Mrs N Matthews

Brockenhurst

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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 17 October 2016 and was unannounced.

Brockenhurst is a residential care home providing accommodation, for up to 38 older people, who are living with dementia and who require support with their personal care needs. On the day of our inspection there were 38 people living at the home. The home is a large property situated in Littlehampton, West Sussex, there are five dual occupancy rooms, where two people share a room, other rooms are single occupancy. It has three communal lounges, two dining rooms and a garden.

The home was the only home owned by the provider, who was also the registered manager. The management team consisted of a registered manager and team leaders. A registered manager is a '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 home is run.

Risk assessments related to some people's needs were in place to ensure that people were provided with safe care. However, not all risks, specific to people's needs had been considered. For example, people were unable to use call bells due to their cognitive abilities, this had not been identified or assessed as a risk and consideration had not been taken to ensure that people could call for assistance if needed.

People had access to medicines and records showed that these were administered on time. However, there were concerns regarding the administering of medicines. For example, medicines were not dispensed using a non-touch method and this increased the potential risk of cross contamination. The administration and recording of medicines and the management of risk to people's safety were areas of concern.

People were supported by staff that had the relevant experience to meet their needs. However, there were concerns regarding the lack of formal training and support that staff received. Observations of staff's practice and of records raised further concerns about the amount of training and support staff had been provided with. The lack of formal training and support provided to staff were areas of concern.

People were asked their consent before being assisted and there were measures in place to ensure that people's relatives' had been involved in decisions about people's care needs. However, practice and the lack of records confirmed that here was a lack of understanding in relation to the practical application of mental capacity assessments (MCA) and the deprivation of liberty safeguards (DoLS) and some decisions were made by people who were legally unable to make decisions on people's behalves. The lack of understanding and practical implementation of the MCA and DoLS were areas of concern.

People appeared to enjoy the food that was provided. One relative told us, "X seems happy with the food here. They enjoy it." However, there were concerns regarding some people's dining experience and some people's access, particularly those that spent time in their rooms, to food and drink. Appropriate measures for a person that had lost weight had not always been taken. The experience of people when having their

meals and the lack of action taken in relation to a person whose weight had decreased were areas of concern.

Care records provided details about the person's care needs, however these did not always contain sufficient information to provide staff with appropriate guidance to suitably meet people's individual needs. Some people, who spent time in their rooms, were at risk of social isolation and there was not sufficient stimulation or meaningful activities to engage people and occupy their time. The lack of information in people's care reviews and the lack of meaningful activities were areas of concern.

People, relatives', staff and visiting healthcare professionals' were complimentary about the leadership, management and culture of the home, they found the manager professional, caring and approachable. Comments within a feedback leaflet completed by a relative stated, 'The home has a homely feel'. However, there was a lack of effective record keeping and robust quality assurance processes to enable the registered manager to have appropriate oversight of the systems and processes used within the home and to ensure people were receiving the care they had a right to expect. These were areas of concern.

People were treated with dignity and respect and their privacy was maintained. There were sufficient numbers of staff to ensure that people's care needs were met. Staff had an understanding of safeguarding and people told us that they felt safe. People had access to external healthcare professionals when they were unwell and relatives' confirmed that they felt confident that people would receive the support if needed. Comments from a relative, on an online care home survey stated, 'My relative's care is always excellent and I know the staff will contact me when needed'. People were cared for by staff that were kind and caring and who knew them well. One person told us, "They're so lovely, so kind to me". Minor complaints that had been received had been dealt with according to the provider's policy.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered manager to take at the back of the full version of the report.

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 home was not consistently safe.

People received their medicines on time. However, there were concerns regarding the management and administration of some medicines.

People's freedom was not unnecessarily restricted. There were risk assessments in place to ensure some people's safety, however these were not always specific to people's individual needs, nor were they always completed sufficiently nor regularly reviewed.

There were sufficient numbers of staff working to ensure that people were safe. Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

Is the service effective?

Requires Improvement

The home was not consistently effective.

There was a lack of formal training and support for staff to enable them to meet people's needs and provide effective care.

People were asked their consent for every day decisions. However, people's consent had not always been assessed and relevant people were not always involved in the decision making process when people lacked the capacity to give their consent.

Most people were supported to eat and drink sufficient quantities to maintain their health. However, some people, who required additional support to maintain their nutrition, had not always received the appropriate support. People had a varied dining experience.

Is the service caring?

Good

The home was caring.

People's privacy was maintained. People were treated with dignity and their independence was promoted.

People were supported by staff that were kind, caring and compassionate. Positive relationships had been developed between people and staff.

People and their relatives' were involved in decisions that affected their lives and care and support needs.

Is the service responsive?

Requires Improvement

The home was not consistently responsive.

