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Bronte

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 4, 5 and 11 February 2016.

The service provides accommodation and personal care for up to 20 older people. On the day of this inspection there were 18 people living there, including one person who was in hospital.

At the last inspection of the service on 19 June 2016 we found many improvements were required. The service was rated as 'inadequate' overall and placed in special measures. We imposed a condition that the service must not admit any more people until such time as we were satisfied they had made improvements to address the failings we had found. At this inspection we found some actions had been taken to address the breaches of regulation, but these were not fully effective and the service continued to be in breach of a number of regulations. People continue to be at risk due to staff not having the right skills, training and knowledge to meet their needs. Risks are not clearly identified and staff were not given instructions about how to manage risks.

The providers are a husband and wife team. One of the providers is the registered manager of the service and the other provider is responsible for the day to day management of the service and is referred to in this report as the duty manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Safe procedures had not always been followed when recruiting new staff. Checks and references had not always been carried out before new staff began working with people. This meant it was not possible to show that new staff were entirely suitable for the job they had applied for.

Medicines were not administered safely. Medicines were administered by staff who had not received suitable training. Poor practice was observed including medicines left on top of an unlocked medicines trolley while the member of staff took medicines to people in their rooms. Safe procedures were not followed when recording medicines. Medicines administration records (MAR) were not always accurate. There were unexplained gaps in the medicines administration records. Audits of medicines had only just started and were incomplete. We also found improvements were needed in the way the service managed creams and lotions.

Staff had received training on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). DoLS applications had been submitted for most people living in the home. However, the provider had not assessed people's capacity to give consent, or to make important decisions about their care and treatment. The care plans did not explain to staff about each person's capacity to make decisions, or guide staff to gain consent before providing care. We observed staff seeking consent before carrying out care tasks.

Staff did not have sufficient information on people's needs to ensure people received care that met their individual needs. New care plans had been drawn up in consultation with the resident, some family members, the deputy manager, the duty manager and the registered manager. However, the new care plans had not yet been introduced to the staff. They had been written in recent months and had not been reviewed. Some of the information was incorrect or out of date. The providers planned to introduce the new care plans to the staff in the very near future. The providers told us they did not expect the new care plans to be fully operational for at least another two months. This meant staff were continuing to work without the right information to assist them in providing safe and effective care.

Risks to people's health had not been fully assessed or regularly reviewed. Some improvements were noted but some areas were still not fully met. Some people were at risk of choking but there was no evidence this had been assessed. Advice or guidance had not been sought from the speech and language therapy team (SALT). Some people were on soft or fork mashable diets but we were unable to see evidence of how staff had reached the decision to provide a soft diet. The providers agreed to seek advice urgently from GP's and/or the SALT team.

No actions had been taken since the last inspection to identify people's social needs. There was no evidence in the care plans to show they had discussed with people the things they enjoyed doing. An activities organiser visited the home for three hours each week. There was no evidence to show that staff spent time with people the rest of the week for any activities other than provision of personal care. We saw people sat in the lounge or in their rooms for long periods without any social interaction.

Staffing levels had increased since the last inspection. They had lost some staff and had recruited additional new staff from overseas. There was an extra member of staff on duty each day therefore we found the staffing levels were adequate. Some newly recruited staff had no previous relevant experience or training and were still in their probationary period. New staff were still getting used to routines. The increase in staff meant people were likely to receive assistance when they needed it. However, people were at risk of poor care because many of the newly recruited staff did not have the knowledge, experience or skills to meet their needs safely. Staff were about to begin to attend weekly training sessions to gain a qualification known as the Care Certificate.

We were unable to see evidence of regular, planned supervision sessions for staff. The provider told us they planned to introduce supervisions in the near future. However, only two supervision sessions had been recorded since the last inspection. This meant staff did not have support to discuss how their role was going and to plan for their training needs.

The provider did not have an effective quality monitoring system in place. The provider had drawn up a system but had not yet begun to implement it. One of the providers had begun to carrying out a medication audit, but this had not been completed. The audit had failed to pick the failings we had found during our inspection.

The providers had failed to evaluate and improve their practice to ensure the quality of the service is continually improved. The providers have not received any further training since the last inspection. They were not planning to gain any further qualifications, although one of the providers planned to attend future training sessions booked for the staff team.

