the night staff – there are not enough of them." We also saw in the 'grumbles register' in March 2017 one of the people who used the service had telephoned their family because night staff had left them on the commode and not returned. The relative then had to telephone Bronte Park Residential Home to get staff to go and assist them. In response to this the registered manager had written, "Had a word with staff and they said they were busy with other residents and one staff was giving medication."

We spoke with the senior night care workers on both days of the inspection. One told us they had started getting people up at 5:00am and the other said 5:30am. Staff told us seven people needed two staff to assist and another three sometimes needed two staff. We concluded two night care workers were not enough to meet the needs of people in a timely way.

The registered manager told us the usual staffing levels were five care workers until 2pm and four care workers from 2pm until 8pm. The registered manager worked in addition to these numbers and their finish time was 5pm, however, they regularly worked longer days, typically leaving between 6pm and 7pm, this was confirmed by duty rota we looked at.

On both days of our visit we saw staff were not always present in the lounge to respond to people's needs. For example, on the first morning of inspection one person came into the lounge, there were no staff present, one of the inspectors had to help them by putting their foot rest in place and passing them a blanket which was on another chair. If the inspector had not been in the lounge there was no call bell nearby to enable them to get the staff members attention. We also saw in the morning there were not enough care workers around. We heard service users calling out to go to the toilet or wanting to be moved and staff were not present to respond. We concluded there were not enough staff on duty to meet people's needs in a timely way.

This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the files of three recently recruited staff and found recruitment procedures were not robust. Disclosure and Barring Service (DBS) checks were done to confirm prospective employees did not have a criminal conviction which would make them unsuitable to work with vulnerable adults. However, we found other checks had not been carried out satisfactorily and the required documentation was not available. In two of the three staff files we found the references were not satisfactory and references had not been obtained from the applicants previous employers. This meant there was no Satisfactory evidence of conduct in previous employment In one of the files we found there was no evidence to show gaps in the applicant's employment history had been explored. None of the files contained proof of identity or a photograph. In one case the registered manager found a photocopy of the applicants passport, this was not in the staff file, they

told us they had found it in the other office. We were not assured people who used the service were protected by robust recruitment procedures.
This was a breach of the Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people who used the service told us they felt safe at Bronte Park Residential Home. Visitors we spoke with felt their relatives were safe, one person said, "My relative is happy – we did have issues at the beginning but we are happy- I have worked in care – I know what is expected- I am happy with the safety."

We saw there were safeguarding policies and procedures in place and information about safeguarding was also on display. We spoke with three members of staff about their understanding of safeguarding and what they would do if they thought people who lived at the home were at risk. Both of them told us they would not hesitate to report any concerns to the registered manager. However, one person told us they had not always felt safe at the service and told us they had been verbally abused and had things thrown at them by another person using the service. They added, "I now lock my room – this has stopped." These incidents had not been referred either to CQC or the Adult Protection Unit. We asked the registered manager about this and it was unclear why they had not made a referral.

On the second day of the inspection we witnessed an altercation in the lounge where one person grabbed at the Zimmer frame which belonged to the person who was sitting next to them. Two care workers were present and saw the owner of the Zimmer frame grab hold of the other person's wrist very tightly. This incident was also not reported to CQC or the Adult Protection Unit.

We saw the registered manager was holding money and bank cards for some people who used the service. We looked at the records of transactions and were concerned there was no detail being recorded about some of the purchases which had been made. For example, £52.10 had been spent on behalf of one person in Debenhams at Meadowhall but the registered manager could not tell us what had been purchased. For another person, £39.29 had been spent in W H Smith but the registered manager could not explain from the receipt what had been purchased. We looked at the services policy regarding financial procedures and found this was not being followed, for example, cash cards being kept separate from to cash held. Following our inspection we spoke to West Yorkshire Police about our concerns, who advised our concerns should be referred to the Local authority safeguarding team.
This was a breach of the Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we arrived at approximately 8am on 27 April 2017 we saw there was some building works in progress on the ground floor adjacent to the dining room. One of the contractors told us these works had been on=going for about three weeks. This area was not safe for people who used the service or staff. We saw tools and materials had been left out on the floor in the 'smoking lounge.' The toilet and shower area, which was being refurbished, had a live light switch and call bell point which had not been secured to the wall and contained live wiring. When the contractors arrived on site tools and materials were removed from the 'smoking lounge' and the switches were secured to the wall.

