Methodist Homes

Brockworth House Care Centre

Inspection report

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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

This inspection took place on 30 June, 1 and 2 July 2016 and was unannounced.

The care home specialised in the care of people who lived with dementia or mental health needs. Some people had become more frail and their predominant needs were now of a physical nature. The care home could care for up to 55 people and at the time of our inspection there were 50 people living there. Nursing care was provided by nurses who were on duty at all times. People's care was delivered across two floors and areas were separated into units. Each unit had its own communal area, bedrooms and bathrooms. People could visit other units but they tended to remain on their own. There were extensive grounds outside to be enjoyed and a safe enclosed garden meant people could enjoy the outside safely and independently if they chose to.

The care home did not have a registered manager in post but a new home manager had been recruited and was due to start in August 2016. It was planned that this manager would apply to the Care Quality Commission (CQC) to become the new registered manager. A registered manager is a person who has registered with the CQC 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.

During this inspection we followed up breaches of the regulations which were identified in our last inspection; that inspection had been on 30 June, 1 and 2 July 2015. The provider had been asked to take action and address these breaches. These had included unsafe care delivery, a lack of personalised care, people not being treated with respect and dignity and staff not providing understanding and compassion. It also included care records not being sufficiently maintained in order for safe and consistent care to be delivered. The provider wrote to us with their action plan on how they would address these shortfalls and by when. During this inspection we found these actions had been taken and the shortfalls addressed.

We did however find people were at risk of not being cared for by staff who were suitable because some recruitment checks had not been fully completed. However, the two examples we identified were addressed at the time of the inspection and just after the inspection. The forms used by the provider had not prompted staff to explore these areas and this was going to be addressed. Arrangements to ensure people were fully assessed and their moving and handling needs were met safely had been implemented. Staff were now consistently ensuring people were supported to move safely. People's dependency levels had been reviewed and had continued to be reviewed and there were enough staff to meet people's needs.

The care home had problems in ensuring people's medicines were available when needed. This was a problem with the way the Pharmacy received prescriptions and managed these. The care home had put strategies in place to try and reduce the risks arising from this to people. The care home's arrangements for medicines were likely to change because of this. Safe practices were in place in the care home for the administration and storage of people's medicines once they arrived.

We received information prior to the inspection that the management staff had confused staff over what constituted abuse. We explored this with the management staff who after the last inspection had reminded staff that in forcing people to do something they did not want to do or to move them in a way they had not been assessed to be moved constituted abuse. The staff we spoke with were very clear about what abuse was, what this looked like and what they would do about this if they witnessed or suspected it had taken place. They were very clear about the fact people could not be forced to receive care they did not consent to but, in order to deliver the care people needed and to meet their duty of care, this had to be done lawfully.

People lived in a safe environment which was kept clean.

People's relatives told us the care their relatives received was effective and met their relative's needs. They were very happy with the standard of care being provided. Staff had received a lot of training and support since our last inspection and we observed this training embedded in staff practices. People now received care which met their personal needs. As reported above people received care which was delivered lawfully. People who lacked mental capacity to give consent and to make their own decisions about their care and treatment were protected under relevant legislation which staff adhered to. People were provided with appropriate support to eat and drink and particular risks relating to this were identified and addressed. Arrangements were in place to make sure people received the medical care they needed and referrals were made to specialist health care professionals appropriately. Staff were particularly proactive in making sure people had access to the right professional. The care home received good support from people's GPs.

We observed people being treated with respect and dignity. Staff approached people with kindness and compassion and showed a genuine desire to ease people's distress. Relatives told us they also felt supported and involved. Communication with those involved with people's care was good.

The staff were able to respond to people's needs because there was detailed guidance in place for staff to follow in terms of people's care plans and risk assessments. The maintenance and content of people's care records had improved. Staff hand-over meetings also provided staff with relevant information.

People had improved opportunities to socialise and take part in activities. We observed examples of this and saw people engaged and enjoying themselves. People could raise complaints, have these investigated and responded to. Any area of dissatisfaction or complaint was seen as an opportunity by the management staff to reflect on what had happened and to learn from this.

Despite there not being a registered manager in place the provider had made arrangements for the care home to receive strong leadership. This had taken staff through a period of improvement which had benefitted people. The provider's quality assurance system had resulted in improvements being made although how completed actions were actually recorded did not make it easy for senior management staff to evaluate its full effectiveness. We fed back our observations on this which the senior management team took on board and would look at reviewing.

