HC-One Limited

Brookdale View

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

The inspection took place on 19 May 2015 and was unannounced. This means that the service did not know we were coming in advance. At the previous inspection in April 2014 we had found that the service was meeting the legal requirements we looked at.

Brookdale View is a purpose built care home which offers accommodation for up to 48 people. There were 33 people in residence on the day of our inspection. Brookdale View provides nursing care on the ground floor and residential accommodation on the first floor. There are two lounges and a dining room on each floor. On the first floor there is a small room set aside for people to smoke in.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that people felt safe when the permanent staff were on duty. However, there was frequent use of agency staff, especially at night, and people felt less safe with agency staff.

We found that recently there had been a reduction in occupancy, which had led to the service reducing staff numbers by one member of staff on both day and night

Summary of findings

shifts. This did not take sufficient account of high dependency levels. People felt there were not always enough staff around. We observed that the size and the design of the building meant that often staff were out of sight. We found that staffing levels were a breach of a regulation made under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood their role regarding safeguarding and knew about whistleblowing. Medication was stored and administered safely. We found people mainly liked the food, and staff monitored people's weight and ensured people had regular health appointments.

The premises and equipment were well maintained and serviced regularly.

The CQC is required by law to report on the use of the Deprivation of Liberty Safeguards which are a part of the Mental Capacity Act 2005. We found that the correct process under this legislation had not been carried out for the use of bedrails. We found this was a breach of a regulation made under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff training was recorded effectively and attendance was monitored. Staff supervision took place every two months. Staff were supported in their roles. Recruitment procedures were thorough and ensured the staff who were recruited were suitable to work in the home.

People commented favourably on the quality of the care, and we observed staff were considerate and helpful. Staff explained the care they were giving and supported people to be independent where possible.

However, one resident and one relative commented that the staff were sometimes too busy to be attentive.

The service often accepted people who were nearing the end of their lives. The home provided a high standard of end of life care and the staff had developed skills and experience in this area.

We found the care files demonstrated person-centred care. However, in the case of one person where English was not their first language not all of their needs had been addressed.

There was a varied schedule of activities but there was no activities organiser in post. This meant there was nobody to drive the home's minibus and trips that had occurred in the past could not take place.

There was an effective complaints procedure. Complaints were responded to within the stipulated time. We knew of two serious complaints which had led to action being taken to prevent a recurrence.

We found the registered manager was liked and respected by both residents and staff. There was good communication amongst the staff within the home.

There was a structured system of audits carried out by the registered manager and more senior staff. We saw evidence that these audits led to action to improve the quality of the service.

In relation to the breaches of regulations, you can see what action we told the provider to take at the end of the full version of the report.

Summary of findings

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 consistently safe .

We found that people felt safe when the permanent staff were on duty, but less so with agency staff, who often worked at night.

We found that staffing levels had decreased with a reduction in occupancy, but this meant people felt there were not always enough staff around.

Staff understood their role in safeguarding. Medication was administered safely. The premises and equipment were well maintained. Recruitment procedures ensured that the staff who were recruited were suitable.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The correct procedure under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards had not been carried out for the use of bedrails.

People mainly liked the food, and staff monitored people's weight.

Staff training was up to date and attendance was monitored. Supervision took place regularly and staff were supported in their roles.

Is the service caring?

Good

The service was caring.

People were pleased with the care they received, and we observed considerate care being given. One resident and one relative commented that the staff were sometimes too busy to be attentive.

Staff explained the care they were giving and supported people to be independent where possible.

The service had developed expertise in providing end of life care and we saw evidence that the staff were skilled in this area.

Is the service responsive?

Good

The service was responsive.

There was a good system of planning person-centred care. We found that in one case not all of a person's needs had been addressed.

A variety of activities was available but there was no activities organiser in post, which restricted activities taking place out of the home.

There was an effective procedure for dealing with complaints. Serious complaints had led to action being taken to prevent a recurrence.

Summary of findings

Is the service well-led?

Good

The service was well led.

People living in the home spoke positively about the registered manager, as did the staff.

There was good communication amongst the staff. The registered manager conducted daily walk rounds and frequent spot checks at night.

There was a good system of audits and quality control. The provider responded to issues proactively to try to prevent them recurring.

Brookdale View

Detailed findings

Background to this inspection

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

This inspection took place on 19 May 2015 and was unannounced.

Two inspectors and an expert by experience carried out the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. This expert had experience of caring for an elderly person.