There was a person who used the service sitting in the 'smoking lounge' when we arrived, however, after we had brought the safety issues to the attention of the registered manager no one else used this room during our visit. We heard on person remark, "We have used the room all week- suddenly they have stopped us going into the room today." This showed us the risk of people using this room whilst building work was in progress had not been addressed prior to our inspection.

We asked the registered manager for the risk assessment in relation to the building works, so we could see what arrangements had been made to ensure the area being refurbished was both kept safe for people who used the service and staff. No risk assessment had been completed. This showed us the risks to people accessing this area of the home had not been assessed and measures put in place to mitigate those risks. Following our visit we reported our findings to Building Control to make them aware of our findings.

When we looked at one bedroom we found the hot water was only warm and would not have been hot enough to wash in comfortably. We asked one of the senior care workers about this. They felt the temperature of the water and said that it was about the same as always. We saw the Food Standards Agency had conducted an inspection on 14 February 2017 and awarded the service three stars for food hygiene, which meant food safety was generally satisfactory. One of the issues they identified was the dishwasher was broken and the water in the kitchen was not hot enough to wash dishes safely. When we went into the kitchen, during the afternoon, we saw a care worker washing up and asked about the dishwasher and they told us it was broken.

We asked the registered manager how long the dishwasher had been broken and they told us it had been out of use for four – five months or longer. They also added it was a steriliser and not a dishwasher. We asked them if any additional checks had been introduced to ensure staff were washing up in water which was hot enough; we established no additional checks had been introduced. When we spoke with the provider they told us they thought they were waiting for some 'parts' so the steriliser could be repaired. Following our visit we reported our findings to Environmental Health to make them aware of our findings. The dishwasher had been replaced on the second day of our visit.

In two bedrooms we saw electrical extension leads were next to the wash hand basins, plugged into live electrical sockets and were switched on. This was brought to the provider's attention on day one of the inspection and we saw on day two one extension lead had been removed and the second had been relocated away from the wash hand basin. However, there were no risk assessments in place regarding the use of these extension leads.

We saw additional free standing heaters in some bedrooms and a 'fan heated' in the lounge, however, could not find any risk assessments regarding their use. We also saw the protective panels on one of the radiator covers was missing exposing the potentially hot radiator surface.

We saw at the cooks meeting held on 19 April 2017 which showed problems had been identified with the oven door and gas rings not working properly. The cook told us the door had been repaired but two gas rings were still not working and one was 'dodgy,'. The provider said these were being dealt with by plumber who was awaiting parts.

We concluded risks related to the premises were not be responded to in a timely way or were not being proactively identified by the provider.

On the first day of our inspection the ground floor bathroom was accessible and we saw there was a bath hoist in place. We asked to see the safety certificate for this piece of equipment, which could not be produced. On the second day of our inspection this bathroom was locked and the handyperson told us a new bath hoist was being delivered that day and the registered manager told us the old one had been condemned. We asked for the safety certificate to be emailed to us. When we got the certificate it was for the installation of the new hoist, which was dated 15 May 2017.

In the upstairs bathroom we saw there was no water temperature bath thermometer available. We asked

the registered manager where the bath thermometer was and they pointed to the room thermometer on the wall. When we asked staff about checking water temperatures of baths, they said they used a bath thermometer. We asked them what temperature they would bath people at safely and two care workers said around 25 degrees. This would not be a comfortable temperature to bathe in as body temperature is around 37 degrees Centigrade so the water would have felt cold.
This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the ways risks to people who used the service were being assessed and what measures had been put in place to reduce or eliminate those risks.

When we looked around the home we saw an air flow mattress on one person's bed, designed to reduce the risk of pressure sores We saw this was on the highest weight setting. When we looked in this person's care file we saw they only weighed 46kgs. We spoke with the district nurse about this and they went to check the mattress and they agreed it was not set correctly. This type of mattress needs to be set according to the person's weight otherwise the therapeutic value is reduced and potentially tissue damage can be caused rather than prevented.

When we arrived on the first day we saw one person who used the service was on the floor. Care workers told us they had slipped out of their armchair. We saw two care workers used a moving and handing belt to assist the person to stand up. We looked at this person's care plan. The moving and handling plan did not include any information about how to safely support the person to get up from the floor despite the fact that the falls risk assessment showed they were at high risk of falls.

