HC-One Limited

Brookdale View

Inspection report

Averill Street
Newton Heath
Manchester
Lancashire
M40 1PF

Tel: 01616887600
Website: www.hc-one.co.uk/homes/brookdale-view

Date of inspection visit:
18 March 2019
19 March 2019

Date of publication:
16 April 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service: Brookdale View is a care home providing personal care and accommodation for up to 48 people. The home is divided into two floors which accommodates people who require nursing care, on the ground floor and residential care on the first floor. On the dates of inspection, there were 39 people living at Brookdale View.

People's experience of using this service:
People received help with the administration of medicines. All medicines were given as prescribed and recorded on the medication administration record. However, we observed a nurse administering a fluid thickening agent with the wrong measuring spoon. A thickening agent is used to enable a thicker consistency of fluids for people who are at risk of choking. Also, body maps for identifying the location of transdermal patches were not always recorded. The provider should assure themselves of the competency of its nursing staff to manage and administer medicines.

People felt safe while being supported by the service and told us there were enough staff on duty to support them. Rotas we saw reflected this. Staff did not appear rushed and were visible. We received three comments about more staff being required. We recommended that the registered provider reviewed dependency levels based on people's individual needs.

Risk assessments to support people were fully completed and regularly reviewed. Staff could describe how people were supported to keep them safe.

Staff were trained to enable them to identify and report any safeguarding concerns. Staff told us they felt the registered manager would listen to concerns they raised and report them appropriately. People told us, if they were worried, they would tell their family, a staff member or the manager.

Internal and external health and safety checks of the service were completed within appropriate time scales.

People were supported to eat a healthy and nutritious diet. Culturally appropriate diets were offered, and a varied menu was available. People told us they could change their mind if they did not want what was on offer and the chef would make them an alternative meal.

The introduction of a pilot programme with the care home nursing team and GP's had enabled people to receive quicker diagnosis and treatment of their illness and referral to the appropriate healthcare services. The programme had enabled people to be treated at the home rather than go into hospital.

People were fully assessed prior to moving into the service to ensure their needs could be met.

The home worked in line with the Mental Capacity Act 2005 and we observed agreements to consent and

decisions were made and recorded in people's best interests.

The home was well equipped to support people with aging conditions, however, we made a recommendation for the registered provider to review signage around the home to help people living with dementia find their way round.

There were caring and kind interactions from the staff team to people they supported. We observed appropriate humour and support throughout our inspection.

Staff were seen to knocked on doors and were polite and respectful to people. Staff spoke to people in a sensitive manner and used other forms of communication such as Google translate and photographs and symbols with people whose first language was not English.

We noted doors were left open while people were in their bedrooms. Although this was not raised as a concern, the service should review peoples preferences for this.

Care plans identified the support people needed. Staff could describe how to support people and told us they were able to read care plans during their induction. Care plans were regularly reviewed and were planned involving people and their families.

Complaints were responded to in a timely manner. People and their relatives knew how to make a complaint and felt their concerns would be listened to.

People were supported at the end of life. Care plans captured any preferences and choices people had about how they wished to be cared for as they neared the end of their life.

Audits were in place to monitor and improve the service. The new registered manager had made improvements to the service since the last inspection. Staff and relatives told us improvements had been made for the better.

Staff felt well supported by the new registered manager.

Rating at last inspection: The last inspection of this service was on 6 and 7 June 2018 where we rated the service as overall requires improvement and inadequate in the well-led domain. We also found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The report was published on 9 October 2018.

Why we inspected: This was a scheduled inspection based upon the previous rating of the service.

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our programme of inspection. If any concerning information is received, we may inspect sooner.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was well-led Details are in our Well-Led findings below.	**Good**

Brookdale View

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: On the first day of inspection, the team consisted of one inspector, an assistant inspector, an inspection manager, a specialist advisor and expert by experience. The specialist advisor was a pharmacy technician with expertise in medicines management. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector returned for the second day of inspection.