Staff demonstrated a positive and caring manner. They were cheerful, friendly, smiling and welcoming. We saw staff communicating well with people seeking consent and explaining the care they were offering, for example moving and handling procedures. Staff understood the importance of treating people with dignity

and respect, for example by drawing curtains and shutting doors when carrying out personal care. They used a fleece blanket to place over people's lower half to protect their dignity when using the hoist. People told us the staff were always kind and caring.

At the last inspection we found the security of the home was not fully effective. During this inspection we found actions had been taken or were in the process of being taken to improve the security. They had ordered new doors to be fitted to the conservatory that will be fitted in the near future to improve security. In the meantime a temporary alarm had been fitted to the door. The providers agreed to carry out risk assessments on other exits from the home to ensure people were protected from harm.

During the inspection we identified repeated breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk from harm because the provider's actions did not sufficiently address the on-going failings. There has been on-going evidence of the provider's failure to sustain full compliance since 2012. We have made these failings clear to the provider and they have had sufficient time to address them. Our findings do not provide us with confidence in the provider's ability to bring about lasting compliance with the requirements of the regulations. We are taking further action in relation to this provider and will report on this when it is completed.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. People continued to be at risk of harm because the provider's actions did not sufficiently address the on-going failings. This was despite the support provided by the local authority to address those failings. There has been on-going evidence of inability of the provider to sustain full compliance since December 2012. We have made these failings clear to the provider and they have had sufficient time to address them. Our findings do not provide us with any confidence in the provider's ability to bring about lasting compliance with the requirements of the regulations. We are taking further action in relation to this provider and will report on this when it is completed

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

People were not safe.

Risks to people's health and safety were not managed effectively.

Safe recruitment procedures had not always been followed before new staff began working in the home.

Medicines were not always securely stored or administered safely.

There were sufficient numbers of staff to meet people's needs safely.

Is the service effective?

Requires Improvement

The service was not fully effective.

People were not supported by staff who had received regular supervision or appraisal to monitor their practice or identify areas where further training or guidance may be necessary.

People's capacity to make decisions about their lives had not been considered or assessed. Applications had been submitted for most people whose liberty may be restricted. However, failure to carry out capacity assessments for every person meant they were unable to demonstrate they had taken adequate steps to ensure any restrictions to people's liberty were managed in line with current legislation.

Newly recruited staff had begun to receive training on essential topics relevant to the needs of people using the service. Further training topics were planned for coming months.

Is the service caring?

Requires Improvement

The service was caring.

Staff supported people in a caring and respectful manner.

Staff understood the importance of providing care in a manner which protected people's privacy and dignity.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans did not always give sufficient or up to date information about each person's needs.

People's social needs were not met. People were not supported to receive a range of activities suited to their individual needs and preferences.

Is the service well-led?

Inadequate

The service was not well-led

The provider did not have effective systems in place to monitor the service. They had failed to ensure all aspects of the service were safe and running smoothly.

The provider and registered manager had failed to keep up their own learning and development needs and did not have a good understanding of current legislation or good practice standards in relation to people's care needs.

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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 4, 5 and 11 February 2016 and was unannounced. It was carried out by two social care inspectors.

Before the inspection we reviewed the information we held about the service. We looked at the information we had received from the service including statutory notifications (issues providers are legally required to notify us about) or other enquiries from and about the provider.

During our inspection we spoke with two providers (one of whom is the registered manager), twelve people living in the home, five visitors and six staff. We also spoke with two health and social care professionals who were visiting the home at the time of our inspection. We looked at the care records of four people living in the home. .

We also looked at records relevant to the running of the service. This included staff recruitment files, training records, medication records, and quality monitoring procedures.

Inadequate

Is the service safe?

Our findings

Although we found there had been some improvements since the last inspection, these were not fully effective and people continued to be at risk of harm. Staffing numbers had improved, but the new staff team were in the early stages of learning basic skills and lacked information and knowledge about how to keep people safe from harm. Staff lacked information and knowledge about how to protect people from such risks as choking, pressure sores, medication errors, or who to contact outside of the home if they were concerned about possible abuse.