The falls risk assessment, for the same person, stated they had a sensor mat on their bed, under the mattress, because they were at risk of falling in their bedroom while going to the toilet. We looked in the person's room and found there was no sensor mat in place. The registered manager told us it had been removed because the person was incontinent; they confirmed no alternative measures had been put in place to alert staff when the person was moving around in their bedroom.

One of the health care professionals we spoke with expressed some concerns about moving and handling practices and said they were not sure what training staff had received in this area.

We heard one person ask care workers on more than one occasion to sit them back in the armchair. Each time care workers used a moving and handling belt and 'lifted' the person back in the chair. This was not safe practice. The Health and Safety Executive guidance states, moving and handling belts should only be used if the person can weight bare.

We looked at the accident records from January 2017 and saw there had been a total of 22 un-witnessed falls. Three of these falls had resulted in paramedics being called and two people going to hospital. From these incidents and the failings identified above, we concluded people were not properly protected from the risk of falls in the home.

Two people who used the service were prescribed thickening powders to add to drinks to help with swallowing difficulties. The label on one person's medicines record stated it should be used 'as directed'. We asked the senior care worker how they knew how much to use to get the correct consistency and they told us they followed the instructions given by the Speech and Language Therapist (SALT). The information was in the person's care plan and stated they should have 1.5 – 2 scoops of thickening powder added to 100mls of fluid. We asked the staff member who was giving out drinks how much they used for the person's

drinks and they told us they used 2 scoops in a cup. When we asked how much fluid the cup contained they were not sure. We asked them how they knew how much of the thickening powder to use and they said it was written on a piece of paper in the kitchen. However, when we asked to see the piece of paper they told us they had been told by senior care staff how much to use. It is important people receive thickened fluids at the correct consistency to reduce the risk of aspiration. We were not assured this was taking place given the responses of staff.

We concluded not enough was being done to assess and take action in order to mitigate risks to individuals using the service.
This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of the inspection we asked one of the night care workers about the fire procedures, they were not sure how many people were using the service and could not easily locate a list of residents to identify who was in the building.

We saw the fire risk assessment for the service had not been updated since January 2013.

We asked to see the personal emergency evacuation plans (PEEPs) and found these were being kept in the outside office, so would not have been readily available if an emergency situation arose and would not have been available to the night staff. It was difficult to find the relevant information quickly as old records had not been archived. Following the second day of inspection we contacted West Yorkshire Fire and Rescue service to make them aware of the issues we had identified.
This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people who used the service how their medicines were managed and people told us that they did not have any issues with their medication and that it was given on time. At breakfast time we saw the care worker who was administering medicines was disturbed on two occasions to attend to the requests of people who used the service. We saw them give medicines to people in the lounge in medicine pots, on a tray and a drink. We saw they stayed with people until they had taken their medicine.

The provider's policies and procedures were not up to date. The provider's medicines policy was dated September 2015 and showed it should have been reviewed in September 2016. The NICE (National Institute for Health Care Excellence) guidance published in March 2014 was not available to staff administering medicines in the home.

Medicines were stored securely and the temperatures of the storage areas and medicines fridge were monitored.

The medication administration records (MARs) were for the most part completed correctly. We found one example of a hand written MAR where the entry had not been signed by two members of staff. The team leader understood the reasons why two staff should check the medicines and sign the records when medication charts needed to be hand written. They acknowledged this had been an error on their part and assured us it would not happen again. Topical medicines, creams and lotions, were recorded on separate charts. They included body maps showing where the creams/lotions should be applied.

When medicines were prescribed to be given at particular times, in relation to food, we found these instructions were followed.

We saw there was guidance for staff to follow in relation to the use of medicines prescribed to be taken 'as required'.

Certain medicines are classified as controlled drugs because there are specific rules, set down in law, about how they are managed. We found controlled drugs were managed safely and checked regularly. We carried out a random stock check and found the medicines were correctly accounted for.

The team leader told us none of the people who lived in the home were administering their own medicines and no one was being given their medicines in a hidden or disguised format.

Inadequate

Is the service effective?

Our findings

The registered manager told us new staff received three or four days induction training when they started work. During their induction they were not included in the staff numbers. This was confirmed by the staff we spoke with. However the provider's policy stated new staff must complete a five day induction programme.