Before the inspection we reviewed the information we held about Brookdale View. This included notifications we had received from and about the home, and the minutes of safeguarding meetings. We also reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We contacted the contract officer of Manchester City Council for information about the council's recent monitoring visits.

During the inspection we spoke with 13 people who were living in Brookdale View, nine relatives and five members of staff. We spoke with the registered manager, the deputy manager and with the assistant operations director of HC-One Limited, the provider.

We conducted an observation known as a SOFI (Short Observational Framework for Inspection). This is a method of observing people and the care they are receiving, to help us understand the experience of people who may have difficulty communicating with us.

We reviewed a range of records about people's care and how the home was managed. These included four care files, staff training and supervision records, three staff personnel records and quality assurance audits that the registered manager and assistant operations director had completed.

Requires Improvement

Is the service safe?

Our findings

We asked people living in Brookdale View whether they felt safe. One person told us, "I'm here on respite, whilst my daughter is away on holiday. I wouldn't be able to manage on my own. It's a safe environment. It's safe, fine, very good. I don't need staff to look after me, just to keep an eye on me, cook and clean and so on. My room is kept clean and tidy, I'm well looked after."

Another person said: "I do feel safe and very secure here. I'm not bullied." Another person commented on the staff's safe use of equipment: "They have to use the hoist to lift me out of my chair. They know how to use it properly. You have to have a good knowledge of the machine."

However, people told us they felt less secure when agency staff were on duty and that this happened quite frequently.

One visitor said: "I think [my relative] is safe when everything runs smoothly, the problem is with agency staff, which we have particularly at weekends and during holidays. They had a pain in their arm once and agency staff offered them a tablet. But they can't swallow, so obviously the agency staff didn't look at the notes. The permanent staff are good at their jobs, they're well trained."

A resident said: "I do feel safe in here. The regular staff are competent, but with the agency staff - some of them are OK, but others not so good."

Another resident said: "There's not really enough staff. It's usually agency staff at nights; it's the luck of the draw if you get a good one or a bad one. When you press the buzzer it can be 15-20 minutes before someone comes. Some of the night staff can't understand you, there's a language barrier."

Another relative expressed concerns that the agency staff at night were often male: "The permanent staff - they're great. If you have a problem, just go to them and they'll sort it. Agency staff are rude - I was ordered out of her room once. She's not happy if there are two male carers in her room at night, which can happen if they are agency staff. They can be quite respectful and be dignified, but she doesn't like it. She doesn't mind being attended to by a male carer, so long as there is a female in the room as well."

We talked with the registered manager and the assistant operations director about the use of agency staff, especially at night. We had received concerns that on some night shifts there was only one regular member of staff and the other three staff were from an agency. The assistant operations director explained to us that they had had great difficulty recruiting a senior care worker to work night shifts, and therefore the senior care worker was always an agency worker. They acknowledged that sometimes this meant there could be three agency staff out of four staff on duty. They added, however, that they asked the agencies to supply the same workers regularly, which often happened. This would mean the agency staff got to know the residents and their needs. The agency would phone in advance if they were sending someone who had not been to Brookdale View before. We were shown an Orientation Booklet which was given to all agency staff on their first shift, which was intended to ensure they understood the basics about the provider's policies and procedures. The agency worker had to sign to indicate they had read and understood the orientation checklist.

We considered the high level of usage of agency staff was not ideal, but was partly mitigated by regular use of the same agency staff. However, there was also an associated issue of staffing levels.

We learnt that the numbers of staff on each shift had recently been reduced. During the day there were one nurse and three care workers based downstairs on the nursing unit, and one senior care worker and two care workers upstairs on the residential unit. This made a total of seven care staff on duty for 33 residents. Until recently there had been an additional care worker upstairs, making a total of eight. Similarly the number of staff on the night shift had reduced from five staff to four staff. We were told by the registered manager that the reduction was due to a reduction in the number of residents.

We also learnt that 15 out of 18 people on the ground floor required two staff to support them with various aspects of personal care, e.g. lifting, moving and handling, and washing. This meant there were high dependency levels. The registered manager and the assistant operations director told us that these levels were taken into account when assigning staffing numbers. But staff told us there were times when they got behind with jobs, and people had to wait longer for breakfast, and personal care.

One relative told us: "She's not really happy here - apart from it not being her own home, she feels, not abandoned but a bit lonely - there's not much staff on. She's managed to fall out of bed, cut her head and suffered bruising. Now there's a small mattress by the side of her bed."