The views of people, their relatives and staff had been sought and considered when making improvements to the service. This process would be further used when the new manager was established in post.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always able to be fully safe. Some shortfalls in staff recruitment practices potentially put people at risk. These risks had been reduced because staff practices were well monitored.

People's medicines were not always available when needed. The care home were doing everything possible to try and manage problems with the supplying Pharmacy and mitigate the risk to people. Once available, the care home's own procedures ensured people received their medicines safely.

The management staff ensured there were enough staff on duty to meet people's needs.

People were protected from abuse because staff knew how to identify this and report any concerns they may have.

People were protected against risks that may affect their health. Environmental risks were also monitored, identified and managed in order to keep people safe.

Is the service effective?

Good

The service was effective. People received care and treatment from staff who had been trained to provide this. Where staff were new to care there were arrangements in place to help them learn and improve their skills.
People who lacked mental capacity were protected because the principles of the Mental Capacity Act (2005) were followed.

People received appropriate support with their eating and drinking and were provided with a diet that helped maintain their well-being.

Staff ensured people's health care needs were met.

Is the service caring?

Good

The service was caring. People were cared for by staff who were kind and who delivered care in a compassionate way.

People's preferences were explored and met by the staff where possible. Staff worked hard to adopt a personalised approach to care.

Staff helped people maintain relationships with those they loved or who mattered to them.

People's dignity and privacy was maintained.

Is the service responsive?

Good

The service was responsive. People's needs were fully assessed. Staff had up to date and accurate information to hand so they could respond appropriately and safely to people's needs.

People had opportunities to socialise and partake in activities. Care staff had been more involved in these and efforts were being made to further make individual activities more meaningful.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed.

Is the service well-led?

Good

The service was well-led. Regular quality assurance processes ensured the service maintained the improvements which had been made. The process however, had often failed to record the completion of the actions/improvements that had been taken.

People had been protected by the provider's arrangements to ensure there was strong leadership in place despite the absence of a registered manager.

The new management arrangements in place had supported improvement which could be evidenced. People were being provided with a good standard of care.

Feedback from people's relatives and staff had been sought and this had been considered when making changes and improvements to the service.

Brockworth House Care Centre

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.

The inspection took place on 30 June, 1 and 2 July 2016 and was unannounced. The inspection was carried out by one inspector with assistance from a second inspector on day two. Before visiting the care home we reviewed the information we held about it. This included a review of all statutory notifications since October 2015. Statutory notifications are information the provider is legally required to send to us about significant events. We reviewed information we had received where there had been concerns about the service. We also sought the views of commissioners and visiting health care professionals on the care and services provided.

During the inspection we spoke with one person who used the service. Some people living there were unable to tell us about their experience because they were living with dementia. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with six relatives about the care their relatives received. We spoke with eight members of staff including two representatives of the provider. We attended two staff hand-over meetings.

We inspected various documents and records relating to the people who lived there and the staff who worked there. These included five people's care files and five staff recruitment files. We reviewed the service's main staff training record as well as some training certificates. We reviewed some personnel records relating to actions the provider had taken in response to staff performance issues. We reviewed records kept in relation to the management of medicines including four people's medicine administration records. We looked at the care home's complaints record and how people's concerns had been responded to.

We also inspected various records and documents relating to the running of the service. These included a selection of quality monitoring audits, records relating to accidents and incidents and daily staff hand-over records. We completed a tour of the internal environment and viewed the outside space.

Requires Improvement

Is the service safe?

Our findings

People had been at risk of being cared for by unsuitable staff because robust recruitment processes had not always taken place. However, the level of risk to people was reduced by the regular checks carried out on staffs' competencies. Some relevant recruitment checks were in place including references and a Disclosure and Barring Service (DBS) check. A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. However some people's previous job history was not always clear or documented in detail on their application form. These gaps had not always been sufficiently explored. Gaps in employment and more appropriate references were followed up after the inspection for one member of staff. The management staff confirmed with us that they had completed this. References from another member of staff's previous employment in care had not been sought utilising instead a character reference. This was rectified at the time of our inspection.

During this inspection we followed up a breach of regulation identified in our last inspection in June/July 2015. This related to a lack of assessment of people's moving and handling needs and unsafe practices relating to this. We observed safe moving and handling practices during this inspection. Staff had received additional training since 2015 as well as on-going and individual support by the training coordinator or was also the lead for safe moving and handling practice. We observed two manoeuvres where people were not easy to support with standing due to their lack of mental ability to understand and follow guidance. Staff stopped to assess the person's ability and levels of concentration before they attempted to move them. When the person was engaged and able to follow simple guidance staff practiced what they had been taught which resulted in a safe manoeuvres for both people. Other examples were seen throughout the inspection and the improvements in staff practice were consistently observed. Staff had also raised concerns with the management staff when they had witnessed any on-going poor practice. People's moving and handling risk assessments had been reviewed and staff were following these in practice.