During the inspection we identified some concerns about moving and handling and asked specifically about the training on this topic. Staff were trained by watching a DVD and completing a questionnaire. In addition, staff told us the registered manager and one of the senior care workers showed them how to use equipment such as the handling belts and hoists. However, neither the registered manager nor the senior care worker had been trained to deliver moving and handling training. The registered manager told us they had completed a 'train the trainer' DVD course but confirmed they had not been externally assessed and passed as competent to deliver this training. We concluded they were not qualified to assess people's moving and handing needs or to deliver moving and handling training.

The registered manager told us they tried to recruit staff with exiting qualifications. They said staff without existing qualifications would be supported to complete the Care Certificate. The Care Certificate is a set of standards for social care and health workers designed to equip them to with the knowledge and skills they need to provide safe, compassionate care. However, we found one member of staff who had recently been recruited did not have previous qualifications and had not completed the Care Certificate. The registered manager told us the staff member was undertaking training to achieve a National Vocational Qualification (NVQ) at level 2.

The providers training and development policy dated January 2017 referred to the Skills for Care Common Induction Programme and made no reference to the Care Certificate which was launched in March 2015.

When we inspected the service in February 2016 we found staff training was not up to date and identified this as a breach of Regulation 18 (Staffing) and told the provider to make improvements. On this inspection we saw the training matrix showed the majority of staff training was up to date and this was confirmed by selection of training certificates we looked at. The training matrix included topics such as safeguarding, fire safety, infection control, moving and handling, food hygiene, dementia, equality and diversity and dignity and respect. The training matrix also identified how often training needed be updated.

The majority of training was completed 'in house' by means of DVDs and questionnaires; the questionnaires were checked and marked 'in house'. Staff told us they usually watched the DVDs in small groups and then completed the questionnaires. They said they helped each other out if they didn't understand the questions. However, our findings on this inspection would question how effective staff training and understanding is as we have identified issues in areas which included, fire safety, moving and handling, people not been treated with dignity and respect and safeguarding.
This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us staff supervisions and appraisals were up to date. This was confirmed by staff we spoke with.

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 authorisation 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.

The registered manager told us two people had DoLS authorisations in place, adding others had been applied for but they were waiting for Bradford Local Authority to come and complete the necessary assessments.

We asked the registered manager if any conditions had been attached to the two DoLS which had been authorised. They told us there was one condition on one of them relating to the person wanting a single bedroom.

When we looked at the authorisations we saw one had three conditions attached to it and the second had four. The registered manager did not disclose this to us during initial discussions. We did see one of the conditions was about the person having a single bedroom to give them more privacy. We saw they were still sharing a double bedroom and in this room there was no privacy screening. There was no care plan in place to show how their request was going to be actioned. We asked the registered manager about this and they told us no single bedroom had become available since the DoLS authorisation had been put in place. However, when we looked at the date's people had been admitted to the service we saw three people had moved into the home and into single bedrooms after this DoLS had been granted.

We saw another condition for the second person was for an end of life care plan to be developed. We saw there was an undated end of life care plan, which gave no detail at all, for example, the answers to many of the questions was 'unsure.' We saw this plan had been reviewed seven times since the DoLS authorisation was granted but no detail had been added.

We concluded these conditions had not been enacted and therefore the service was not meeting the legislation. The service was not taking appropriate action to ensure it acted in the best interests of people who lacked capacity.

The registered manager did not understand the DoLS process. When we asked if they assessed people's capacity before making a DoLS application they told us they did not because the DoLS assessors would do this. We saw an application had been made for one person whose records indicated they had capacity; the registered manager said the person's relatives had asked them to make the application. This showed inappropriate use of the DoLS process.

We saw one person's DOLS authorisation had expired. The application to renew the DOLS authorisation had

been submitted on the expiry date which meant there was no time for the supervisory body to consider whether a new DoLS was required before it expired.

The care files we looked at did not contain information about any Lasting Power of Attorney (LPA) orders which were in place. A LPA is a legal document that allows someone to make decisions for you, or act on your behalf, if you're no longer able to or if you no longer want to make your own decisions. LPA's can be put in place for property and finance or health and care. The registered manager told us four relative's had LPA's, however, when we asked for evidence that these were in place none could be produced.

We saw the consent to care and treatment form in one person's file had been signed by their relative. We spoke to the registered manager who told us the relative had LPA for finance. This meant they did not have the legal authority to make decisions about the person's care and treatment.