Staff did not fully understand how to protect people from harm or abuse. At the last inspection we found staff had not received adequate training or information to enable them to recognise potential abuse or know how to report suspected abuse. At this inspection we found some improvements had been made but these were not fully effective which meant people remained at risk of harm or abuse. Staff had received training and understood how to recognise abuse. However, staff we spoke with did not know how to involve other professionals under safeguarding procedures. They did not know the contact details of other professionals, such as the local safeguarding team, or the Care Quality Commission. One member of staff said "I know if I am unhappy I can tell the managers, but I did not know I could speak to anyone else". They explained there had been times when they would have liked to have complained.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

The management of the service had taken insufficient action to improve people's safety. At the last inspection we found risk assessments had not been completed for health risks such as skin damage and pressure sores, constipation, weight loss, dehydration, choking, or falls. During this inspection we found that new care plans had been drawn up containing greater information about each person's needs. However, the care plans were not yet in use by the care staff. Where risks had been identified, plans to address the risks were unclear or poorly co-ordinated. The plans did not contain any monitoring tools that had helped staff identify the level of risk.

Where care plans identified people were at risk of skin damage there were no risk assessments to help staff identify the level of risk. For example one care plan said "She has very sensitive and dry skin" and went on to say "Staff to observe her skin and call district nurses immediately." However, there was no risk assessment in place to help staff identify the level of risk of pressure sores, or the need for equipment such as pressure relieving mattress or pressure cushion to be put in place. Staff told us there were no people at risk of pressure sores and no pressure relieving mattresses in place. However, one care plan said a person "Sometimes suffered from soreness on her bottom," and guided staff to apply a barrier cream "as directed".

At the last inspection of the service we found the home had failed to take suitable action to protect people from the risk of choking. At this inspection we found the service had failed to take action to address this failing. They had not sought assessment, treatment or guidance from specialist health professionals such as the Speech and Language Therapy Team (SALT) to ensure the risks were managed safely. Risk assessments

were not in place to show how the staff had assessed the risk of choking, the level of risk, or any preventative measures that should be put in place. One person told us "I have choked before and it worries me that it will happen again. Some of the food on my plate is hard. I don't say anything I just leave it on the side of my plate as I don't want to choke again". The person was at risk of choking on food that had not been prepared in line with a SALT assessment. A member of staff discussed how they supported another person to eat as they were at risk of choking. They explained they had to watch the person as "They store food in their mouth". We spoke with the cook and other staff responsible for serving and preparing people's food. They were aware of those people who may be at risk of choking and had taken action to mash or dice foods. However, they had not sought professional advice on the risk of choking and had not been given information about foods people may eat safely or those to avoid. One member of staff informed us "We do try to mash people's food if they need it, but some people like to do it themselves. If someone needs soft food or wants chips we would make soft ones".

Where care plans identified people may be at risk of falls there was no evidence to show how they had assessed the level of risk or considered the need to involve other professionals, for example to review any equipment needed. There was no evidence to show the incidence of falls had been taken into consideration when reviewing the care plans or level of risk.

Where people were at risk of weight loss this was highlighted in the care plans. For example, one care plan instructed staff to offer the person snacks between meals. The care plan referred to the use of monitoring tools such as a Body Mass Indicator (BMI) and a malnutrition screening tool, but these were not included in the care plan file. People were weighed regularly, but where weight loss had been recorded the care plans did not show how the risk had been reviewed, or the care plans adjusted. For example by carrying out more frequent weight checks, or considering the need to seek advice from specialist health professionals such as the GP, Speech and Language Therapists, or a dietician to provide support and guidance in line with best practice.

Where people were at risk of constipation or diarrhoea care plans guided staff to encourage people to drink plenty of fluids. However, they had not considered the need to record fluid intake levels or monitor intake to make sure people were not at risk of dehydration.

Where people required equipment to help them to move safely there were no moving and handling assessments in place. There was insufficient information in the care plans to instruct staff on how to use the equipment safely. For example, one care plan said the person needed to be assisted to move with the use of a hoist and wheelchair, and said two staff were needed to assist the person. There was no information about how to carry out the manoeuvres. There was no information about the slings to be used on the hoist, or the correct settings for the slings. This placed people at risk of receiving unsafe care.

The service placed people at risk because staff did not handle medicines safely and there was a risk people may not receive them as prescribed. At the last inspection we found medicines were not managed safely. At this inspection we found insufficient action had been taken to address this. We observed medicines being administered at lunchtime. The member of staff checked the medicine administration records (MAR) before dispensing the medicines into pill pots and taking them to the person. However, they did not sign each record immediately after giving each person their medicines. Instead they signed a number of records in a batch. This meant there was a risk they may fail to record every medicine they had administered.