Also during the last inspection we had recommended that the service review how it established there were enough staff to meet people's needs. The management staff had addressed this by ensuring people's dependency levels had been fully reviewed following our last inspection. Dependency levels had then been closely monitored by senior management staff and adjustments made accordingly when needed. During this inspection there were enough staff in number to meet people's needs. The management staff informed us there were far more staff allocated to be on duty each day than the provider would normally recommend. This was because there were several new staff who required the support of more experienced staff to meet people's needs. To further assist management staff in establishing the required staff numbers information from senior staff working in the home had been considered in relation to people's dependency levels.

As well as care staff there were regular volunteers and additional ancillary staff (as seen in our last inspection) but how staff were deployed had also been improved. We observed people's needs being met when required and staff being able to give people the time they needed.

There were arrangements in place to protect people from abuse. We had received information that staff

were confused about what they could and could not do in relation to people's care delivery and in relation to what constituted abuse. We spoke to the management staff who had spoken in a staff meeting about different types of abuse.

The training coordinator told us "Sometimes it's just that staff don't know the right way to do something, they just need to be taught the right way". They explained they worked closely with staff to help them acquire the right skills to support people, who at times, were resistive to care. This involved knowing how and when to approach a particular person and if they remained unable to accept care that staff returned at other times to deliver that care. Staff we spoke to were very clear in their understanding of what constituted abuse and they were able to demonstrate their knowledge of safeguarding people from the risk of abuse. They told us they had received safeguarding training and the training records confirmed this. One staff member said "If I saw anything that concerned me I wouldn't hesitate to report it". The statutory notifications received from the provider and some records reviewed during the inspection showed that staff had reported concerns when they had them and that the management staff had taken appropriate action. Allegations of abuse had been appropriately shared with other agencies who also have responsibilities to safeguard people. Their advice and instruction had been followed by the management staff.

People's risks were identified and actions put in place to manage these. These included strategies to reduce the risk of pressure ulcers, falls and altercations between people who lived with dementia. We saw risks assessment which recorded what the risk was, the level of risk and then what was being done to reduce the risk. We observed staff being aware of people's risks and delivering the appropriate strategies to manage these. Where people presented with behaviours which could be perceived as challenging we observed care staff with the right skills manage these. One situation called for staff who spoke the same language as the person to communicate with them and establish a line of communication. This incident was well managed by these staff who could understand the person's language and therefore what they perceived to be a threat. The staff sought to reduce the person's distress. They instructed other staff to give the person space and to leave the immediate vicinity. Other situations were also managed well. Again lines of communication were established or people were just given the space they required. Staff were often aware of what triggered people's anxiety and distress and they took action to avoid this occurring. One person was unpredictable in their behaviour which could result in harm to others so this person's actions were monitored from a discreet distance at all times. All staff received training in how to manage challenging behaviour and how to support people safely when they started work at the care home. As there had been several new staff recruited in the past few months they were continuing to receive training and support in this.

The care home had struggled at times to ensure people's medicines were available when needed. There had been problems and were on-going problems in how prescriptions were electronically received by the supplying Pharmacy. There had also been other specific issues with the supplying Pharmacy which had delayed people's medicines arriving in time. This was despite the care home correctly adhering to the Pharmacy's requirements. Medicines prescribed outside of the main monthly order were also difficult to get delivered by the supplying Pharmacy within a reasonable time frame. For example, antibiotics prescribed by the GP taking a week to be delivered. In cases like this the care home had started to take individual prescriptions to a local Pharmacy rather than wait for the supplying Pharmacy to deliver.

To manage this situation and to reduce the impact on people, conversations had been had with the GP surgeries and were on-going with the supplying Pharmacy. Specific nurses had been allocated to manage the ordering and delivery of medicines so as to maintain continuity with the on-going issues. We observed these nurses checking a delivery in during the inspection and every medicine delivered was checked against people's medicine administration record (MAR) to establish what had not been delivered. The additional issues included having stock delivered which had not been ordered by the care home during the months

order. So the nurses also had to control stocks of medicines and return unwanted items. Where there were gaps in the delivery of medicines the nurses addressed these immediately and followed the issues through to the end. We were informed that these issues were likely to result in the care home altering their medicines arrangements.