We found out two people had moved from single bedrooms to double rooms. Neither of them were able to tell us they had made the choice to move rooms. We asked the registered manager about this and they told us one move had been discussed with the person's son and the other with their social worker. We looked at both care files and could find no record of any discussions. The registered manager and lead senior carer looked through the daily records but could find no evidence to support why people had moved rooms or this was in their best interest.
This was a breach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The organisation of mealtimes was poor and was not a dignified process for some people. These were some of the issues we identified:

We observed breakfast and lunch in the dining room and lounge areas. At breakfast time there was one care worker in the dining room. We saw some people had to wait an unacceptable amount of time for their breakfast, we saw one person sitting at a dining table for over an hour before they were assisted with their meal. Three people needed one to one support from staff with their meals in the dining room. However, we saw the member of staff had to break off from supporting people individually to meet other people's requests.

We saw one person who had received one to one support had food dripping from their face; they had been left so the care worker could help someone else. The care worker was requested by one of the provider's to clean the person's mouth.

The care worker who was giving one to one support was then publically told by the registered manager, "Please do not leave the service user who is supposed to be given one to one until you have finished feeding them totally."

We saw one person was being assisted with their meal by a member of staff. The care worker did not sit down and because they were standing this made it difficult for the person they were assisting.

We saw one person, who was sitting in the lounge, was given a slice of bacon, a fried egg and slice of toast. We saw they ate this with their fingers and care workers had not left them with a serviette. They asked one of the inspectors if they could get them something to wipe their hands with. There were no tissues or wipes in the lounge so the inspector went to the dining room to get a serviette.

At lunchtime in the dining room we saw the care workers supporting one person with their meal kept

changing. One care worker had started to assist them with their meal then left them. The same meal was warmed up by another care worker and then taken away by a third care worker who brought an alternative meal.

At lunchtime, in the lounge, no one was offered a cold drink with their meal and no condiments or serviettes were offered. We saw one care worker assisting one person with their meal but they did not explain what the meal was or what the individual components were.
This was a breach of the Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the records of one person we saw they had lost nearly 10kg in weight since September 2016. We looked at the MUST (Malnutrition Universal Screening Tool) which had last been reviewed on 18 March 2017 and showed the person had a low risk of malnutrition. The MUST score had not changed since September 2016 despite the unplanned weight loss. The person's nutritional care plan had been reviewed every month but there had not been any changes to the care plan in response to the weight loss. An entry in the records in December 2016 showed the registered manager was planning to speak to the community matron about the person's weight loss. There was nothing recorded in the 'professional visits' section of the care records to show this had been done. We asked the registered manager and they told us they had spoken to the community matron but acknowledged this had not been recorded. It was therefore not possible to establish when this conversation had taken place and if the community matron had been made aware of the full extent of the weight loss the person had experienced. On the second day of our inspection we saw food charts had been put in place to monitor the person's food intake. We concluded not enough action had been taken in response to the unplanned weight loss. A re-assessment of their needs had not taken place in a timely manner.

We saw there was information in the kitchen about how to fortify foods for people to provide them with additional nutrition. However, we found not all of the ingredients were available to do this. The cook told us some people had fortified milkshakes and whichever member of staff did the tea trolley would make these. We did not see anyone have a milkshake on either of the days we inspected.

We saw staff were recording the food and fluid intake for some people. We saw the format for the fluid charts did not allow for daily totals to be calculated and there was no evidence of the charts being monitored to make sure people were getting enough to drink. No details about what people's individual target fluid intake should be were recorded. We asked the registered manager about one person and they were not clear what the person's daily intake should be. This meant checks were not effective in ensuring people were properly hydrated.
This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people who used the service about the meals at Bronte Park Care Home and generally people did not raise any issues about the choice of meals. One person told us, "I do like my breakfast." A second person said, "I am OK with the food." A third person commented, "The food is awful, do not get enough and just eat what they give." A fourth person said, "I do like the food that is on offer."

The menu was on display in the lounge and showed what meals and choices were on offer. There was also information about the food which was available when the kitchen was closed from 6.30pm to 6.30am.

We asked people who used the service about their healthcare. One person told us, "They get the doctor for me when I need them." A relative said, "They are on the ball when it comes to my relative's health- any

issues they would call me."

We spoke with four visiting health care professionals. They said staff reported concerns about people's health promptly and followed the advice given. They told us the staff were caring and supported people who lived in the home and their relatives.

In the eight care records we looked at we saw people had been seen by a range of health care professionals, including GPs, community matrons, district nurses, opticians and podiatrists.