Requires Improvement

Is the service safe?

Another relative said: "There's not enough staff. The carpet is disgraceful; I could feel my feet sticking to the carpet, like in a dirty pub. The window ledge where they keep all their photos and bits and pieces, is covered in a layer of dust."

We asked staff about staffing levels. One member of staff said: "It is sometimes a struggle. Some days are busy. There's no time to stop. It can be difficult if two staff are doing a transfer and someone else needs help." We also saw in the minutes of a staff meeting on 2 April 2015 that staff had been given advice on how to prepare for our inspection. The minutes stated: "They may ask you if you think there are enough staff on duty. Be careful what you say as if you say we could do with more, this will go on the report as non-compliance."

We noticed that there were times when no member of staff was visible and it was difficult to locate one. The corridors on each floor were long and went round three sides of a square. On the upstairs floor there were three members of staff on duty. If two members of staff were occupied in giving support or personal care to one resident, that meant only one more member of staff was available. We observed when one resident pressed a buzzer to summon assistance a care worker came within two minutes, but the resident told us they were not always that quick.

One member of the night staff had told us that when there was one nurse and one care worker on the nursing unit things could sometimes be hectic. They said when buzzers went off it was difficult to know how to prioritise. They added that they had raised this with the registered manager who said that they should be able to cope with the number of residents.

We considered that when there had been a reduction in occupancy levels in the home it ought not to have been regarded as an immediate opportunity to reduce staffing numbers. Although the ratio of staff to residents was in itself acceptable, the levels of dependency and need were high, and the remaining residents would have benefited from maintaining the previous numbers of staff. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with care staff about their understanding of good safeguarding practice, their duty of care, their responsibility to keep people who used the service safe and what action they would take in response to concerns. Care staff we spoke with had completed training in adult protection and were able to tell us what action they would take in response to concerns and how they would ensure people's safety. Staff demonstrated a good understanding of what constituted abuse and were able to give examples; equally they were able to demonstrate what action they would take. Staff also understood the term 'whistle blowing'. One staff member said to us: "I wouldn't tolerate any abuse. If I saw anything I would first make sure the resident is safe, then I would tell the registered manager."

We talked with staff who had responsibility for administering medicines to people living at Brookdale View. We looked at medication records and looked at how medication was stored at the home. Medicines were all stored in a room called a clinic. Each person's medicine was kept in a separate container with their name and room number on, to help ensure the correct medicine was administered to each person. Some medication was also stored in a refrigerator or in a locked medication trolley and where necessary in a locked controlled drugs cabinet secured to the wall. (Controlled drugs by their nature need to be stored more securely.)

We checked a sample to verify that the balance of medicines recorded in the controlled drugs record book matched the amounts in the cabinet. We observed that the book was incorrectly completed in one respect. Some staff were recording the time the medicine had been administered in the column headed 'current balance in stock'. This had the potential to cause confusion. We discussed this with the deputy manager who was responsible for medication, and said they would remind staff of the need to complete the record correctly. We looked in detail at medication records. We found that people received their medicines as prescribed. We found that medication records were maintained. We did notice that some initials on Medication Administration Records (MARs) were not recorded on the index of initials at the front of the file. This would make it more difficult to identify who had administered a particular medicine in the event of a query. The deputy manager told us the staff whose initials were not on the index were agency staff, and said they would ensure that their initials and names were added to the index. In the clinic on the first floor we saw only two people's initials were on the index, but several other staff had signed the MAR sheet.

Requires Improvement

Is the service safe?

We found care staff had completed medication training and staff updated their training. This meant staff were skilled and competent to assist people living in the home with the day to day management of their medicines.

One resident told us: “They look after my medicine, it’s always on time. When I buzz them, the [waiting] time is not too bad.”

We saw records relating to the safety and maintenance of the premises. We were given a copy of a detailed fire risk assessment. This assessment took place annually. We learnt that actions recommended in the latest assessment such as replacement of fire doors were in progress. Personal emergency evacuation plans were on each care file. This showed that ensuring people’s safety in the event of a fire or other emergency was taken seriously.

We saw documents confirming a recent test of the electrical system, service of the lift, hoists, slings and the specialist bath. This meant the provider was ensuring the equipment was well- maintained and safe.