Service and service type: Brookdale View is a care home. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided and we looked at both during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The inspection was unannounced which meant the provider did not know we were visiting.

What we did: We used information we held about the home to inform our inspection planning. This included statutory notifications which is information about significant events the home is required to tell us by law. We contacted the local authority and to seek their views. There were no comments made about the service.

We spoke with the registered manager, the quality assurance manager, the area director, one health professional, 16 people who used the service, six relatives and six staff members. We also completed a short observational framework for inspection (SOFI) which allows us to observe how people who are unable to communicate, respond to support from the staff.

We looked at fives peoples care plans, eight people's medicines records and four staff recruitments files. We looked at documents relating to staff induction, supervision and training and information about the health and safety of the home.

Requires Improvement

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

At our last inspection in June 2018, safe was rated as "Requires improvement". We found there was insufficient staff to support peoples assessed needs. At this inspection, we found the deployment of staff was better managed, and staff were visible throughout the inspection.

Most people told us they thought there were enough staff on duty although three comments stated more staff would be helpful. Comments from people being supported were "They [staff] are always checking on us."; "They come if I need them." and "I am checked on throughout the night."

Staffing and recruitment

● Of all the people and relatives, we spoke with, three comments were that more staff may be needed. We noted throughout the inspection, staff were visible and there were times when staff were assisting people in their rooms. Rotas reflected the number of staff on duty during the day and night were consistent. Two relatives told us, their relative had to wait to use the toilet once they had summoned for assistance, and their relative could not always access the garden as there were not enough staff to sit with them. We reviewed the call bell records which did not display any excessive waits for assistance and staff told us, they felt there was enough staff on duty and they now received regular breaks. Dependency levels were reviewed monthly which assisted to clarify staffing levels. We recommend the service continues to review individual care needs to ensure the number of staff is reflective of people's assessed needs.

● Staff were recruited safely. We saw completed application forms in each staff personnel file. A disclosure and barring service (DBS) check was in place for each employee. A DBS helps protect unsuitable people from working with vulnerable adults. References were obtained for new staff members, but they were not always from the most recent employer. Also, some references completed on the HC-One portal had not been dated and we could not identify the authenticity of the reference. We were told that some employers did not always provide a reference and we could see the service had requested references from other referee's where this had occurred. The registered manager told us she would feedback information about the portal to the registered provider. We will review this on our next inspection.

Using medicines safely

● Although there was no evidence to suggest people were not receiving their medicines as prescribed, we noted some aspects of medicines management could be improved. For example, we noted the nurse administering medicines used a teaspoon rather than the provided measuring spoon, for measuring out a thickening agent. A thickening agent is used to enable a thicker consistency of fluids for people who are at risk of choking. While this did not cause any harm to the person, thickening agents should be measured out with the correct measuring spoon.

● We also noted body maps that accompanied medication administration records (MAR) for the application

of transdermal patches, were not always completed which meant we could not be assured the patches were being placed on the correct position each time they were applied. We discussed this with the registered manager and we saw training had been requested on the use of body maps by the second day of inspection. Transdermal patches are used to deliver medicines through the skin.

● MAR charts were fully completed and there were no gaps on signing for medicines. People told us they received their medicines as they should do, and no one raised any concerns over the management of their medicines. Stocks of medicines were accounted for.

● As required medicines had protocols in place for the administration of medicines when needed. We saw one protocol did not have clear directions and another was not listed as being an "as required" medicines, however, this was rectified following the second day of inspection.

● Staff received training to safely administer medicines and had annual competency checks.

● The provider should assure themselves of the competency of its nursing staff to manage and administer medicines

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe while living at Brookdale View. Comments includes, "Oh yes, I am safe here" and "Yes, it's a nice place, clean and pleasant."

● Staff had received training in protecting vulnerable people from abuse. Staff could describe signs and symptoms of abuse and were confident they could raise concerns, and they would be addressed. Staff were aware of the whistle blowing policy and that they could report concerns without fear of reprisals.