Requires Improvement

Is the service caring?

Our findings

We asked people using the service if they liked the staff and we received the following comments. One person told us, "I'm fed up with her [nodding at a care worker] she's the boss." Another person said, "I really like (the name of the care worker); he is very caring and good with me." A third person commented, "No one is nasty to me – some care workers are good – some are not." A fourth person said, "Yes they are caring – they are polite."

We saw in their direct dealings with people, staff were kind and patient. It was clear some staff knew people very well and were aware of their individual preferences.

We saw there were practices in the home which showed a lack of regard for people. These were some examples: Care workers entered people's bedrooms without knocking first. There was no privacy curtaining in two of the double bedrooms we looked in and in a third double bedroom the privacy curtains were 18 inches off the floor and one had faeces on it. In one double bedroom there were sticky labels on the under sink drawers with the first names of two people. One of these people no longer occupied the room. There were two dirty combs in this cupboard and an unopened letter postmarked 23 March 2017 which was not for either occupant of this bedroom. There was also a tube of Steredent which belonged to someone else.

We saw a number of bedrooms had small combination wardrobe and drawer units which provided limited hanging space for clothing. This meant items such as skirts and jumpers were not being hung up and we saw people wearing clothing which looked 'crumpled.'

We found there were no plugs for the hand washing sinks in two of the bedrooms. We asked one of the care workers how two people in one bedroom got a wash, as there was also no washing bowls in use. They told us they used 'wet wipes' to wash people.

We heard care workers referring to people who needed assistance to go to the toilet as 'singles' and 'doubles.' This referred to the level of assistance they required from either one or two care workers and showed a lack of personalisation and was undignified for people.

We saw one person's urinary catheter bag was in clear view throughout our visit. We saw another person wearing ripped trousers and odd socks.

During afternoon of the first day of our inspection we saw a person who lived in the home looking a bit uncomfortable. We asked if anything was wrong and they said they could not see the TV and there were hurting their neck trying to lean forward to see it. They told us they had glasses but they had been left in their bedroom. After the inspector intervened staff went and got person's glasses and moved their chair nearer to the TV. On the morning of the second day of inspection we found this person's glasses in the drawer of another person's bedroom. We heard the same person asking for a tissue to blow their nose. There were no tissues in the dining room and the registered manager gave them napkins from kitchen. When we looked in bedroom there were several packets of tissues in their drawers.

We saw the majority of the men were wearing 'jogging pants' and could not determine from the care plans we looked at if this was by personal choice.

We concluded people were not always being treated with dignity or respect.
This was a breach of the Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked visitors if they were made to feel welcome. One person told us they visited every day, were always made to feel welcome and had good relationships with staff.

Inadequate

Is the service responsive?

Our findings

We asked relatives how they had chosen Bronte Park Residential Home, One person told us, "It was recommended and is very close to where mum and dad used to live and dad knows where he is in terms of location."

People who used the service told us staff would attend to them eventually when they used the call bell. One service user said, "At night I do ring the buzzer- they do not come quickly- I think they are short staffed. Also during the day it is difficult for me to reach the buzzer when I am in my chair."

When we arrived at 7:50am on the second day there were 10 people up and dressed, seven were in the lounge and three in the dining room. The senior night carer told us they sometimes started getting people up at 5:00am but that morning they had started at 05:30am. They added one person had been up since 03:00am and had been washed and dressed at 05:30am as they were 'wet through' and added had only been given a quick wash because they were in a foul mood. We were unsure how they were washed as when we looked in their bedroom there was no plug in the wash hand basin and the soap and bowl were dry. The daily notes stated the person had gone to bed around 10pm and slept late, which was inaccurate.

We found out most people were going to bed before the night staff came on duty at 8:00pm. On day two of our visit the senior night care worker told us when they came on duty at 8:00pm on 7 May 2017 there were only six people up. Another care worker told us all the 'doubles' (meaning people who required two staff to assist them) went to bed before the night staff came on duty. This meant 17 people had been assisted to bed before 8:00pm and showed a lack of person centred approach.

We saw the lack of staff presence in the lounge area meant care workers were not responding to people's needs. For example, one person was brought a cooked breakfast, but fell asleep. When they awoke the bacon and egg was cold. We were sitting next to one person who told us they needed the toilet, no staff were present and it was another 10 minutes before a member of staff came into the lounge. One of the inspectors told them one person had requested to go to the toilet it was another 20 minutes before they returned with another care worker to respond to the request. This meant the person had waited 30 minutes to go to the toilet.