People did not always receive person-centred care that met their individual needs.

There was a lack of stimulation and interaction with people and some people were at risk of social isolation.

People had access to a complaints policy, complaints were investigated and the provider took action in response to people's concerns.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

Quality assurance processes did not sufficiently monitor practice to ensure the delivery of high quality care and to drive improvement. Records were not always completed consistently and therefore it was not clear if people's care needs had been sufficiently met.

People and staff were positive about the management and culture of the home.

People were treated as individuals, their opinions and wishes were taken into consideration in relation to the running of the home.

Brockenhurst

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 checked 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 home, and to provide a rating for the home under the Care Act 2014.

The inspection took place on 17 October 2016 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of home. Before the inspection we asked the registered manager to complete a Provider Information Return (PIR). This is a form that asks the registered manager to give some key information about the home, what the home does well and improvements they planned to make. Prior to the inspection we looked at previous inspection reports and notifications that had been submitted. A notification is information about important events which the registered manager is required to tell us about by law. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with two people, two relatives', eight members of staff, a visiting healthcare professional and the registered manager. We reviewed a range of records about people's care and how the service was managed. These included the individual care records for eight people, medicine administration records (MAR), eight staff records, quality assurance audits, incident reports and records relating to the management of the home. Some people had complex ways of communicating and most people had limited verbal communication. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We observed care and support in the communal lounges, dining rooms and in people's own rooms during the day. We also spent time observing the lunchtime experience people had and the administering of medicines.

The service was last inspected in August 2014 and no areas of concern were noted.

Requires Improvement

Is the service safe?

Our findings

People and relatives' told us that people felt safe. When asked why they felt safe one person told us, "I feel looked after". However, observations of practice and of records, raised concerns over people's safety and we found areas of practice that required improvement.

Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines. Some people were supported to have their medication given covertly. People who may not be able to make decisions about their treatment and care may need to be given their medicines without them knowing, for example, hidden in their food or drink. Records showed that the registered manager had ensured that a best interest decision had taken place with the involvement of the person's next of kin or their power of attorney and the GP. There was guidance for staff to follow in relation to the type of medicine that was to be administered covertly and how this was to be administered. Staff told us that this was always used as the last option and attempts were always made to encourage people to take their medicines, however, if they continually refused these then these would be administered covertly to ensure they had access to medicines that maintained their health and well-being.

Observations showed people being supported to take their medicines during and after having their lunch and drinks were available to enable people to take their medication comfortably. Relatives' told us that they were happy with the support that people received with their medicines. People's consent was gained and they were supported to take their medicine in their preferred way. For example, one person wanted staff to place the tablets onto their hand so that they could independently put these into their mouth. However, observations and answers to questions, whilst medicines were being dispensed and administered, raised concerns over the competence of staff. Observations showed one member of staff dispensing medicines. The member of staff demonstrated good practice by ensuring that medicines were dispensed to one person at a time and asked people if they preferred to take their tablet medicines all at once or one at a time. The member of staff also demonstrated patience when assisting people to take their medicines, ensuring that people had time to take these at their own pace. People's right to refuse their medicines was also respected and the member of staff explained that they would return to the person after a period of time to offer the medicines to them. However, most medicines were stored in pre-filled blister packed containers, the member of staff took the blister pack to the person and dispensed these into their own hand before passing these to the person. This did not maintain infection control and was not a dignified way for people to take their medicines.

Each person had a medicine administration record (MAR) which contained information on their medicines as well as any known allergies, these had been completed correctly and confirmed that medicines were administered appropriately and on time. The MAR contained guidance for staff to follow with regards to the administering of certain medicines such as tablets, however, lacked detail in relation to the administering of topical creams or patches. When staff were asked how they knew where to apply patches, that were required to be applied on alternate areas at each application, they explained that they knew people and would remember where they had located a patch on the previous occasion. Not recording the application of patches could potentially mean that patches were not applied to alternate areas.

People had been prescribed medicines that they could take as and when they required them. The National Institute for Health and Care Excellence (NICE) quality standards 'Managing Medicines in Care Homes' recommends that care homes should ensure that a process for administering 'when required' medicines is included in the care homes medicines policy. It states that policies should include clear reasons for giving 'when required' medicine, minimum time between doses if the first dose has not worked, what the medicine is expected to do, how much to give if a variable dose is prescribed, offering the medicines when needed and not just during 'medication rounds' and recording 'when required' medicines in people's care plans. Although the registered manager had a medicines policy, there were no guidelines that related to individual people for staff to follow in relation to 'as and when required' medicines. This was raised with the registered manager and staff who explained that they knew people well and were able to ask them if they required any 'as and when required' medicines or would discuss as a staff team and make a decision. However, one person who was prescribed 'as and when required' medicines to assist them with their anxiety and distress, was unable to indicate to staff when they might require these medicines. Staff told us that they would be able to notice if there were changes in the person's condition and discuss this as a team and a decision would be made as to whether the person required their 'as and when required' medicines. Staff were not provided with clear guidance to follow in relation to 'as and when required' medicines. This meant that people may not have had access to medicines when they needed them or that they may have been administered in an inconsistent way.