When we looked at the MAR charts we saw some unexplained gaps in the records. The member of staff had failed to identify the missed signatures. We checked the stocks of medicines to see if the correct amounts of medicines were held. Where medicines had been supplied by the pharmacist in monitored dosage packs the

tablets had been removed from the packaging on the days/times corresponding with the missed signatures. This meant it was likely these medicines had been administered correctly, although the member of staff had failed to sign the MAR chart. However, where medicines were supplied in packets or bottles the amounts of medicines received into the home, or carried over at the end of each month, had not always been checked and recorded. This meant it was not always possible to check the stock levels were correct, or to check that medicines had been administered according to the prescriber's instructions as printed on the MAR charts.

We asked the member of staff if they had received training on administering medicines safely and they told us they had been trained by one of the providers. We asked the provider if they had received training on safe administration of medicines and they told us they had not received any training on this topic that they could remember. This meant staff were unaware of current safe practice relating to medicine administration. We asked the member of staff and the provider if they had a policy on the safe administration of medicines that set out clearly the safe procedures to be followed when administering medicines. The member of staff was unaware of any policy. The provider was not sure where the policy was kept, and confirmed it had not been reviewed recently.

One person had been prescribed a medicine (Warfarin) which was on a variable dosage. The dosage changed each day. A new prescription was sent to the home from the person's doctor on a weekly basis giving the dosage instructions for the following week. In addition verbal instructions from the doctor's surgery were given to the home by telephone. This was because there was a delay of at least one day each week before the written instructions reached the home. Details of the telephone call were not recorded within the medicine records or care plan for the person. This meant that there was at least one day each week when staff did not have clear written guidance on the correct dosage of Warfarin for this person.

The provider had recently started to carry out an audit of medicines held in the home, but the audit was incomplete and had failed to pick up missing signatures or instances where staff had failed to record the amounts of medicines received into the home.

Medicines were not always stored securely. During the lunch time medicines round we saw medicines were left on top of an open and unlocked medicines trolley while the member of staff took medicines to people in their rooms. Care plans showed that at least one person was at risk of overdose or taking medicines inappropriately. This meant the poor security of medicines may place people at risk of harm.

We also found creams had not always been signed for after administration, and some had not been listed on the MAR charts. Creams had not been dated when opened and the provider was unaware of safe disposal dates. Some entries in the MAR chart were incorrect. The providers said they had booked a training provider to give training on medicines administration for the near future.

Care plans did not always provide up to date or accurate information about medicines prescribed to each person. One care plan said that a person was prescribed morphine. However, when we checked the stocks of medicines we were unable to find the morphine. The person's MAR chart did not record any morphine currently prescribed. When we spoke with the provider they were unsure where the information about the medication had come from and agreed the information was incorrect.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Safe recruitment processes were not always followed before new staff began working in the home. Staff

recruitment files did not contain sufficient evidence of checks and references carried out to determine the suitability of applicants for the posts they had applied for. Some files contained references, but these were not evident in every file. New staff had been recruited from abroad using a recruitment agency. The provider had carried out telephone interviews over the telephone but had failed to record any details of the interviews. This meant they were unable to show they had checked the applicant's previous employment history, qualifications, or English language skills.

The provider told us all new staff were employed on a six month probation period. However, the recruitment files did not contain a copy of the employment contract or evidence of any probation periods. Where staff had been recruited outside of the European Union the provider showed us evidence of their right to work in the United Kingdom. The recruitment files contained evidence that police checks had been carried out in the applicant's home country. However, the provider had not applied to the Disclosure and Barring Service (DBS) to carry out checks following their entry into this country. DBS checks provide evidence that applicants have not been barred from working with vulnerable adults. They also provide evidence of any relevant convictions for crimes carried out in the United Kingdom. This meant the provider had failed to carry out adequate checks to ensure applicants were entirely suitable for the posts they had applied for.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Staffing levels had increased since the last inspection. During the day an additional member of staff was on duty and this had resulted in staff being less rushed. A cook was employed seven days per week – this was an improvement. The staff appeared cheerful, relaxed and welcoming. A relative told us "There is always enough staff. Always staff around who are willing to help out."

Staff told us staff numbers had improved over the last year although they still felt concerned they did not have enough time to give to people. One member of staff explained "it is better now as we are not full, when we are full it is hard to support everyone and do all our other jobs".

A member of staff informed us "It can be difficult when we are busy and call bells are ringing, if there is more than one bell ringing I will see who it is, I know which one is more important and will go to that one first", they gave the example of someone being at risk of falling.