We saw care plans did not always reflect people's current needs. In one person's records there was a care plan for 'violent and aggressive behaviour. However, when we read their care notes we saw there had been no incidents of aggression since 2015. This meant staff were being given inaccurate information about the person which could influence their approach to delivering their care.

We saw another person was not wearing any socks. We asked one of the care staff and they told us the person didn't like wearing socks because their feet got too hot. We looked in this person's care plan and this information was not recorded. When looking at the records we saw the person's photograph showed them wearing glasses but when we had seen the person in the lounge they were not wearing glasses. We saw the person's glasses had been left in their bedroom.

On the second day we saw another person was not wearing their glasses. We looked in their bedroom and found them in their bedside drawer. We cleaned them, gave them to the person, who then wore them for the duration of our visit.

A number of people using the service were living with dementia and we saw some areas of the home were not providing a suitable environment. For example, the carpet in the lounge was highly patterned and we saw one person bending down from their armchair to try and 'pick' something up from the pattern. Also, the tablecloths in the dining room had very 'busy' patterns on them. The Alzheimer's Society guidance (Making Your Home Dementia Friendly) recommends plain carpets and table covers.

We saw on one of the notice boards the registered manager was named as the lead for dementia care. We asked them what training they had done for this role and they told us they had not done any additional training. We asked if they could give us an example of any good practice guidance they had implemented to improve the quality of care experienced by people living with dementia. They told us they had tried to increase the number of outings for people living with dementia. However, when we explored this we found there were limited opportunities for people to go out unless they were taken out by their family or friends.

We concluded care and support was not being planned and provided in a person centred way.
This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people who used the service what activities were on offer. One person told us, "I have no TV- nothing much to do- I do go in the garden but it is cold." Another person said, "I sit around all day doing nothing- It would be nice to do something." A third person commented, "I sit in my room most of the time watching TV- I have no one to speak to – I cannot go out on my own- I wait until my relative's come- they take me out." A fourth person said, "We sit here by the window – all day – or go to sleep."

In notes of staff meeting March 2017 we saw a reminder to staff to pay their lunch money as this was used to fund activities for people living in the home. This showed us there was a lack of provision to provide planned activities.

When we arrived on the first day, the television was on in the lounge with breakfast television and was left on throughout the morning and lunchtime. No one was watching it. One person said, "I'll tell you what I like to watch, films. Any film, I'm fed up with this, [nodding at the television.]"

We saw there was a monthly activities plan indicting activities such as painting, board games, baking, films, music and beauty therapy were on offer.

The registered manager told us they used to provide activities in the afternoons, from 2pm – 4pm, but found that most of the people who used the service went to sleep. They have moved activities to 11am -12pm as people were more active at this time. We saw a care worker offering people a hand massage during our visit.
We concluded there were not enough activities to keep people occupied and mentally active.
This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the complaints procedure was on display in the front lobby, an area not accessible to people who used the service as the front door was locked. This procedure was out of date. We also saw a compliments and suggestions box in this area. We looked at the complaints log and saw four complaints had been recorded since April 2016. We also saw a 'grumbles register' which gave the date, name of the person, the

grumble, action taken and whether or not the grumble had been resolved. However, some serious issues had been raised, for example, staff not responding to the call bells in a timely way. There was no evidence of any investigation or exactly what action had been taken to prevent a reoccurrence.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post and people who used the service did not raise any issues regarding management of the service. Relatives told us, "I would recommend this home to my relatives- my relative is happy here- management do listen- if I have issues –they talk it through." "If I have any issues - management sort it out straight away." "Very good with us and my relative."

We asked staff about the management of the service and they told us, "I am really happy here – management support me." "We are one big family." "Management have provided us with good training and are very supportive..."

We did not find an open and honest culture at the service. Staff found it difficult to answer direct questions or were not honest in their answers. For example, we asked one of the team leaders if there was a copy of the National Institute for Clinical Excellence (NICE) Guidance available in relation to medicine management. They told us there was but when we asked where it was it became evident this document was not available.

When we asked the registered manager for the risk assessment for the building work which was being completed, they brought us a file which contained a general risk assessment dated June 2013. Eventually we ascertained no risk assessment had been completed.