We asked about recruitment practices and inspected three staff files relating to recent recruits. We saw that the necessary checks were made to ensure that staff were suitable to work with vulnerable adults. Each personnel file had a checklist of documents that needed to be seen at the time of appointment, including proof of identity, a DBS check (Disclosure and Barring Service checks for any convictions or cautions) and references. There was a copy of the application form and a record of the interview, including the results of tests given to the job candidate. We observed that on one file the notes taken of the job candidate’s answers to questions at interview were sparse. This meant that the record of the interview contained minimal information. There was also a health questionnaire. These processes were designed to ensure only suitable staff were appointed.

Requires Improvement

Is the service effective?

Our findings

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which form part of the Mental Capacity Act 2005 (MCA). They are intended to protect the rights of people who lack the capacity to make their own choices about their care. Under the legislation a provider must issue an 'urgent authorisation' when they believe they may be depriving someone using the service of their liberty. At the same time they must apply for a 'standard authorisation', to a supervisory body, in this case Manchester City Council..

All staff were expected to undertake training via e-learning in 'Understanding the Mental Capacity Act and DoLS.' We saw a record confirming that 31 staff (out of 36) had completed the training, two recent starters were still working through it, and three others were due to complete it.

In the PIR the registered manager stated, "If we feel we are depriving any resident of their liberty, we arrange a best interest [meeting] and DoLS referral supported by the Local Authority." However, no notifications regarding DoLS authorisations had been submitted in the 12 months since the previous inspection, or prior to then. We discussed this with the registered manager and assistant operations director, and asked them whether DoLS applications were made when needed.

We saw on several care files that a mental capacity assessment had been carried out, although not entirely in line with the principles of the Mental Capacity Act 2005. For example, one assessment, dated February 2015, said simply: "[the person] lacks capacity" but did not state which decision this judgement related to. An assessment of mental capacity should not be an overall assessment of lack of capacity, but should be done separately in relation to individual decisions. Another person's assessment stated: "has not got capacity to make any decisions or choices." This again was not a proper assessment under the MCA. On another file we found a partially completed form without any signatures or date.

In two cases we learnt that people who were assessed as lacking capacity in other areas were using bed rails. These are raised sides to the bed which prevent people falling out of bed. Because they also prevent people getting out of bed when they want to, they may be seen as a deprivation of liberty, which means that if the person cannot consent to using them, the procedure in the MCA and DoLS needs to be followed. No capacity assessment was recorded as to whether these people could consent to the use of bed rails. It was likely that they could not consent, in which case an application for a DoLS authorisation should have been made.

The lack of DoLS applications and the failure to follow the principles of the Mental Capacity Act 2005 meant that the service had not followed the correct procedure relating to people who were incapable of consenting to a restriction of their liberty. This was a breach of Regulation 11(1) and 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw consent forms on some of the care files we looked at. For example, one file contained a signed consent for use of the resident's photograph. Other files did not contain this form. On another file we saw a consent form which was incorrectly completed. The person's name had been written next to both 'I consent' and 'I do not consent' rendering the form meaningless.

The food served in Brookdale View was brought over from the kitchens of the neighbouring sister home, Averill House. There was a temperature chart which recorded the temperature of incoming food at the time it was served. We asked all the residents we spoke with about the food. One person said: "The food is good, I enjoy it. There's a choice of food and I can eat breakfast anywhere I want." Another person said: "I enjoy the food, and there's plenty of it." A third person said: "The food? You get what they give you - it's alright. There's enough of it. It depends on what you like." The only adverse comment came from a visitor who said: "The food's not very appetising. [My relative] asks me to bring things in, like a loaf of bread, but what can they do with it?"

There was a menu board although the food served did not entirely match what was on the menu.

During lunch jugs of cold squash were available on a side table. We observed staff frequently encouraging people to drink something, focussing on people who appeared reluctant to drink or had difficulty helping themselves. We knew that since the last inspection there had been two

Is the service effective?

cases where people had been admitted to hospital suffering from suspected dehydration. However, on the day of our visit we saw that there was ample liquid refreshment available.

In each dining room was a comments book, which recorded comments about the food. We were told this book was regularly inspected by the chef from Averill House. We saw a comment saying "no fork mashable food again" from early in 2015, suggesting that an earlier comment had not been acted upon, and also that some food had been unsuitable for some people. 'Fork mashable' food means food which can be mashed easily to assist consumption and digestion. However, there had been no such comments since March 2015 indicating the problem had not recurred.