Cleaning staff were not employed. Cleaning tasks were carried out by the care staff. Staff told us they had to complete all care tasks by mid-morning so that they could begin the cleaning tasks. A member of staff said "We are busy especially in the mornings as we also have to do the cleaning; when there are more people living here it is difficult".

While we were satisfied that people's personal care needs were met by the current staffing levels, there were insufficient staff employed to meet people's social needs. We spoke with the providers who told us they will consider employing an activities organiser to meet people's social needs. They also told us they were in the process of recruiting another new full time member of staff which will mean further improvement in the staffing levels will be in place in the near future. They also agreed to look at the way they organise cleaning duties. However at the time of the inspection current staffing levels were not meeting people's social needs.

A person told us "The staff are very good I have difficulties with my health but they are always there to help me if I need them". People had access to call bells and on the days of the inspection call bells were responded to in a timely manner.

People told us they felt safe and were happy. One person informed us "I don't like being around people, staff come and see me to make sure I am ok, I like my door open they come and check it is locked at night." A visiting relative informed us they felt that the person they were supporting was safe at the home, but had not been safe living on their own, they explained "We were very worried about their safety and the risk of them hurting themselves by falling, that risk is less since moving here. One person told us they did not like the mat on the floor by their chair but they knew it was there to keep them safe and stop them falling, they explained staff came as soon as the alarm on the mat was activated. We witnessed a quick response from staff when the person stepped on the mat.

At the last inspection we found that people and their belongings were not always protected because there were shortfalls in the security of the home. Doors were sometimes left open allowing people to enter or leave the building without staff being aware. At this inspection we found some improvements had been made, or were in the process of taking place. New doors had been ordered for the conservatory and were due to be fitted in the near future. When completed the doors will be alarmed and this will ensure staff are aware of anyone leaving by this exit. Where people had patio doors from their rooms into the garden risk assessments had not been completed. The providers agreed to complete this promptly.

Requires Improvement

Is the service effective?

Our findings

People's capacity to consent to care or treatment had not been assessed or recorded. At the last inspection we found that consent was not always sought from people before care and treatment was provided. At this inspection we found staff had received training on the Mental Capacity Act (MCA). However, there was no evidence to show that staff had considered each person's capacity to make decisions. Care plans did not contain evidence to show people had been consulted about their care needs or had been asked to consent to their care. Care plans did not hold any evidence to show they had considered the need to seek agreement for procedures to be carried out in a person's best interest. For example, we saw evidence to show some people had medication administered covertly, but we could not always see evidence that the person's capacity to consent had been assessed, or that best interest agreements had been reached with people acting on the person's behalf.

Staff were observed seeking consent before carrying out tasks and explaining the procedures they were about to carry out, for example when offering to assist a person to move, and asking a person if they wanted their medication. Staff we spoke with had understood the importance of gaining consent and what to do if people could not consent. They confirmed they had recently received training on MCA. One staff said "If I am trying to support someone and they didn't want me to I would discuss with my manager the best way to help them". Another member of staff informed us "We support people who do not speak English. I try to break down what I am trying to say to them. I try to show them what I mean". Another member of staff informed us "I know people are allowed to leave but we have to make them safe, so I would go with someone if they needed to leave".

The provider told us they had submitted Deprivation of Liberty Safeguards (DoLS) applications for most people living at the home. There was no evidence in care plans to show how they had reached the decision to apply for DoLS authorisations , and care plans did not contain evidence of application documents. People's capacity to consent to their care and treatment had not been assessed. There was no evidence to show they had assessed the possibility that people admitted to the home in recent months may be restricted, or may need DoLS authorisations. This meant we could not be certain the key requirements of the Mental Capacity Act 2005 were fully understood or carried out. After the inspection the providers told us they were in the process of carrying out mental capacity assessments on each person, and they had submitted a DoLS application for one person in addition to nine applications previously submitted.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

There was a risk people's needs may not be fully met because training had not been effectively planned or provided to ensure all staff were competent in all aspects of people's needs. At the last inspection we found staff had not received appropriate training or professional development. During this inspection we found some improvement. Staff had received some training, but not all essential topics had so far been covered. Training sessions for the Care Certificate were booked to begin 12 February 2016 and will be held weekly every Friday for the next 12 weeks. This meant the level of training was improving and there was a

programme of training in place. However, the breach of regulation had not yet been fully met.