● Any concerns raised in relation to safeguarding had been reported to the local authority and the Care Quality Commission. Staff were aware of the registered provider's and local authority safeguarding procedures.

Assessing risk, safety monitoring and management

● People were risk assessed to ensure any risks presented were reduced. Risk assessments were regularly reviewed and captured people's preferences on how they would like to be supported.

● Where people were at risk of choking, appropriate assessment and involvement from the speech and language team had taken place and risk assessments developed to manage any identified risk. People at risk of falls had monitoring equipment in place to reduce the risk. Where people were at risk of pressure sores, monitoring charts confirmed regular repositioning was taking place.

● Premises safety was regularly reviewed with risk assessments in place to monitor the general environment. Regular internal and external checks were made and recorded for the passenger lift, hoists and slings, electrical, gas and water safety.

Learning lessons when things go wrong

● Staff were aware of how to report accidents and incidents. All accidents and incidents were recorded on an internal reporting system and were reviewed by the registered manager.

● There were systems in place for reviewing accidents and incidents. They were analysed to look for patterns and themes. Where patterns and themes were identified, for example, where people were falling at particular times of the day. Additional measures were put in place to reduce the risk.

Preventing and controlling infection

● Measures were in place to control the spread of infection. Staff told us, and we saw there was access to plenty of personal protective equipment such as disposable gloves, aprons and protective clothing.

● The home was clean throughout. The house keeping staff followed cleaning schedules and all areas of the home were regularly checked by the registered manager.

Good

Is the service effective?

Our findings

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

People's outcomes were consistently good, and people's feedback confirmed this.

People were supported and treated with dignity and respect; and involved as partners in their care.

At our last inspection in June 2018, effective was rated as "Requires improvement", as we found the meal time experience was not satisfactory, and staff did not have an induction at the commencement of employment recorded. At this inspection, we found improvement in the meal time experience, including the availability of meals from other cultures. The registered manager also showed us evidence of staff induction.

People told us the food was enjoyable and there was always lots of choice. Comments included, "There is a choice of meals, the food is good, but I can change my mind." and "The meals are very nice."

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

- We observed meals times on both floors and found the experience to be pleasant and calm. Staff were respectful in offering choices and checking people had enough to eat and drink. People were supported to the dining table to eat and could sit with friends or alone if they preferred. We noted people did not always transfer from wheelchairs to dining chairs to eat, although no one commented on this being a concern or looked uncomfortable.
- Where people required a modified diet such as soft or pureed meals, we saw this was documented in the care plan and the chef was continually informed of changes to people's dietary intake. We spoke with the chef who told us they worked closely with people, relatives and the staff to find out people's likes and dislikes. Alternative menus were now in use and people could request a diet from their own culture. We saw one menu was written in Chinese. The chef continually updated their knowledge on providing healthy and nutritious food and had attended training to enable them to find ways of 'softening' food to allow it to be suitable for people with swallowing difficulties.
- Everyone we spoke with was complimentary of the food. Tables were set nicely with condiments and people could choose to eat in their room. People who required support with eating and drinking were assisted respectfully.

Staff support: induction, training, skills and experience

- Staff received an induction to the service and training to enable them to carry out their role. We saw new staff could spend time working alongside more experienced staff members to get to know people and learn about the care people required. Induction was recorded and was delivered in line with the Care Certificate. The Care Certificate is a set of agreed standards, people working in social care should adhere to.
- Training records showed staff received regular training. Staff told us they were supported to access training and they felt it enhanced their knowledge.
- Staff received regular supervision and told us they felt more confident in discussing their role now a new

registered manager was in place.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care

● People received a full assessment of their needs. Assessments captured people's preferences of how they wanted to be supported and the assessment fed into care plans.