We saw weights were checked weekly and records kept on care files to ensure that any rapid changes in weight would be identified. People's health needs were recorded in their files and we saw evidence of professional involvement where appropriate. Relatives we spoke with told us they were kept informed of all events and incidents and that professionals were called when required. One relative said: "They see that she gets everything she wants, they treat her well, go with her to hospital and all her appointments."

We looked at training records and saw that most staff had completed training in mandatory areas, such as health and safety, first aid, safeguarding, fire awareness, dementia care, infection control and moving and handling. One member of staff told us the training was of a good quality, including the online training for safeguarding and medication.

Staff received supervision every two months and an annual appraisal. One member of staff said that supervision was a valuable opportunity to discuss their work as well as to receive information about the home and any changes in policies. For example, advice about protecting residents from sunburn was given in supervision following an incident in the summer of 2014. And following concerns raised after one resident had been admitted to hospital, the registered manager conducted supervisions with all staff in December 2014. These sessions reiterated the importance of maintaining record charts fully and accurately, in particular the fluid balance charts, which recorded the amount of liquid consumed. The registered manager recorded on their supervision records: "Food and fluids are extremely important to residents' well-being and this one aspect of the resident's life needs to be an important focus in the care home life."

Good

Is the service caring?

Our findings

A family had written a card to the staff, "Thank you for your kind and considerate care of our parents."

We asked people about the care and attention they received and their comments were mainly positive: "The staff are friendly and nice. They're helpful and can have a chat with you. They are respectful? Of course, yes. They talk to you, not over you, or at you." Another person said: "The carers are very good - they're thinking about me." A third person said, "The nurses have a hard time, but they look after me well. They're kind and gentle. They put cream on my legs every day." And another person said: "Yes, I'm happy here. They look after you here, I've no complaints."

We witnessed a practical example of considerate attention being given. Whilst we were talking with a resident in their room, they were having tea and cream cake. They dropped their cake on their lap and the floor. We retrieved it and offered to get another piece. A care worker came in with another piece and started to wipe the cream and crumbs from their lap and the floor. This was done in a respectful manner, addressing the resident by name, explaining what was being done, and maintaining their dignity.

One person told us: "I am happy with this place. The staff are nice. They usually discuss with me what they are doing." And another person said: "Yes, I'm happy here. They look after you here, I've no complaints."

A minority of comments were less positive. One person said: "Staff only come in when they are tending to you. They haven't got the time. They come in, see to you and go out. I don't feel like an individual to them, just a job to be done. They do treat me in a respectful and dignified way though." Similarly one relative said to us: "She's left alone quite a lot, she's a bit lonely. The staff don't make much effort to talk to her."

During our observation in one of the lounges we observed good interaction between staff and residents. A resident who was in a wheelchair was supported to a chair by staff and then encouraged to transfer themselves into the armchair, which they were clearly able to do. This meant the staff were supporting that person to be independent when they could. Another resident was supported to start a drink and then finished it themselves. Another staff member responded to a resident's need by sitting down low alongside them and holding their hand while she spoke with them softly. This demonstrated that staff had positive friendly relationships with people living in Brookdale View. Staff we spoke with confirmed this to be the case.

After lunch, we observed two carers using a hoist to transfer two people, in turn, from their wheelchairs to armchairs in the lounge. This was done in a caring and competent manner, with the people being treated respectfully, by name and with an explanation of what was being done. This showed that staff involved people in their care, when possible, by explaining what they were doing.

There was a standard section in each care plan to record whether the resident themselves, a family member or an advocate had been involved in creating the care plan. This showed that the provider wanted to identify whether consent had been given to the care plan and was willing for an advocate to be used where necessary. However, on one file we looked at the section had been left blank which meant it had no effect.

We learnt from the PIR that Brookdale View operated a 'Resident of the Day' scheme. Each resident in turn was given special treatment for that day, such as having an individual choice of activity, their room being deep cleaned and the chef discussing menu preferences. This was designed to promote wellbeing and a sense of being special.