The provider said they had purchased DVDs on a range of training topics and they had planned training for staff at monthly intervals over the coming year. They said "We are taking it slowly in regards updating our staff training as we do not wish to overload staff". One member of staff said they received training every month. Some staff from overseas had completed training in their own country although some of the qualifications were not relevant to health and social care. The provider said some staff were developing their English which would support them with their training. One member of staff informed us "I do not have any experience but I am learning, lots from my computer". Another member of staff informed us "I have experience and training from working in another home. That helps me here".

Staff were seen to safely support people who had restricted mobility. One professional informed us they had witnessed a person being supported in a hoist safely, although they also commented that there were some manoeuvres staff needed additional training or guidance in. They gave the example of staff trying to support a person to stand with the support of a frame, they explained that staff had not been able to help the person weight bear in the correct standing position and felt additional training would benefit staff, we passed this information back to the deputy manager.

Some staff said they had received some manual handling training others were waiting for this training. A member of staff explained "I did not understand how to move people when I first started work here, but I was shown by [staff member's name]." We looked at the training records and found the member of staff responsible for this instruction had not had the relevant manual handling training to allow staff to shadow them, this meant people were at risk of being moved by staff who had not received the relevant training to support people safely. After the inspection the provider told that although the staff member had missed the most recent training session on moving and handling people they had received this training in 2014. They said staff member has been working at Bronte for the past six years and has had this training on a number of occasions.

Throughout the inspection we observed staff supporting people who had poor mobility in an unrushed and reassuring way.

At the last inspection we found the providers had failed to ensure staff received appropriate supervision, training or professional development. During this inspection we found that only two supervision sessions had taken place since our last inspection. This meant staff had not received adequate support and their competence and training needs had not been monitored.

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

People could see health care professionals when they needed to. Staff told us they received good support from district nurses and they would visit people at the home when needed. One professional informed us their instructions were always followed and they were always made welcome in the home. Another professional visiting the home informed us "There is always a nice atmosphere in the home and people seem to like living here". They explained they had spoken to the person they support in private and they are happy.

At the last inspection we found people were at risk of missing medical appointments as the systems for recording and planning medical appointments were not fully effective. On the first day of this inspection a

person was escorted to a hospital appointment. The provider told us people always attended medical appointments. Staff were less certain about this. A member of staff said "It can be frustrating as we are supposed to be supporting people. It upsets me sometimes when things like appointments are missed. Our job is to help people. We need someone else in the office doing the other things like the paperwork". We discussed this concern during the feedback session. The provider showed us diary records of medical appointments booked for the near future. They also showed us entries on the staff rota showing where staff had been specifically allocated the responsibility of taking people to medical appointments. This meant the systems for recording and arranging people to attend medical appointments had improved, although the possibility of missed appointments may not have been fully addressed.

At the last inspection we found people were not offered an adequate choice or variety of food at mealtimes. Since the last inspection an additional cook had been employed. In total two cooks were employed and between them they cooked the main meals seven days per week. The cook told us about each person's likes and dislikes and dietary needs. The cook spoke with people each day to let them know the meals offered and agree any alternative they wanted. For example, some people preferred traditional Chinese food. Their families had supplied foods they could choose if they did not like the main meals offered.

Staff told us they offered drinks and snacks regularly throughout the day. In the evenings people were offered bedtime drinks and also snacks such as cakes, sandwiches or whatever the person wanted.

People told us they enjoyed the meals. Comments included "Always a choice. Food is OK."

Requires Improvement

Is the service caring?

Our findings

During our inspection we saw staff treated people in a caring, dignified and respectful manner. The staff sought people's consent before providing any care or support. While they assisted people they explained the procedures they were about to follow and there was friendly conversation, smiles and laughter. Staff were attentive to people's needs and people responded well to staff. The atmosphere in the home was relaxed and friendly.

Staff respected people's privacy. All rooms at the home were used for single occupancy. People could spend time in the privacy of their own room if they wanted to. Bedrooms were personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. Staff knocked on doors and waited for a response before entering. We noted that staff never spoke about a person in front of other people at the home which showed they were aware of issues of confidentiality. Staff addressed people using their preferred name and they were discreet when offering people assistance with personal care needs.

When staff assisted a person who needed assistance to move from their chair to a wheelchair they used a fleece blanket to protect the person's dignity during the procedure. When a person who was in their bedroom asked staff for assistance with personal care we saw staff pulled the curtains and ensured the door was closed before carrying out personal care.