● The assessment provided information about on-going health conditions to ensure referrals were made to professionals for continuity of care. We saw where there were concerns around people's health, for example where people were regularly falling, had concerns with dietary intake or changes in well-being, timely referrals were made to the appropriate professionals. People told us they could see a GP if they felt unwell and this was recorded in care files.

Supporting people to live healthier lives, access healthcare services and support

● The home was part of a pilot with the GP service and community care home nurses to assess, monitor and manage people's health conditions. We saw a weekly ward round took place with the GP and care home nurses visited most days to diagnosis and review people. This had reduced admissions to hospital and enabled timely diagnosis and treatment of illness' such as infections. Each person had a care plan in place which identified how health conditions would be manage. A health professional involved with the pilot told us, the registered manager and staff had been responsive to the project and found the team to be supportive.

● We saw timely referrals to the speech and language therapy where people had been identified as at risk of choking. Advice given had been embedded into care plans and staff were able to describe safe eating and drinking techniques for each person they supported.

● People were encouraged to play games and attend arm chairs exercises to promote their fitness levels.

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

● The home was purpose built and designed to meet the needs of people who lived with health conditions. Rooms were personalised with photographs and ornaments and had a toilet and washbasin. Larger toilets and assisted bathrooms were situated along the corridors. Communal areas were well decorated, light and airy.

● Furniture was modern and clean. Where people needed support from pressure cushions, they were placed on chairs and wheelchairs.

● The home was appropriately decorated for people living with dementia. Walls and carpets were plain, and handrails were painted a different colour to make them easier to identify. Whilst areas such as the dining area and lounges where designed and decorated to provide a visual prompt and aid, there was no signage to identify people's rooms or photographs of something meaningful. We recommend this is reviewed.

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

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- People had their capacity assessed. This was to check if people could consent to living at the home, to use bedrails or falls monitoring equipment or consent to personal care and support. Where the assessment determined people were unable to consent, an application to deprive people of their liberty was made to the local authority,
- Staff had received training on the MCA and DoLS and could tell us who had a DoLS in place and any restrictions recorded for the person.
- We saw where authorisations had expired, a new referral had been made to the local authority and personal care and support was being provided in people's best interests.

Good

Is the service caring?

Our findings

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

People were supported and treated with dignity and respect; and involved as partners in their care.

At our last inspection in June 2018, caring was rated as "Requires improvement", as we found staff did not have the time to care for people. At this inspection, we found staff to be less rushed and we observed staff to be caring towards the people they supported.

People and their relatives told us they felt well cared for, comments included, "I am absolutely delighted and thrilled to bits [name] is here, the care and attention is great. There is nothing too much trouble." and "Staff – they really care, they can't give [name] enough care and attention."

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

- We saw caring interactions from staff and people living at Brookdale View. People told us they felt cared for and staff popped in their rooms to check on them. A relative told us, "I haven't met a bad one [staff] and I visit every afternoon." Another relative said, "They [staff] have been lovely with [name], you can't fault the care, we appreciate the way they look after [name]."
- We noted people were well dressed and had been supported with personal care. Some people showed us their nicely manicured and painted nails and told us the staff had done them. A relative told us they always found their relative to be clean and well shaven. People's preferences to who supported them with personal care were recorded in the care plan. This was also confirmed by people and their relatives.
- People were protected from discrimination and were supported with their cultural preferences. This information was recorded in the care plans and regular groups from all faiths visited the home.

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

- People and relatives felt they were involved in their care. One person told us they had met with the social worker and the registered manager prior to moving into the home to plan their care. Relatives told us they were always kept up to date with any changes in care needs and the staff gave their relative enough care and attention. We saw one person enjoyed looking from their window into the garden. Their relative told us, "I came in one day to find [name] sat at the windows watching the squirrels in the garden and they [staff] just did it. I didn't have to ask."
- People were given choice and control about their daily life. People told us, they could get up and go to bed when they wanted, eat what they wanted and could change their mind if they wanted something different. We noted people could spend time where they preferred either in their room or communal areas and choose to join activities or sit and talk with their friends.
- Information was available about advocacy advice and support.