We had received a high number of notifications of deaths from Brookdale View during 2015. The registered manager explained that the home had acquired a good reputation for supporting people near the end of life, and was often asked to admit people who were expected to die soon, often within six weeks of entering the home. The deputy manager, who was new in post, commented that the staff provided excellent end of life care. The service had enrolled in the Six Steps programme, which is designed to enable care homes in the North West to improve end of life care. We saw that paperwork was present, where appropriate, in some people's files, which was designed to help avoid unnecessary pain and suffering in the last days or hours before death. We saw one end of life care plan had been signed by the resident. It confirmed their wishes to remain in Brookdale View, rather than be transferred to hospital, and specified other wishes. There was a Six Steps checklist

Good

Is the service caring?

at the front of the file, and a correctly completed DNAR form (this means "Do not attempt resuscitation" and when in place prevents paramedics or staff from attempting cardiopulmonary resuscitation).

We saw the provider's End of Life Care Policy which clearly set out their approach to providing end of life care within the home wherever possible. We knew from death notifications that the majority of deaths did occur within the home. The registered manager explained that often the hospital would discharge patients back to Brookdale View towards the end.

We saw a recent letter from a relative who had written: "The care my mum received at Brookdale View was second to none and I will be forever grateful to the wonderful caring staff that looked after her."

Good

Is the service responsive?

Our findings

We looked at five care files. We examined whether the care being provided was person-centred. Person-centred care means care which is individualised and specific to the person concerned. That means care which recognises people's particular strengths and needs, and offers them compassion, dignity, respect and choice. One aspect of person-centred care is to build up a detailed history of people's past lives, in order to enable staff to build up more meaningful relationships with them.

We saw each care file contained a detailed medical history and a list of the person's needs and preferences. This was called an 'individual room profile' although it was a profile of the person, not their room. There was a list of their preferred activities and their daily routines. All of this information would enable staff, and in particular new staff or those who had not worked with the person before, to gain a good picture of their personality and their needs, and deliver personalised care.

The files contained regular reviews and updates. There was a form on each plan for either the resident or a relative to sign to indicate they agreed with the contents. However, one relative told us: "They've done a new care plan, we know it exists, but we haven't been involved and don't know who deals with it."

We found care planning information was incomplete for a person who could speak little English. Their social and psychological care assessments were blank. There was reference to communication problems or barriers throughout the care file. These communication problems derived from language rather than any physical incapacity. A note on the care file stated: "Due to barrier of language problem, [person's name] is not able to express their needs correctly." Their health needs were not documented on the care file. The person's weight was being monitored, however. We discussed this with the registered manager who said that a family member had been into the home to discuss with the chef (from Averill House) how to make the person's favourite dishes.

We observed a staff member asking someone about menu choices for the next day – they went through the options several times to ensure understanding and support the person to make the decision. This demonstrated that people were actively encouraged to make choices where they could.

We saw a four week activity schedule which included a variety of activities. These included indoor games such as floor skittles, dominoes and bingo, and armchair aerobics. One resident on the first floor told us: "Sometimes I go downstairs to do the exercises." Another person told us: "I read the newspaper, watch TV, do the crosswords. My son comes in every morning and I have a conversation with him." One relative stated their view that: "There are not enough activities and stimuli."

The former activities co-ordinator had left and not yet been replaced. This had been the only member of staff authorised to drive the minibus used by the home. Some residents and relatives mentioned to us that this left a gap, because previously there had been trips to Blackpool and meals out. The registered manager told us the service was actively recruiting a new activities co-ordinator who could drive the minibus.

We were given a copy of the provider's Compliments, Concerns & Complaints Policy, dated January 2015, which set out the provider's attitude towards complaints. It stated: "Any concerns and complaints raised about any of our services will be investigated in an honest, open and transparent manner and an appropriate response given to the complainant in a timely manner."

In the PIR the registered manager stated the service had received nine written complaints which were managed under their formal complaints procedure, and all nine had been resolved within 28 days of the complaint being made. This showed that complaints were dealt with in a timely fashion in line with the complaints policy. The registered manager also stated that there had been a theme of poor communication, resulting from a lack of understanding of spoken English or a breakdown in transferring information to the relevant people. Daily handover records had been introduced in order to ensure the registered manager was informed in writing of any concerns raised by residents or families.

We knew of two serious complaints over the last year relating to residents who were admitted into hospital allegedly suffering from dehydration as well as other health conditions. One of these complaints formed the subject of

Good

Is the service responsive?

a series of safeguarding meetings conducted by the local authority. The outcome was that the complaint was unsubstantiated; however, comments were made about poor record keeping regarding fluid intake. The assistant operations director stated at the meeting that action had been taken to improve the accuracy of records. The second complaint regarding dehydration was substantiated, and was placed into the hands of the provider's solicitors. This complaint had not been dealt with within the 28 day period set out in the policy. Supervisions were held with all staff to reinforce the importance of maintaining hydration and keeping records. These two examples showed that the service was willing to accept criticism and to respond positively to complaints.