We observed staff assisting some people to eat their meals. Staff sat with people, taking time to communicate with the person and check they had finished each mouthful before offering more food. We also saw one person who was able to eat independently but needed support and encouragement from staff regularly during the meal. Staff kept a watchful eye to make sure they were eating the meal. When the person stopped eating staff offered support in a discreet manner.

Staff demonstrated a good knowledge of people's needs. They understood each person's likes and dislikes and individual needs. One person told us "I am very happy here the girls are very patient, I have everything I want". Another person said "They are all very good here it a good place to come and stay". A relative told us "We visit all the time the staff are very good with [person's name]" Another relative said "The girls are lovely – always pleasant."

One member of staff informed us "It can be difficult caring for people who are very old, we have to be so careful with their skin. I try to keep people's independence and encourage them to do as much as possible for themselves. I like to give them choice and control."

Treatment Escalation Plans (TEP) were in place for people near the end of their lives and we saw these had been completed following discussion with the person, or with their next of kin. However, care plans contained little or no other information about each person's wishes for their care at the end of their lives. There were sections in the new care planning documents for end of life care planning but these had not been completed.

We recommend that the service seek advice and guidance from a reputable source, about supporting people to express their views and involving them in planning for their care at the end of their lives.

Inadequate

Is the service responsive?

Our findings

At the last inspection there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's care was not person-centred. Care needs had not been fully assessed, monitored or reviewed and people had not been fully consulted or involved in drawing up or agreeing how their care needs should be met. At this inspection we found new care plans had been drawn up with significantly increased level of information about each person's care needs. The providers had received support and advice on care planning from the local authority's quality improvement team (known as (QAIT). The new care plans had taken many months to complete. However, these had not yet been introduced to staff. In the meantime the staff had continued to use the old care plans which contained insufficient information about people's needs. This meant staff did not have adequate information on each person's health and personal care needs.

People had not been involved or consulted in drawing up their care plans. There were sections for people to sign the new care plans but these had not been completed. The provider told us they planned to involve people in their care plans in the future when the staff began working with the new plans.

People who had recently moved to the home had not had their needs assessed prior to moving into the home. Care plans did not hold any information regarding pre admission assessments.
Pre admission assessments help to determine whether a home can meet people's assessed needs and preferences. A visitor told us "We have not been invited to any reviews or meetings regarding [person's name] but we would know if they were not happy as they would tell us. If we needed to complain we would speak with the manager".

A relative informed us "When [person's name] moved in we rang the home manager to see if there were any vacancies. It only took a couple of days. We have not been involved in the care plans, and did not have any assessments before [person's name] moved here, but we do ask to see [person's name] daily records so we can see what they have been doing. We are very happy".

Some of the new plans were out of date or held information that was no longer valid. For example, one care plan said a person was prescribed Morphine for pain. When we checked their medications Morphine was not included. The provider told us the information had been transferred from documents they had received when the person was admitted to the home. They had failed to make sure the information was still correct. A senior member of staff had been involved in writing the new care plans. They had transferred some information from the old care plans and from knowledge gained from working with the person as their keyworker.

The providers said they were about to hold a staff meeting to discuss the introduction of the new care plans. They said they expected the new care plans to be fully implemented within the next two months.

Social needs had not been assessed or reviewed. The care plans did not show how the service planned to meet each person's social needs. No improvements had been made since our last inspection to increase the

level of activities within the home. We spoke with the providers who agreed the new care plans did not include any information about each person's history, their social needs, interests, or the things they would like to do.

The level of planned activities for people each week was inadequate. An activities organiser visited the home for one hour three times a week. During these visits group activities such as Bingo were offered. People enjoyed the sessions, but for the remaining week there was no evidence of any activities offered by the home. One person said "I like to get my hair done. The hairdresser comes each week, and we also have a lady come in three times a week for one hour to do things like bingo and quiz". On the second day of our inspection the activities organiser cancelled their visit to the home at short notice. Staff provided a Bingo session instead. However, for the remaining time during our inspection we saw people sitting in the lounge or in their rooms with no evidence of any individual or group activities or stimulation. We saw many people sleeping in their chairs. We spoke with the providers who said they would consider ways of increasing the level of social stimulation throughout the week.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Residents meetings were held every three months and were held in the lounge. One person informed us they took the minutes of the meeting with the support of the deputy manager they discussed issues and asked anyone if they have any concerns. They informed us that people were invited to these meeting at lunch time before the meeting was to be held. They informed us they had never received any complaints or concerns from people living at the home.