We observed staff administering medicines and this was done safely and people were provided with the support they needed. Peoples MARs were maintained correctly and were checked on a regular basis to ensure staff were completing these correctly at all times. We checked three medicines which required additional procedures to be in place for their storage and use. These procedures were being adhered to and staff had received additional training from health care professionals to administer one of these medicines. One person received their medicines covertly (hidden in food). All appropriate processes and documents had been completed under the Mental Capacity Act 2005 to ensure this person received these medicines lawfully. One relative spoke with us about how happy they had been with how the GP and staff had managed their relative's symptoms. The improvements had been due to the administration of a medicine which was then appropriately administered by staff at various times during the day. The relative said, "It's as if [name] has been switched on".

People lived in a safe environment. The maintenance team and staff carried out numerous health and safety checks to ensure this remained the case. Well maintained records recorded frequent monitoring and servicing of various systems and equipment. Contracts were in place with specialist service providers and maintenance companies. For example, a company serviced and maintained all lifting equipment, which included passenger lifts, care hoists and slings. Similar arrangements were in place to maintain the nurse call system, emergency lighting, fire alarm and fire safety equipment. There were arrangements in place to manage the risk of Legionella and to keep the water and heating systems safe. Contracts were also in place for the safe disposal of waste.

Good

Is the service effective?

Our findings

The service was effective in meeting people's needs. During this inspection we followed up a breach of regulation identified in our last inspection in June/July 2015. This related to people's needs not being effectively. Staff had also been, at times, disinterested in resolving people's distress. This had been observed in practice and staff were not following people's plans of care. During this inspection this was not the case at all. We observed staff meeting people's individual needs effectively. We were told people's care plans had been reviewed and there was on-going work in this area to ensure these became even more personalised. Staff had been reminded to make sure they were aware of the content of people's care plans and had been given time to do this. Staff we spoke to had either read these fully or they were newly recruited and were familiarising themselves with these. Staff also received a hand-over of information about people's care needs before they started work. Staff therefore received enough information to help them look after people effectively.

When we spoke to people and relatives about the effectiveness of the care provided one person told us they felt they were well looked after. One relative said, "I'm very happy with the care. [Name] is so much better since being here". Another relative said, "We are very happy with the care so far. They look after [name] so well". Another relative told us about the concerns they had experienced when moving their relative from a care home in another part of the country. They said, "The care is very good here and there is good support for me and my family".

People were supported by staff who had access to and had received relevant training. During the last inspection we had also recommended the service review how the effectiveness of staff training was monitored. This was because staff had previously received training which had not resulted in good practice. The deputy manager had been allocated this task. They had regular conversations/meetings with the training coordinator and also worked themselves alongside staff. This had resulted in much closer monitoring of people's care delivery which made it easier to identify staff training needs. Staff had been given experiential training. For example, training had involved exercises to help staff try to experience what it was like for people when care was delivered. This was to try and make staff more aware of what impact good and bad practice had on people. Staff had received one to one support often to improve their approach to people and care practices. Staff responsibilities and duty of care had been discussed. Action had been taken to eradicate poor practice and general unkindness. There was also a record of staff training requirements put up on a staff notice board within a month of them needing refresher training. It was staffs' responsibility to book their required trainings and their management of this was monitored and followed up in their one to one sessions with senior staff (called supervision).

Staff had undergone many training subjects the provider deemed as mandatory such as infection control and equality and diversity. Staff also had access to training that met people's specific needs such as dementia training and challenging behaviour. The training was a mixture of face to face and computer based learning. Feedback from a health care professional told us staff still required further training in supporting people with dementia. The care home had appointed a new manager who was due to start soon. Once in post the management staff would look to access dementia lead and dementia link worker courses

run by the local authority. This would provide further support staff in managing the needs of people who lived with dementia.

New staff with no background in care had commenced the Care Certificate. The Care Certificate is awarded to those staff that have completed training in a specific set of standards that demonstrates they have the relevant knowledge and skills. The service had three members of the team who were care certificate assessors. New starters with a background in care undertook induction modules that were aligned with the Care Certificate. A member of care staff said "I feel really well trained and supported here".

As previously reported training was enhanced through experiential learning. For example, staff were expected to experience being hoisted whist blindfolded and how it felt to be fed. There were regular spot checks of staff competency in place. The training coordinator said " I like to go out on the floor and spend time working with staff, that way you really see if they have taken the training on board". Staff told us they felt well supported. There was recorded evidence of regular supervisions taking place and staff confirmed they received this. During these times staff could discuss how they were doing and identify any learning needs. There was also a record of observations made on staffs' communication with people with reflections on their performance discussed during supervision. The management staff had also made referrals to specialist health care professionals if staff required support and further knowledge with the management of specific people's behaviours.