Staff had an understanding of positive risk taking, ensuring that people were kept safe whilst not restricting their freedom. One member of staff told us, "We don't stop someone doing something for themselves if they can. We let them go where they like in the home". Our observations confirmed this as people were seen independently walking around the home. Records showed that some risk assessments had been undertaken for people, such as risk assessments in relation to people's skin integrity and risk of developing pressure wounds, mental health, physical health as well as behavioural risk assessments. However, these did not always identify all of the risks. Care plan records for one person contained a pre-admission assessment which described their history of several and serious falls before their admission into the home. A falls risk assessment had been undertaken when they first moved into the home, in 2015, which identified the risk of falls as a medium risk. There were no subsequent reviews of this risk assessment in the person's care plan and the person had continued to experience falls within the home. People had call bells in their rooms, however, observations showed that most call bells were not within people's reach and therefore they had no way of calling for assistance if needed. When the registered manager was asked how people would call for assistance or use their call bells, they told us that due to people's mental capacity they would be unable to understand how to use their call bells, therefore staff undertook regular checks to ensure their safety. However, there were no risk assessments in place to assess the risk of not being able to use a call bell whilst in their room alone and as a result there was no guidance for staff to follow to advise them of how frequently they should undertake checks on people who were in their rooms alone.

There were concerns regarding the administration and recording of medicines and the management of risk to people's safety. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Checks had been undertaken on the environment to ensure it was safe and people had individualised plans to inform staff of how to support them to evacuate the home in the event of an emergency. Accidents and incidents had been recorded in accordance with the provider's policy. However, these had not been analysed or used to inform changes in practice in relation to people's care.

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing identity and security checks had been completed and their employment history

gained, as well as their suitability to work in the health and social care sector. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people.

Staff had an understanding of safeguarding adults and could identify different types of abuse and knew what to do if they witnessed any incidents. There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. A whistleblowing policy enables staff to raises concerns about a wrongdoing in their workplace. One member of staff told us, "I know my manager would do something if there was abuse going on". Another member of staff told us, "I would let you (CQC) know if a manager didn't do something about abuse".

Staffing levels were sufficient to meet people's needs, there were five members of care staff during the morning, three members of care staff during the afternoon as well as a team leader and the registered manager. At night there were three members of care staff. Records showed that this was a consistent level of staffing. The registered manager did not use a formal dependency tool to assess people's needs and identify staffing levels, instead they ensured that there were a set amount of staff to meet people's needs who required support from two members of staff and those that required slightly less assistance. Staff told us that they felt that there was enough staff and that there was a consistent staff team, a majority of whom had worked at the home for a number of years.

Requires Improvement

Is the service effective?

Our findings

People were cared for by experienced staff that knew them well. Relatives' told us that they felt staff were well trained, particularly with regard to dementia care. When asked about the training staff had completed, they told us, "I've done my NVQ (national vocational qualification diploma) Level 3". Another member of staff told us, "The training is very good here and there is plenty of it". However, despite these positive comments we found areas of practice that required improvement.

A majority of staff had worked at the home for many years, some of whom held Diplomas in Health and Social Care and it was clear that they had practical skills to support people and meet their needs. Staff told us that new staff were supported to learn about the provider's policies and procedures as well as people's needs and their competence was assessed before undertaking work on their own. However, training records showed that only three out of twenty care staff had completed induction training. When asked about the formal induction training of staff the registered manager informed us that one member of staff was in the process of completing the Care Certificate as part of their Diploma in Health and Social Care, however there was no evidence that could confirm this. The Care Certificate is a set of standards that social care and health workers can work in accordance with. It is the new minimum standards that can be covered as part of the induction training of new care workers. Within the information the registered manager had submitted, when asked about improvements they planned to make, it stated, 'To introduce a new support matrix for staff to evidence when each member receives a particular support, including training, supervision, attendance at staff meetings and appraisals. To ensure that all staff will have completed the Skills for Care Common Induction or Care Certificate and/or Diploma in Health and Social Care'. This acknowledged that these areas had been recognised as being in need of improvement.