Another complaint had been about not protecting a resident from sunburn. The social worker who investigated the complaint commented that the registered manager and her deputy had co-operated fully and had agreed a series of measures which would prevent a recurrence.

Good

Is the service well-led?

Our findings

One resident told us: "The place is well organised, well run. When the ambulance brought me here, the ambulance man said, 'this is one of the best places around here'. My relatives watch what's going on. If they're unhappy, they'll challenge the manager. If I need to see her I'll send down for her. She's nice. I know I can get cantankerous, but I don't have any problems here."

Another resident said: "The manager, I don't see her very often, but feel OK talking to her. She's approachable. I've no complaints." However, one set of relatives were less complimentary, "We know who the manager is and she knows who we are. But to be honest, I don't think she interacts with the residents very well. If you ask her something, it's always 'I've got this form to do', or 'I'll try', but I don't think she does. She's too busy."

We asked staff about the management of Brookdale View. Their responses were positive. One staff member said: "I feel we are well managed. The manager and the seniors are always available and get things done."

We observed a 'flash' meeting which took place every morning at 11am, involving all available staff. It was led by the nurse in charge. The meeting highlighted current issues, needs and requests, for example, how one person was coping with their new wheelchair, and discussed any health concerns requiring closer monitoring or a GP visit. This meant that staff were kept informed of any immediate needs. There were also regular staff meetings.

The registered manager told us that the service tried to obtain the views of relatives and any ideas for improvement. There was due to be a relatives' meeting the week after our visit. We saw minutes of an earlier meeting in March 2015 where only two relatives had turned up. The registered manager recorded in those minutes that relatives tended to call in and see her in person when they were visiting the home, and therefore, did not feel the need to attend relatives' meetings. A relative said, "I've not been asked for feedback. There are forms but I've not filled in any. If I was seriously unhappy, I would."

The registered manager told us, and staff confirmed, that she conducted daily walk rounds to help identify any areas for action and to keep in touch with all of the people living in the home and staff. In addition, she conducted fairly frequent night time spot checks; five between February and May 2015. We saw her attendance record which proved these checks were undertaken at different times of the night and on different days of the week. Recently the registered manager had found one night carer asleep on duty, and appropriate disciplinary measures had been taken.

As a large corporate provider HC-One Limited had developed a system of audits and quality control which was implemented by the registered manager and more senior managers. We saw copies of a monthly medication audit which was a detailed list of questions in ten sections. Each question only allowed the answer 'pass' or 'fail' but there was also space for comments, which was used several times on each audit. This showed that the audit was used proactively and not just treated as a tick-box exercise. Of the three most recent audits two had been carried out by the registered manager and one by the deputy manager, meaning that a different pair of eyes would be looking at the detail.

We also saw a falls audit, listing the falls each month and identifying any trends. It included a check of the physical environment to ensure there were no trip hazards. A meeting had been held to discuss the outcome of this audit. We noted that the action plan was identical in successive months, perhaps suggesting it had been copied from the previous month rather than thought through again. We also saw audits of pressure ulcers, weight management, accidents, hospital admissions and infections. In addition, three care plan audits were completed each week.

The assistant operations director conducted monthly visits and produced a 'home visit report'. She spoke with residents, relatives and staff, observed manual handling and the dining experience. She checked that care audits had been completed, and on one occasion identified that not enough had been done that month. She wrote a summary of the visit, and an action plan with timelines. There was a box to record that actions had been completed, but we did not see this box used on the copies of the reports we received. The detail in the reports showed that the visits had been thorough, and that the assistant operations director did not hesitate to draw attention to issues which could be improved.

We knew from our records that for the most part the registered manager submitted notifications of deaths, serious injuries and other notifiable events to the CQC as

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required by regulations. There had been a period between September and December 2014 when notifications of deaths were not submitted. We had queried this and received four retrospective notifications of deaths in January 2015. At this inspection the assistant operations director told us that she now checked that notifications of deaths were sent; she also checked the forms before they were submitted to the CQC. This showed that the provider responded constructively to errors and implemented strategies to ensure they could not recur.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed to meet the needs of service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Care and treatment were being provided without the consent of service users and not in accordance with the Mental Capacity Act 2005.**