Respecting and promoting people's privacy, dignity and independence

- We noted people's bedroom doors were generally kept open while people were in their rooms. Although

no-one raised any concerns about this one person we spoke with, told us, "They [staff] don't like it if I shut it. The staff are nice, they work hard but there is not enough of them." We raised the doors being kept opened with the registered manager and explained this practice did not always ensure privacy and dignity. The registered manager told us this was people's preference. We noted when personal care was being completed the door was shut. We recommend the bedroom doors being left open is reviewed with each person / relative and clearly documented that it is the persons choice.

● We saw staff knocked on people's doors and requested permission to enter. Observations of interactions of staff with people were kind, caring and meaningful. For example, we saw one staff member ask a person about the clothing they wished to wear that day. The staff member gave suggestions to help enable the person to choose clothing appropriate to the weather while not taking away their right to choose.

● People had access to the communal areas, gardens and their own room. One person who used a wheelchair to mobilise told us it was important for them to still be able to get around. They told us, "I do as I please, as long as I can get around, I am happy."

● People were supported to maintain links with their family and friends. We saw visits from families and friends throughout our visit.

Good

Is the service responsive?

Our findings

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

People's needs were met through good organisation and delivery.

At our last inspection in June 2018, responsive was rated as "Requires improvement". We found the provider had not assured themselves that care planning was accurate to enable a person to be safely supported. Also, the provider did not promote inclusion for people whose first language was not English. People who could not speak English relied on their relatives to communicate their needs. There had been no attempt made to integrate people with their communities or promote communication. People who could not speak English were isolated. At this inspection, we found improvements had been made and we observed alternative communication techniques being used links had been made with cultural community groups.

People and relatives told us they had been involved with planning their care. One relative told us, "Yes, we have been able to get involved. We were able to discuss this after the assessment."

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People were supported by a staff team who were aware of their needs. Staff could describe to us, each person's needs.
- Care plans had improved and reflected people's current needs. They were regularly reviewed and updated with the person, their relatives, the staff team and health professionals if required. Care plans were comprehensive and could be lengthy depending on the person's needs. Some dividers maybe helpful to separate the plans to make them easier for people to be read.
- Care plans captured people's choices and preferences. Care plans had particularly improved in describing the support needed for people whose first language was not English or where religion or requirements with a cultural diet needed additional support. People had formed links with groups of people from their own culture. People were supported to visit drop in centres and engage in visits from community groups.
- The service would in line with the Accessible Information Standard. Staff used technology to communicate such as Google translate and photographs and symbols as well as using common phrases in the persons language. A copy of common phrases was kept in care files and people's rooms. We observed a staff member using these methods of communication and found the person to be responsive.
- People could have TV channels streamed into their room, presented in their first language. We observed one person interacting with the programme and chatting in their own language.
- Activities were varied although they did not always follow the activity plan and people were encouraged to join in. On the first day of inspection, owls' visited from a local sanctuary. We saw people's face's light up as they had their photo taken with them and could touch them. People told us they could join in activities and had one to one time with the staff. A relative told us," [Name] was in a pipe band and staff always put music on for them." We saw trips out to Albert Docks and the museum had taken place. Regular singers visited the home.
- We spoke with the activities co-ordinator who was passionate about developing activities for people. They told us, "We have developed links with the local churches and have the community gospel choir visit every

Sunday. We have worked to improved flash cards for people whose first language is not English and even had a school in before Christmas who sang in French." We noted people living with dementia could use twiddle muffs and dolls to keep their hands busy. Twiddle muffs are garments that provide tactile and sensory stimulation.

Improving care quality in response to complaints or concerns

● Complaints were listened to and responded to in a timely manner. A complaints policy was in place which allowed the service to work to timescales and investigate and resolve complaints quickly.