Although staff demonstrated skills in meeting people's needs there was a lack of formal training to ensure that staff's practice was current, up-to-date and that they were working in accordance with best practice guidance. The registered manager explained that they maintained links with external professionals to ensure that best practice was shared with members of the team, such as the falls prevention team and the dementia crisis intervention team. However, we were unable to find evidence within records of their involvement. Two meetings had taken place within the last two months, which guest speakers had been invited to, these had covered safeguarding adults, the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS). However not all staff had attended these. When asked about the lack of formal training the registered manager explained that they had been responsible for training staff and sharing their knowledge but that this was not formally recorded. The registered manager had recognised that this needed to improve and had attended courses to enable them to formally train staff with regard to safeguarding adults. They had also arranged to work with an external training provider to ensure that staff were provided with training that the registered manager felt essential to their roles, however, this was yet to be implemented or embedded in practice. Although staff demonstrated skills and experience when working with people, observations that had raised concerns, such as the lack of practical application of the MCA, lack of effective record keeping, the administration of medicines and some people's poor dining experiences further confirmed that staff would benefit from formal training.

Records of staff training raised further concerns about the lack of training that staff had undertaken. Twenty staff provided care for people, out of this number ten had attended the meetings for safeguarding adults at risk, MCA and DoLS. Eight staff had completed dementia care, infection control and falls prevention training. Two staff had also completed moving and handling training. Records indicated that no staff had completed up-to-date training for courses that were highlighted on the registered manager's training records, such as food hygiene, health and safety and the safe handling of medicines.

Staff told us that they felt well supported and able to seek support and guidance from the registered manager when needed. However, there was a lack of formal support systems for staff. When asked about staff meetings to share information with staff and enable them to voice their views the registered manager informed us that these took place twice a week, one for day staff and another for night staff, however, acknowledged that these were not recorded. There was a lack of formal support for staff. The provider had a supervision policy which stated, 'This home understands clinical supervision to be a formal arrangement which enables each member of staff to discuss their work regularly with another experienced practitioner.' It went on to state, 'The aim of supervision is to improve practice, increase understanding of work related issues, and provide support to care staff, promote personal and professional development and promote quality care'. Records showed that no supervision meetings had taken place. When this was raised with the registered manager they told us, "There is no formal staff supervision. Instead, we do this on an informal basis, it is not recorded and I observe my staff and supervise them in that way". The Social Care Institute for Excellence (SCIE) warns that although this type of informal supervision may enable a supervisor to deal with an immediate need, it may lead them to making rushed decisions and actions. It also warns that there is a danger that this type of supervision means that issues are not recorded and that issues raised within supervisions are not carried forward to the next formal supervision. Staff records contained only one appraisal for staff, despite some working at the home for many years. The SCIE advises that the ultimate goal of providing supervision and appraisal is to improve the outcomes for people. Without having supervisions and appraisals in place there was a risk that performance issues were not addressed and dealt with in a timely and sufficient manner. The failure to ensure staff received appropriate induction, supervision and training was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people had access to sufficient quantities of food and drink and were provided with a degree of choice with regards to what they had to eat and drink. The registered manager did not employ a chef, instead, care staff who were sometimes allocated the role of cook, prepared the meals. There was a menu which was repeated every two weeks, people were provided with a choice of one main meal and could choose other alternatives such as poached eggs, soup or salads. Observations showed people appeared to enjoy their food. One relative told us, "X seems happy with the food here, they enjoy it."

The National Institute for Health and Care Excellence (NICE) guidance for nutrition states that healthcare professionals should ensure that care provides food and fluid of adequate quantity and quality and in an environment that is conducive to eating. There were two dining rooms allowing people who required more assistance to sit in one dining room and the other enabled people with more independence to eat their meals in another. However, observations provided varied opinions in relation to people's dining experience. Staff demonstrated good practice by enabling people to be as independent as possible, offering assistance when this was required. Most staff took time to interact with people and ensure they were enjoying their food. However, the main meal was served to people at midday and observations showed people being assisted to the dining room as early as 11:15am, some people were woken up from sleeping in their chairs to sit at the dining tables, despite their meal not being served until at least 45 minutes later.

The environment was not conducive to a social and relaxed meal time experience. Both dining rooms were

very bare, tables were laid with cutlery and kitchen roll for people to wipe their mouths after eating, however, there were no condiments for people to season or flavour their food and it was not apparent that this was offered to people. One member of staff stood over a person and assisted them with eating, rather than sitting discreetly beside the person. There was little interaction or communication with the person when they ate their meal and the member of staff appeared to offer no explanation of their actions, advise the person of what they were eating, ask if they were ready for some more food or if they were enjoying their meal. This did not create a discreet or pleasant experience for the person and did not show respect for the person's dignity.