People who lacked mental capacity to be able to make specific decisions about their care and treatment were protected under the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. All staff had completed relevant training in MCA and understood their role in protecting people's rights in accordance with this legislation when delivering their care.

We saw mental capacity assessments recording people's lack of ability to understand, retain, weigh up and make decisions about their care and treatment. Care was delivered to meet people's needs and done in people's best interests. Appropriate records were kept about these decisions and about who was involved in making these decisions. The process of decision making involved staff, health care professionals, a representative/relative (with power of attorney for health and welfare) and sometimes an independent mental health assessor (IMCA). IMCAs can represent people who lack mental capacity when significant decisions are made on their behalf and when they lack any other person to speak independently and on their behalf. If relatives did not hold designated power of attorney they were consulted about the decisions being made so they could express an opinion. One relative told us they had been part of a meeting which looked at how better their relative could be supported. This person could be, at times, resistive to care so staff had wanted to explore with the relative how their involvement may help to ease this person distress.

People who needed to live at Brockworth House and who required constant supervision in order to keep them safe and receive the care and treatment they needed had been referred for Deprivation of Liberty Safeguards (DoLS) authorisations. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People were provided with support to manage their food and drink intake. Some people ate as they walked and others sat down at various times at dining room tables or in their armchairs and ate and drank. Risks relating to food and drink intake were identified and managed and they predominantly related to loss of

weight and swallowing problems. People at Brockworth House lived with illnesses such as dementia which can interfere with the normal ability to know when food and drink are needed, the desire to eat and know how to eat and drink. We observed many staff available at mealtimes to help individual people to eat and drink. Some people required feeding and this was done in a dignified manner with staff sociably conversing with people as they provided this support. Others required various levels of supervision and prompting which was carried out effectively. Where people retained skills to feed themselves they were supported to do this but with staff ensuring they also ate and drank enough. Meal times started at set times to give some structure to the day but food and drink was available when people were hungry or thirsty, including at night time. People told us they enjoyed what they were eating and we observed them generally enjoying the mealtime experience. There was an overall calm and cheerful atmosphere. We sampled a mouthful of both dishes served at one meal. These smelt nice, looked colourful, had different textures and were full of flavour so when the meals arrived they reminded people it was time to eat. They were designed to be appealing and appetising as well as nutritious.

People's care records recorded their weight usually monthly or more often if staff wanted to monitor someone's weight more closely. Trends in weight gain or loss were monitored and staff used an assessment tool to calculate levels of risk. People's GPs were also involved in monitoring their weight and sometimes they prescribed nutritional supplements. Foods were also fortified by the chefs so contained additional butter, cream and dried milk powder in order to get additional calories in people. Drinks were always available and we saw staff constantly providing drinks and snacks to people who required these in-between meals. This was easily done as each floor of the care home had a fully fitted kitchenette.

We spoke with the hospitality and kitchen staff. The hospitality manager explained how he and his staff kept a check on people's nutritional needs, including making sure they had up to date knowledge of people's specific requirements such as allergies, or the need for a pureed diet. People from different countries were also considered, for example a person living at Brockworth House was originally from Poland and because of this the kitchen staff made sure they always had some polish food to offer them.

The kitchen staff also had a record of people's general likes and dislikes. The hospitality manager told us if someone didn't want what was on the menu then they would be offered something else. They were also about to start an option for a light supper called 'night bites' where people could have something to eat later on in the evening if they chose like sandwiches or soup. The kitchen staff cooked everything from fresh including baking a variety of cakes for afternoon tea.

People had access to health care professionals and where prompting was needed to gain this access staff were very proactive in ensuring this took place. People's records recorded visits from professionals such as continence assessors, speech and language therapist when there were swallowing/speech problems, specialists in wounds and pressure ulcer management, occupational and physiotherapists where support was needed with equipment, mobility and seating, dental and optical care and chiropody services. Access was also gained to specialist mental health teams to include Psychiatrists. People's GPs visited regularly and during staff hand-over meetings staff were informed where changes in people's condition had taken place and GP visits had been requested. People were also supported to attend health appointments outside the care home, sometimes by their relatives and sometimes by the staff.

Good

Is the service caring?