We saw one person walking along the corridor towards the lounge. As they were passing the area under the stairs, where wheelchairs were being stored, one chair fell over and narrowly missed hitting them. We asked the registered manager for the wheelchair service records. They told us there were no records of servicing as this was done by Airedale NHS. This meant in the absence of any documentation we could not be assured wheelchairs were safe to use.

We saw various audits were being completed, however, we found these were not identifying or addressing issues. These were some examples we identified:

We saw a housekeeping audit had been completed on 24 April 2017 which had checked the following in the bedrooms: carpet cleanliness, bed mattresses and base, curtains – cleanliness and condition, sink and taps, wardrobe, bedside cabinet, drawers, light fittings and other furniture. In one bedroom the audit had identified the carpet needed shampooing but no other issues had been identified. When we looked in this room we saw a handle was missing off the drawer and the knob on one of the doors was missing on one of the bedside tables. The drawers on one of the wardrobe units were broken and when one was opened it pulled the drawer beneath it out as well.

In another bedroom we saw the carpet was stained, an electrical extension lead was trailing on the floor and the end of the extension lead was on a cabinet next to the wash hand basin. These issues had not been picked up through the April 2017audit which had taken place three days before our inspection.

We found records we asked for were not readily available and it was not easy to locate the most up to date

records. For example, we asked to see the service and safety certificates which related to the premises. We were given a file which contained records which went back a number of years, making it difficult and time consuming to locate the most recent documentation. We could not locate the most recent safety certificates for the two bath hoists or the stand aid. At the end of the first day the provider told us the necessary checks had been made and the contractor was going to email the up to date documentation. On the second day of the inspection these certificates were still not available. Following the inspection some certificates were emailed to us, but these did not include the certificate for the ground floor bath hoist.

Whilst we were looking through the same file we found the Food Standards Agency quality rating sticker, which is good practice for services to display, in the folder. We brought this to the attention of the registered manager who told us it was their fault it was not on display and they got a care worker to put it on the front door.

We saw accidents were being listed on a monthly basis, we asked the registered manager if any trends or patterns had been identified from these audits. They stated individuals who had fallen were discussed with district nurses and/or the community matron. They also told us they had identified the need for staff to be in lounge more and had told the staff to do paperwork in lounge rather than sitting in office or dining room. However, we saw the time accidents happened were not being recorded and noted there had been 22 un-witnessed falls between February and April 2017.There was no evidence the high number of un-witnessed falls had been identified as a concern or investigated

There were no audits of complaints or 'grumbles' taking place to see if there were any themes or trends. For example, we saw there had been two concerns raised about staff taking too long to answer the call bells and this echoed what some people told us. This showed us there was a lack of action to put measures in place to prevent a re-occurrence of problems which had been raised by people.

We saw the provider also undertook monthly monitoring visits and the last one had been completed on 25 April 2017, two days before the first day of our inspection. This visit did not identify any of the issues we identified, for example, around health and safety, lack of hot water, the dishwasher being broken. This showed the audit was not fully effective.

We found there were policies and procedures in place; however, these were not being followed. For example, we looked at the privacy and dignity policy which stated, "Ensure the environment allows privacy in which the intimate care, treatment and support needs of the person who lives here are met." We found two double bedrooms did not have any privacy curtaining and staff were not always knocking on people's bedroom doors before entering which meant people's dignity was being compromised.

We saw there was a policy in place regarding what the service was required to report to the Care Quality Commission. This policy had been signed by the registered manager; however, we identified a number of incidents which they had not reported to us. This had not been picked up by the providers monitoring visits.

Another policy which was in place was in relation to financial procedures to ensure people using the service were protected from financial abuse. However, we found these were not being followed and care plans did not contain up to date information regarding the support people needed. We found the registered manager was holding bank cards and money for safekeeping for some people who used the service. We found some receipts attached to people's financial records, however, the registered manager could not tell us what purchases had been made.

We found 8 breaches of regulations. The service had not operated effective systems to ensure compliance

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

We saw residents meetings were held and saw the minutes for the last three meetings. We saw each meeting had been 'themed' around different areas. For example, Christmas, home decorating and meals.

The registered manager told us staff meetings were held every other month. The staff meeting records showed us a seniors meeting had taken place in April 2017 and a full staff meeting in March 2017. Prior to this a seniors meetings had taken place in November, August and June 2016 and last full staff meeting was in May 2016. This meant they were not being held as frequently as the registered manager told us.