The Alzheimer's Society suggest that as dementia progresses eating can become difficult for some people. It states that, 'The environment plays an important part in the eating and drinking experience. A good mealtime experience can have a positive impact on the person's health and well-being'. Within the tips provided to carers, it states, 'Make the environment as appealing to the senses as possible. Familiar sights such as tablecloths, flowers and playing soothing music at mealtimes can all help'. The registered manager was asked about the poor dining experience that some people received. They acknowledged that this might make the experience more pleasant for people who still had a degree of independence, however, for people who were living with dementia that was more profound, they explained that they felt this would not be possible as they would pull items off the table or pour items, such as condiments, into their food. Although observations showed people in the communal areas having regular access to drinks, observations of some people who spent time in their rooms showed people did not have access to drinks other than at dedicated meal or tea times.

The registered manager used an assessment to assess people's risk of malnutrition, known as a Malnutrition Universal Screening Tool (MUST). This had not been completed in its entirety nor had it been regularly reviewed. Each MUST had only recorded the person's weight, it had not been completed to identify if the person had lost or gained weight or if they had been unwell and it had not been totalled to provide an overall score and indication of risk. A risk assessment, in relation to one person's nutrition, had identified that a MUST should be completed each month to monitor the risk to the person. However, records for this person showed that this had only been completed sporadically and sometimes the person had not been weighed for a period of three months, despite the person showing signs of unplanned weight loss during the previous months of being weighed. Records of the person's weight showed that they had lost over eight kilograms within a seven month period. Records also showed that the person's weight had not been recorded since July 2016, despite them losing four kilograms in the previous two months.

When this was raised with the registered manager they explained and were able to show us, records that a conversation with the person's next of kin had taken place within a six month care plan review. They explained that they had also discussed the reduction in the person's appetite with a practice nurse of a local surgery, who had recommended the use of a nutritional supplement. However, this had taken place seven months prior to the person losing the eight kilograms. The National Institute for Health and Care Excellence (NICE) guidance for nutrition states that nutrition support should be considered for people with a low BMI and who have had unintentional weight loss of more than 5% of their body weight over a three-six month period. Records for the person showed that staff had sometimes recorded the person's food and fluid intake in their daily records, however these were not always completed sufficiently and did not enable effective monitoring of the person's daily food and fluid intake. The registered manager confirmed that apart from the initial conversation with the practice nurse, before the person started to lose weight, appropriate actions taken such as the fortifying of all meals to increase the person's calorie intake, an increase in regular snacks or a referral to a dietician or speech and language therapist (SALT) for advice had not taken place.

Not all people were being supported sufficiently by staff to eat and drink sufficient amounts to ensure their

health and well-being was maintained. People were not provided with an appropriate environment that was conducive to a positive dining experience. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment 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). We checked whether the registered manager was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had demonstrated some understanding of this and had submitted DoLS applications for all people and was waiting for authorisations from the local authority.

One person's care plan contained a mental capacity assessment, this had correctly assessed the person's ability to understand information, retain and weigh up the information and communicate their decision. However the mental capacity assessment did not relate to a specific decision and simply assessed the person as not having capacity due to the fact that they were living with dementia and diabetes. The form stated, 'X is vague, unable to make a decision, unable to articulate and lacks capacity'.

Observations identified that some people had bed rails in place. Under the Mental Capacity Act (MCA) 2005 Code of Practice, where people's movement is restricted, this could be seen as restraint. Bed rails are implemented for people's safety but do restrict movement. Records for one person, who we were informed did not use bed rails, contained a policy for their use. This stated, 'Bed sides are put on the beds of residents' we feel are vulnerable and prone to falling out of bed'. This form had been signed by the person's next of kin. However, there were no bed rail risk assessments which considered the risk, how to eliminate the risk or identify that the least restrictive options such as the use of low profile beds or crash mats, had been considered. Therefore it was not evident how this was decided in the person's best interest or was the least restrictive method to use.

Some people were supported to have their medication given covertly. People who may not be able to make decisions about their treatment and care may need to be given their medicines without them knowing, for example, hidden in their food or drink. Records showed that the registered manager had consulted the person's GP and next of kin to ensure a best interest decision was made in relation to administering medicines covertly, however had not assessed the person's mental capacity in relation to this to determine that the person lacked capacity to consent to receiving their medicines covertly.

Although it was clear people were involved in every day decisions and choices, the registered manager informed us that every person lacked capacity to be involved in more significant decisions that related to their care. Records showed that the registered manager had involved people's lasting powers of attorney or next of kin's to make decisions on people's behalves. However, the registered manager had not seen nor held a copy of the lasting power of attorney and therefore was unable to confirm that people involved in decisions affecting people's care had a legal right to make decisions on their behalf.