Our findings

During this inspection we followed up a breach of regulation identified in our last inspection in June/July 2015. This related to people not always being treated with respect, dignity and compassion. During this inspection people's care was delivered with kindness and compassion and they were treated with respect and dignity. One relative said, "They're [staff] amazing, so warm towards [name]", Another relative said, "The staff are all very kind". Another relative said, "They [staff] are always so welcoming. I'm greeted with a smile each time". Another relative referred to the care home as having a "lovely atmosphere". Another relative said, "I really enjoy visiting now. I have noticed there is really good eye contact and interactions with people, the staff seem to really care".

We observed staff treating people in the same way irrespective of their disability, behaviour or gender. Senior staff also told us this was the case irrespective of people's sexual orientation, race or religion. We observed staff listening to what people had to say and taking time to communicate with those who found expressing themselves difficult. Where people's communication was not appropriate staff managed this in a non-judgemental way. Staff knew the people they were looking after so they knew what they liked and did not like. We observed personal preferences being met. One person was given food which they had chosen and then threw on the floor (the trigger for this not obvious at the time). Staff addressed this by quietly clearing the food up and taking time to ascertain what the person wanted; which was for a member of staff to sit with them which they did. People's distress and discomfort was addressed straight away. Staff showed compassion and a genuine desire to try and find out what was causing any on-going distress. Medication was sometimes used as prescribed to alleviate this but not without other actions being tried first.

Where possible people were very involved in making simple day to day decisions. Staff we spoke with were clear that where people could make their own daily decisions they should be supported to do so. A member of staff told us "I will give them a choice and ask them to make the decision". We observed people being supported to do this but not to the point where this triggered anxiety. If people could not make a choice about something staff often made a suggestion which they knew a person would be happy with and often the person agreed. This also helped to maintain people's dignity. Where they did not accept a suggestion staff quietly told them they would come back, which they did and support was provided again. Often these were simple decisions such as what they would like to eat, where they wanted to sit, if they wished to use the toilet, what activity they wanted to do. For many these were difficult decisions because they lived with dementia or had mental health needs which compromised their ability to think through options. Staff were observed to be patient and kind during this process. One relative referred to how staff helped people make decisions and choices about their food. They said, "I like the way they give a choice of what there is to eat on small dishes to help people make a choice".

People's relatives and representatives also felt supported, listened to and involved. One relative spoke highly of how care staff updated them and involved them in the care of their relative. They said, "Communication with me is very good. I get home sometimes and there may be a message on my phone just letting me know everything is okay". They referred to their relative sometimes being distressed when they initially left and the telephone call reassuring them. Another relative told us their relative, who was the

person's next of kin, was well informed of any changes in their relative's condition. Relatives and others people important to those living at Brockworth House were able to visit at any time. Staff explained that sometimes different times were better for people than others and relatives were advised of this if this were the case.

Information about people's health and care was kept confidential. Care records and any electronic records were kept secure. We observed staff talking about people's care in private and away from people's hearing. The only time this was not the case was when information was handed over to staff coming on duty at the dining room table with some people (who lived with dementia) sitting at the same table. By doing this people were not put in a position of feeling excluded from a meeting taking place in their dining room and staff could still provide supervision but information about other people was being discussed in front of people.

We recommend the service review their arrangements to make sure confidentiality is being sufficiently maintained.

People's privacy and dignity was maintained. We observed staff ensuring this were the case by for example, delivering personal care behind closed doors and maintaining people's dignity in other ways. For example, making sure that any inappropriate removal of clothing by a person was managed quickly so their dignity was maintained. Accidents relating to toilet needs were managed by staff discreetly. We observed people being helped to clean themselves after eating and their food protectors were removed when not needed.

Good

Is the service responsive?

Our findings

During this inspection we followed up a breach of regulation identified in our last inspection in June/July 2015. This related to information held about people's care not maintained sufficiently well enough to provide up to date guidance for staff and information for visiting health care professionals. Since our last inspection staff responsible for maintaining people's records had been reminded of their responsibilities relating to this. They had also received further training in record keeping and care planning. Care plans and other documents such as risk assessments were checked on a regular basis by management staff to ensure these were reviewed and amended monthly or when needed. Managers were also looking to see if progress was being made in the personalisation of care plans so they were specific to an individual's needs rather than being a generic document. Although many had improved we were told some staff still needed to improve in how they wrote a care plan. Despite this, care plan audits were scoring between 90 and 95 percent for meeting the provider's requirements in terms of content and accuracy. This was not the situation at our last inspection.