Inadequate

Is the service well-led?

Our findings

The providers are a husband and wife team. One of the providers is the registered manager of the service and the other provider regularly manages the service and is referred to in this report as the duty manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. After the inspection the providers sent us a copy of the management structure of the service showing there was a registered manager, a deputy manager and three senior care assistants who each had responsibility for supervising a group of care assistants.

At our last inspection we found the systems to assess, monitor and improve the quality of the service were not fully effective. This meant there was a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.During this inspection we found very little action had been taken to address this breach. The provider told us they had been given information on how to set up an effective quality monitoring process by the local authority Quality Improvement Team. They had adjusted the documents to suit Bronte. However, they had not begun to implement the monitoring system. It was unclear how much time it would take to begin to implement their new quality monitoring system, or for the system to be embedded. After the inspection the providers sent us a copy of their first quality monitoring audit carried out after the inspection. Although the audit tool covered many essential areas it did not explore in sufficient depth all areas of risk. For example, moving and handling audits, risk of choking and falls were not included in the audit. This meant we did not have confidence that the quality assurance system would enable the providers to effectively review and improve the service.

The provider had not carried out regular checks or audits on all areas to ensure the service was running smoothly. They had only just begun to carry out a check on medicines a few days earlier but the check was incomplete. They had only checked a few medicines. No other checks on the medications had been carried out since our last inspection. The medication checks failed to pick up the concerns we found during this inspection.

All accidents and incidents which occurred in the home had been recorded but there were no systems in place to analyse trends or consider any actions needed to prevent recurrence. .

People had not been actively involved in developing the service. They had not been involved or consulted over their own care needs. The providers had spent time working on drawing up new care plans for each person. They told us this had been their main priority and this meant other areas of their action plan had taken a lower priority. When we asked them for an update on their action plan in January 2016 they told us the new care plans would be in place by the end of January 2016. However, at the time of this inspection we found that although new care plans had been written for each person they were not being used by the staff team. After the inspection the providers sent us blank copies of questionnaires they planned to give to people living in the home, relatives, staff and professionals to seek their views on the service.

Information was not always stored securely - some improvements in security of confidential information were noted, although still not fully effective. New care plans were stored in a filing cabinet but the lock on the cabinet was not working fully. Most confidential information was kept securely. Planning permission was being sought to create an extension to the building to provide a new office where information could be kept securely and the door locked when not in use. The provider said they will purchase a new filing cabinet to ensure all care plans are kept securely locked.

The providers had failed to evaluate and improve their practice to ensure the quality of the service is continually improved. The providers have not received any further training since the last inspection. One of the providers had gained a nursing qualification several years ago. They also held a Certificate in Residential Social Work, Diploma in Management Studies, Advance Management in Care (City & Guild 3253), Registered Manager's Award and National Vocational Qualification Level 4 in Care.
However, these qualifications were gained several years ago and the providers were unable to show how they had kept up their knowledge of current legislation and good practice. The providers confirmed they were not planning to gain any further qualifications, although one provider said they planned to attend the future training sessions booked for the staff team. The providers said they were considering employing a registered manager.

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

Staff felt they needed the support of a registered manager who could concentrate on what was happening on the floor, they felt the current system meant they did not receive the support they needed.

Staff did not receive any formal supervision. The provider said they were planning on starting supervisions with all staff in the near future. One member of staff told us "We can't do everything, we are always busy we need someone in the office who can deal with other things".

Staff meetings were taking place. Staff informed us they had recently had a meeting where they discussed the new care plans and how these were going to be set up.

The home has notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive care that had been fully assessed, reviewed or planned according to their individual nneeds

The enforcement action we took:

NOD

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity to make decisions about their care had not been assessed.

The enforcement action we took:

NOD to restrict admission

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive care that met their needs safely.

The enforcement action we took:

NOD to restrict admission

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not fully safeguarded from the risk of abuse.

The enforcement action we took:

NOD to restrict admission

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People did not receive a service that was well managed.

The enforcement action we took:

NOD to restrict admission

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were not fully protected from harm or abuse because the providers had failed to follow safe procedures when recruiting new staff.

The enforcement action we took:

NOD

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People did not receive support from staff who had sufficient training, experience or supervision to enable them to meet people's needs safely.

The enforcement action we took:

NOD to restrict admission