Care and treatment of people must only be provided with the consent of the relevant person. Decisions for some people had been made by someone who was legally unable to make those decisions and best interest decisions had not always involved the relevant people. As a result people's movement was restricted and

they were provided with medicines and used bed rails without their consent. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's communication needs were assessed and met. Observations of staff's interactions with people showed them adapting their communication style to meet people's needs. People's health needs were assessed and met. People received support from healthcare professionals when required, these included GPs, chiropodists, opticians, dentists and district nurses. Staff told us that they knew people well and were able to recognise any changes in their behaviour or condition if they were unwell to ensure they received appropriate support. Relatives' told us that staff ensured that people had access to medicines or healthcare professionals when they were not well.

Good

Is the service caring?

Our findings

People were cared for by staff that were kind and caring. Observations demonstrated that positive and warm relationships had developed between people and staff. People and relatives' confirmed that staff were kind and caring. One person told us, "They're so lovely, so kind to me". Another person told us, "Yes I feel looked after, I've got everything I need here". When asked if they would recommend the home to others, one relative told us, "Of course". Feedback about the home from an online care home survey, contained comments such as, 'The care my relative receives at Brockenhurst is excellent, when I visit they seem happy, well-fed and have an obvious connection with the staff. The staff make a difficult situation easier' and 'From the start they were treated with dignity and kindness from all the staff, nothing is too much trouble'.

People's dignity was maintained and people were treated with respect. Information held about people was kept confidential as records were stored in locked cabinets and offices to ensure confidentiality was maintained. Observations showed staff respecting people's privacy by discreetly assisting them when they needed support with their personal care needs and knocking on people's doors before entering when people were in their rooms. Several people shared rooms, measures had been taken to ensure their privacy as privacy curtains, that could be closed in-between each person whilst they received support, were available. Two people had adjoining rooms. The home is a large property, consisting of two houses that have been joined together. A door, which was also used as a fire door and therefore was unlocked, joined the two rooms, in each of the houses, together. Observations showed staff using this door as a short-cut to enable them to access either side of the house without them having to continually negotiate the stairs and therefore they had to walk through these two people's rooms to get to the other side of the house. When one person was asked if this worried them, they told us, "Sometimes". When this was raised with the registered manager following the inspection, they explained that they had already taken measures, since the inspection, to address this, as this had been discussed with staff and they had been reminded not to use the rooms to access other parts of the home.

People were cared for by a majority of staff who had worked at the home for many years and who knew their needs well. One member of staff told us, "This is a very caring place. We know the residents' really well". Another member of staff told us, "We are a good team and I think we provide good care". A third member of staff told us, "I think it's very caring here. We try to give people a good life". It was apparent that positive and caring relationships had been developed and people responded well to the interaction they received from staff. There were warm and friendly interactions between people and staff and people told us that they liked the staff and were happy. Observations showed people asking staff for hugs or holding their hands and it was evident that this was something people welcomed and found comforting. One person was rubbing their arms, indicating that they were feeling cold, a member of staff noticed this and was overheard saying, "Are you cold X, would you like me to go and get you a cardigan"? The member of staff then went to the person's room and collected the person's cardigan and assisted the person to put this on. When asked if they were feeling warmer and more comfortable the person confirmed that they were.

People were encouraged to maintain relationships with one another as well as with their family and friends. Observations showed people being introduced to other people they were sharing a dining table with and

staff took time to speak to people who were in the communal areas. People were able to have visitors' to the home and observations showed that they were welcomed. Photographs showed people had enjoyed celebrating their Birthdays' with family and friends' and efforts had been made to ensure people were provided with a party, cake and presents.

People's differences were respected and staff adapted their approach to meet people's needs and preferences. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. Diversity was respected with regards to people's religion and care plan records showed that people were able to maintain their religion if they wanted to and there was a monthly service that people could attend if they wished.

People were involved in every day decisions that affected their lives. Records showed that people and their relatives' had been asked their preferences and wishes when they first moved into the home and that care plans had been reviewed in response to people's and relative's feedback. Relatives' confirmed that they felt involved in the delivery of care to people and could approach staff if they had any questions or queries relating to it or were contacted if there were any changes in people's needs. Feedback about the home from an online care home survey, contained comments such as, 'No worries about my relative's care, it is always excellent and I know the staff will contact me when needed' and 'I live some distance from the home and have always been kept up to date with my relative's condition'.

Resident's meetings did not take place to enable people to share their views about the home. When the registered manager was asked about the lack of resident's meetings, they told us that due to people's cognitive abilities they would not be able to make their views or feelings known within a meeting. Instead people were asked each day and on an individual basis to ensure that they were involved in some decisions that affected them. When people lacked the capacity to be involved in decisions staff made decisions in the person's best interests based on their knowledge of the person before their condition deteriorated or by involving the person's family and friends.