● People and their relatives told us they felt confident they could make a complaint if needed and the registered manager would appropriately investigate their concern. Information on how to make complaints was available in the home and on the registered providers website. People living at the home told us they would raise any concerns with their family or staff. One person told us they felt it was an environment where they could speak up and another person agreed with them.

● Staff told us they would listen to anyone wishing to make a complaint and would take the concerns to their line manager for further discussion.

End of life care and support

● People were supported to plan for how they would like to be supported at the end of their life. Any decisions were clearly documented in the care plan and staff could describe people's wishes and preferences.

● Where people had made decisions on resuscitation and had do not attempt cardiopulmonary resuscitation (DNACPR) forms were in place. These forms were placed at the front of the care file for quick reference and staff were continually updated on DNACPR decisions.

● The service worked with the care home nurses to provided good end of life care and to keep people supported at the home, if that was their preference, until the time came.

● Staff had received training in end of life care and felt supported by the registered manager to deliver care to people. We saw where people were close to the end of their life, the service worked with GP's and other professionals to ensure anticipatory medicines were available. Anticipatory medicines are prescribed by a medical professional to ease any symptoms of pain or discomfort as people approached the end of their life. Logs of medicines stocked were clearly documented and only administered by a registered nurse.

Good

Is the service well-led?

Our findings

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

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

At our last inspection in June 2018, well-led was rated as "Inadequate". At that time we found there had been little done to address low staff morale from previous inspections and staff continued to feel unsupported. At this inspection, we found a new registered manager had been appointed and staff felt morale was improving.

Staff told us since the appointment of the new registered manager they felt well supported. One staff member told us they were, "Really happy now." People and their relatives told us the registered manager was, "Visible, approachable and willing to listen."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff.

- Staff felt their concerns were being listened and responded to. We saw the registered manager had held regular staff meetings and had given staff the option to progress in their role by offering additional training and to giving opportunity to take on more responsibility such as leading a shift. Staff felt the registered manager had been a positive influence on the home and told us, "[Registered manager] is always available, it's much better here now" and "I feel I can approach [registered manager], the atmosphere is much improved."
- The registered manager had held managerial roles in other organisations and was clear on their responsibilities of registration with the Care Quality Commission (CQC). Records showed notifications about events at the service had been reported in a timely manner and the service was displaying the last CQC rating which is a legal requirement.
- There were internal audits in place to monitor and improve the service. Audits were reviewed by area managers to ensure actions were taken to improve the service. We saw audits included the review of falls, nutrition, pressure areas, medicines, infection control and training. Each audit showed the service had steadily improved from the previous audit.
- Provider inspections of the home allowed the service to clarify the findings of the internal audits. This meant the service could clearly demonstrate the improvements being made.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility.

- People and relatives told us they felt they could raise any concerns with the registered manager. One relative told us, "I wouldn't hesitate in speaking to [registered manager] as they are very approachable." A second relative said, "There were some concerns initially but its improved since the new manager came, and

its now much better organised. I now feel the staff are happier as well, so now [name] feels much more confident."

● The registered manager had met with people and their relatives to share information and to listen and respond to any questions they had.

● The registered manger held daily flash meetings with the heads of departments to share information. We observed one of the meetings and saw information was cascaded to teams such as maintenance and housekeeping. Changes in people's dietary intake was communicated with the chef and where there were changes in people's health and well-being such as someone being cared for at the end of life, this was communicated to ensure the person and their relatives privacy was respected.

Working in partnership with others

● The service was part of a pilot to improve the health care of people in care homes. The pilot was working to reduce hospital admissions, plan good end of life care and diagnose illness' in people living at Brookdale View faster. A health professional told us the working relationship with staff was very good and they found staff to be responsive and knowledgeable. They told us the addition of the new registered manager had been a welcome asset to the service and the staff were doing well under their leadership.

● The service worked with many health and social care professionals to keep people healthy and safe. We saw examples of staff following physiotherapy guidelines and a GP visiting when a person was unwell.

● We saw relationships had been built and sustained with local churches, community groups and schools.