At the time of this inspection Brockworth House responded to the needs of people between the ages of 46 years and 105 years old. Some people had very complex needs and there was a mixture of physical and mental health needs to meet. People were admitted to the care home following an assessment of needs. Although staff aimed to involve people in the gathering of information about themselves, usually they were heavily dependent on relevant information from relatives and care professionals involved. This information was recorded and staff made decisions as to whether they could meet a person's needs based on this information. A trial period was usually agreed. Several people were admitted from other care homes where staff had not been able to meet their increased needs due to their level of dementia or mental health needs. One relative who had experienced this described this as a stressful time but said, "I'm just so pleased with the care given here". They described the difference between where their relative had previously been and Brockworth House. They said "with [name] here I feel calmer and less stressed; they [staff] are so supportive". One of the management team spoke with us about one such person. They said "staff have responded so well to [name's] individual needs" and "nurtured them." They went on to explain that health and social care professionals were now considering if the person's wish to live in the wider community again, with support, may well be possible.

People's needs and the care they were to receive were recorded in the care plans. These documents provided staff with up to date information and guidance so care could be delivered consistently and safely. Some relatives confirmed they had been involved in reviewing their relative's care plans although managers told us the recording of this was not always seen in people's care files. This was therefore an area of required improvement which the provider wanted to see and which had already been recognised by the service. The care files we reviewed recorded people's likes, dislikes and preferences They included a "Life Story" which gave detail of past employment, family connections, important dates/events in a person life and what their hobbies and interests had been.

One care plan for one person gave detailed information about what the person could managed with regard to their personal hygiene. Some additional arrangements had just commenced and these were due to be

added to the care plan. For the same person other care plans gave good detail and also recorded what the person could and could not achieve independently. This person's appetite had reduced and a clear audit trail was seen between amendments in their nutritional risk assessment and then amendments in the care plan. The records then recorded when the person had started to put on weight following additional support which had been recorded in the care plan and delivered by the staff. Records relating to another person's wound care were easy to follow with photographs of the wounds to help evidence areas of improvement or deterioration. It had been recorded in this person's care plans that specialist wound care professionals thought it unlikely staff would be able to improve these wounds due to the person's poor general health. Therefore guidance for pain relief and other areas of support were well recorded. For two people who required medicines to avoid further ill health, but who sometimes refused these, there was clear guidance recorded in relevant care plans for staff to follow.

One person's challenging behaviour had not resulted in records being kept to try and identify triggers for this so we questioned why not as this would have been expected. We were told that mental health professionals who knew this person had visited and told staff the person was presenting in a way they had always done so looking for triggers was not needed. One senior member of staff had however taken a proactive stance and requested that a referral be done to the Psychiatrist for this person. Therefore for this one person, in relation to their challenging behaviour, there was little guidance for staff recorded in their relevant care plan. We were told staff would follow the training they had been given in relation to this so it did not need to be recorded. This however left records reading for example, "[name] has been aggressive" but without a recorded description of how this had been managed. This was the only case we found like this and we fed back our findings to the member of staff present. They said they would review how staff were recording their actions in relation to the episodes of challenging behaviour.

People were provided with opportunities to socialise and take part in activities. The teams of volunteers supported these opportunities and spent a lot of time on a one to one basis with some people chatting, supporting a simple activity or taking them for a walk. We observed one person talking with a volunteer for some time. Afterwards they told us they really enjoyed the chats they had with this volunteer. They said, "He's cheeky, he makes me laugh". Activities were coordinated by two activity coordinators. At this inspection one activity coordinator was present. We saw examples of activities taking place where people were engaged and enjoying themselves. One activity held on a regular basis involved listening to different types of music as well as singing. The session we witnessed had a classical musician who had volunteered to come and play the piano. It was joined by several relatives who joined in on a regular basis. People were very engaged and those who did not sing a long could be seen to be tapping their feet or following what was going on around them. The activity coordinator focused on these people by holding their hands or singing in front of them to maintain their engagement in the session. Other activities included for example, craft based activities, baking, exercise sessions and reading or being read to. One relative spoke with the activities coordinator and asked what activities their relative had taken part in. They were keen to be reassured that these activities also took place when the activities coordinators were not present; for example at the weekend. The activities coordinator was able to reassure this relative that care staff did support their relative to partake in activities they enjoyed. We saw records of individual activities that had taken place as well as those relating to this person at weekends. This relative did comment that they felt there had been an improvement in the activities lately.