Observations showed most people were asked their opinions and wishes and staff respected people's right to make certain decisions. Staff explained their actions before offering care and support and staff treated them with respect. The registered manager had recognised that people might need additional support to be involved in their care, they had involved people's relatives' when appropriate and explained that if people required the assistance of an advocate then this would be arranged. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

Independence was encouraged. Observations showed some people independently walking around the home, eating their meals and choosing how they spent their time. People were encouraged and able to continue to do things for themselves and records and observations confirmed this.

Requires Improvement

Is the service responsive?

Our findings

People's health and physical needs were assessed. Care plans documented people's choices and preferences. When asked about how they met people's needs, one member of staff told us, "Each person's care is different, we have that in mind". However, despite these positive aspects, we found areas of practice that required improvement.

The Social Care Institute for Excellence (SCIE) recommends that older people should be encouraged to construct daily routines to help improve or maintain their mental well-being and reduce the risk of social isolation. There was an activities timetable and photographs displayed that showed people's involvement in some activities such as daily tasks and enjoying visits from pets. However, there was a lack of stimulation and meaningful activities for people, particularly for those that required assistance, were less independent and who spent time in their rooms. When asked about activities and stimulation provided to people and the fact that there had been no provision of activities throughout the entire day, the registered manager told us, "Usually today we would have had activities, however, the staff have been busy with other things today, if you come back tomorrow we will have a piano player here". The Alzheimer's Society states that taking part in activities based on the interests and abilities of the person can significantly increase their well-being and quality of life.

Observations showed people spending their time sitting in their armchairs, sleeping, walking around the home and appearing to look for things to do. There was a lack of assessments to meet people's specific needs. For example, several people spent their days in their rooms, either in their beds or sitting in arm chairs and as a result were at risk of social isolation. The registered manager had not identified that this posed a risk to people and there were no records in place to assess the risk of social isolation nor to identify possible ways of reducing this risk. Observations raised further concerns regarding people's ability to summon for assistance, three people were observed to be calling out numerous times throughout the day. One person was observed calling, "Help", "Hello", "Where am I" and "I don't know where I am". The person remained in a state of apparent anxiety and calling for assistance for some time, a member of the inspection team went into the person's room and although the person was unable to verbally communicate their needs, appeared calmer and less anxious when someone was present, therefore showing that the person responded well to interaction with others.

Observations showed people spending extended periods of time, alone in their rooms, or other areas of the home with minimal interaction from staff, other than to provide personal care or to provide food and drink. Some people had radios or televisions in their rooms and the registered manager explained that people would usually have one to one support from staff such as having their nails painted, painting and looking at books, however there was no evidence in people's daily records to show that this had taken place.

Care plans contained information about people's physical and mental health. Some people's care plans contained detailed life history, informing staff of people's lives before they moved into the home and before their condition had deteriorated, therefore providing staff with useful information that enabled them to build meaningful relationships with people. Assessments for people's specific needs, such as mobility and

moving and handling had been completed. Records showed that people's relatives' or next of kin's were involved in a care plan review a month after people had been admitted into the home and then every six months thereafter, to enable them to have an input into the care people received. However, reviews for people who did not have family involvement and of the original assessments that had been completed had not taken place regularly, records showed that some reviews of assessments had not taken place for 17 months after the original assessment. When reviews had taken place they lacked detail and did not always advise staff of the changes in people's needs in sufficient detail to enable staff to have an understanding of what support the person needed to meet their needs. For example, one person's behavioural assessment stated, 'X does not communicate verbally, will sometimes shout and scream and sometimes becomes aggressive for no reason'. Records did not show that attempts had been made to determine why the person became distressed not did it identify possible triggers for this behaviour. There was no guidance for staff to follow as to how they could support the person during their times of distress and anxiety and therefore de-escalate the situations, which could keep people and staff safe.

The lack of meaningful activities, interaction and one to one time with staff, increased risk of social isolation, the failure to identify person-centred information and changes in people's needs, through the review process, were areas of concern. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to make choices in their everyday life and their individuality was respected. Observations showed staff respecting people's wishes with regards to what clothes they wanted to wear, what they chose to do with their time, what they had to eat and drink and what they needed support with. People's rooms were furnished according to their tastes, preferences and individuality and they were able to display their own ornaments and photographs.

There was a complaints policy in place. Minor complaints that had been made had been dealt with appropriately and according to the provider's policy. The registered manager encouraged feedback from people and their relatives. Leaflets requesting feedback were displayed and had been sent to people's relatives' to gain their feedback.

Requires Improvement

Is the service well-led?