The activities coordinator told us there had been an improvement in the care staffs' confidence and desire to get involved in activities. They said, "Staff are catching on that it is okay to be involved". The management staff had supported this involvement by making sure this was possible by for example, considering this when they set the staffing numbers. It was hoped, the more care staff got involved with activities, the more skilled and confident they would become at delivering these. One relative said, "There's been an

improvement in activities. A new activities coordinator started in January and staff have relaxed. They have been given permission by managers to sit and chat with people". External entertainers were also used to provide a variation to the entertainment and singers and theatre based groups had visited. The activity coordinators also evaluated the sessions and people's individual involvement and a plan to try and personalise activities more was in progress.

There were arrangements in place for people, relatives and visitors to raise areas of dissatisfaction and complaints. Information was given on admission about how to make a complaint and information was available in the reception area. Complaints that had been received had been recorded, responded to, investigated and learning established from these.

Good

Is the service well-led?

Our findings

People benefited from living in a care home that was well-led despite there being no registered manager in position. We were informed that a new manager had been recruited and was due to start August 2016. Relatives and staff told us the service had improved. The previous registered manager had not managed the service since January 2016 and had formally left their position in February 2016. Since then the deputy manager, employed in January 2016, had been supported by representatives of the provider to manage the service. A representative of the provider had been present in the care home most days since the registered manager had left.

The provider's expectations had been made clear to staff in meetings and one to one sessions. The management team had clearly been very visible during this time because staff and relatives told us they had been. Staff told us the management staff had been both approachable and supportive during this time. The staff we spoke with said they very much enjoyed working at Brockworth House. One member of the care staff said "I absolutely love it here". Another member of the care staff told us "I haven't met our new manager yet but I find the deputy manager very approachable and supportive".

The management team explained that a lot of team building had been undertaken. Where we had needed to liaise with the care home about issues that had arisen the management staff had been responsive and open in their communication with us.

Following our last inspection in June/July 2015 a comprehensive action plan had been written and implemented. This included the breaches in regulation identified in our last inspection. The management team had taken accountability for ensuring that the requirements issued by us had, in the main, been addressed. Representatives of the provider also explained that changes in the provider's senior management structure had made it easier for senior managers to be "more proactive rather than reactive". The service had detailed evidence that related to each requirement made by us. For example, the need to demonstrate that all staff had moving and handling refresher training, and that staff's communication skills had improved. It also included evidence relating to the other areas we followed up during this inspection.

The quality, safety and effectiveness of the service was monitored by a variety of audits. Whilst there was evidence that these systems were in place and actions arising were being undertaken, there was a lack of documented evidence that the audit loop had been closed. Documentation was not consistent around the evidence for how actions were completed, when and by whom. This was a record keeping issue more than the quality assurance system not being effective but it made it difficult to measure the actual effectiveness of the system. It also meant the identification of what actions worked and what didn't work, which actions were outstanding or needed adjustment could not be easily identified or overseen by the provider's representatives. It made the evidence for the driving of improvements through quality assurance less quantifiable. We fed this back to the senior management team who took this observation on-board and told us they would look at altering this.

There was an annual 'Standards Assessment' quality audit in place. It was very thorough and covered large

areas of the service such as staff training, care plans and staffing levels. The Quality Business Partner (one of the provider's representatives) told us that if this audit identified any concerns then they could undertake a "deep dive" of these areas. The tool also allowed for the acknowledgement of areas of good practice. We reviewed the 2015/2016 audit. Where issues had been identified there was an action plan in place with who is responsible to complete the action and by when. However, there was again no documented evidence in this tool which recorded that the action had been completed. For example, there was an action to consider new ways to involve people in recruitment with a completion date of 24 March 2016. There was no evidence that this had been considered or completed. When we spoke with the deputy manager she was unaware of this action. In another section there was an action to set up a system to ensure all care plans were reviewed with the family on a six monthly basis. Whilst we were told this was happening on an ad hoc, informal basis there was no documented evidence of completion of this action or a formal six month family review system having been put in place.

Care record audits were in place and again actions had been identified, for example daily support plans not being countersigned but there was a lack of evidence of completion. However, we could see that where concerns had been raised further audits were undertaken after a period of time and this evidenced an improvement in the audit score.

Medicine audits also revealed regular checks of the safety of the systems in place but again lacked a consistent approach to documented evidence of completed actions to rectify shortfalls

Feedback from people's relatives and staff had been sought and this had been considered when making changes and improvements to the service. This would be further developed when the new manager was fully in post.

We recommend that the service seek advice and guidance from a reputable source about improving the recording of completed actions as part of their quality assurance processes.