Our findings

People, relatives', a visiting healthcare professional and staff were complimentary about the leadership and management of the home. They told us that the registered manager was approachable and friendly. One member of staff told us, "The manager is great, they're very hands on and you can always speak with them". Another member of staff told us, "I think it's well-led, everybody knows what's expected of them and we work well together". Feedback about the home from an online care home survey, contained a comment from a relative which stated, 'Matron is the most professional and caring person. She actually cares for and knows each and every one of her residents' and she leads a magnificent team'. However, despite these positive comments, we found areas of practice that required improvement.

A range of quality assurance audits should take place within a home to ensure that the systems and processes used are effective, this also helps to identify areas of practice that need to improve and drives change. Some quality assurance processes and audits were completed every month by staff, these related to health and safety and an audit on the amount of deaths that had occurred. However, not all the audits were effective, or documented. Staff explained that some of the audits conducted were visual checks and that these were not recorded. There was a lack of robust quality assurance systems and processes and there were concerns with regards to the lack of effective quality monitoring for the range of systems and processes used within the home. This included the observation and monitoring of staff practice with regards to ensuring people were not socially isolated and had access to stimulation, the auditing of care plans which might have highlighted the lack of information in people's assessments, reviews and records and the insufficient monitoring of people's weights which could have resulted in people receiving inconsistent care and a poor quality service. The registered manager had recognised that this was an area of practice that needed to improve and had sought guidance from a consultant as well as employing a member of staff to ensure records were up-to-date and effective. Measures had already been taken to improve the quality assurance processes. Feedback leaflets had been sent to people's relatives' to gain their feedback and audits for the monitoring of accidents and incidents as well as medicines had been devised but were yet to be fully implemented or embedded in practice.

Records, in relation to people's care and treatment, were not always consistently maintained. For example, in addition to the lack of information in people's assessments and reviews, other records, such as daily records documenting people's moving and positioning had not been consistently maintained. One person's daily record, who was required to be repositioned every two hours, showed that the person had only been repositioned during the night. According to the records the person had not been supported to reposition throughout the day. Observations raised further concerns regarding this as the person was observed to be in the same position throughout the day. When this was raised with the registered manager they explained that staff would have repositioned the person and the person may have themselves rolled onto their back. However a falls risk assessment for the person stated 'X is now bed ridden, they do not move, two hourly turns needed'.

When the lack of stimulation or interaction for some people who spent time in their room was raised with the registered manager, they told us that people were often visited by staff that sat with them and engaged

in activities with them. However, care records did not show any record of the interaction. This, as well as the lack of recording in relation to regular turns, raised concerns regarding the care people received as it was hard to establish if people had received the necessary care or if staff had forgotten to accurately record their actions in people's records. This was raised with the registered manager who explained that they would ensure that staff accurately recorded their actions when offering support to people.

There was a lack of effective quality monitoring systems as well as a lack of maintenance of records relating to the care and treatment of people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team consisted of the registered manager and team leaders. When the registered manager was asked about their ethos and philosophy, they told us, "To maintain a safe, caring environment which is well-led. We have outstanding characteristics, of which I think there are several. We have referrals from other homes for people to come to us and we also like to give people as much freedom as possible". When people and relatives' were asked about the culture of the home, one relative told us, "There is a nice atmosphere here".

The home was the only home owned by the provider. To assist them to keep up-to-date with best practice they maintained contact with a network of home owners and also participated in local manager forums with the local authority. The registered manager also undertook continuing professional development to ensure their skills and knowledge were maintained and had sought advice from a consultant, who, we were informed, worked on a freelance basis with them, to ensure that the registered manager and the staff were advised appropriately and kept up to date with best practice and changes in legislation and guidance. The registered manager was aware of the implementation of the Duty of Candour CQC regulation and had a policy in place providing guidance to staff. (The intention of this regulation is to ensure that providers' are open and transparent with people who use services and other 'relevant persons'.) Records of reviews showed that this was also implemented in practice, people's relatives' had been informed of changes in people's needs and care requirements. The manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had not ensured that the care and treatment of service users was appropriate, met their needs or reflected their preferences. They had not carried out collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had not ensured that suitable arrangements were in place for obtaining and acting in accordance with the consent of service users or establishing and acting in accordance with the best interests of the service user in line with Section 4 of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured that suitable arrangements were in place for ensuring that care and treatment was provided in a safe way, had not effectively assessed or mitigated the risks to service users and had not ensured the proper and safe management of medicines.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered person had not ensured that the nutritional and hydration needs of service users was met, they did not ensure that service users were in receipt of suitable and nutritious food and hydration which is adequate to sustain life and good health.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured that systems and processes were established and operated effectively to: Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). Maintain securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not ensured that there were: Sufficient numbers of suitably qualified, competent, skilled and experienced people or that staff had received appropriate support, training professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.