Tuella Limited

Brookdale House Care Home

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?	**Requires Improvement**

Summary of findings

Overall summary

Brookdale House is owned by Tuella Limited who, throughout this report, are referred to as the provider. Tuella Limited purchased the service in September 2016. The home is located in a residential area close to local amenities in Chandlers Ford. It can accommodate up to 22 people. On the ground floor there is a kitchen, a dining area and three separate lounge areas of varying sizes. The laundry and office are situated on the first floor. The accommodation is arranged over both of these floors with a stair lift available to access the upper floor. Three of the rooms were currently arranged as shared rooms. To the rear of the service there is currently a self-contained bungalow that was used as living accommodation by the previous provider. The new provider has plans to redevelop this building into an extension containing an additional 11 rooms, a lounge, quiet room, ground floor bathroom and platform lift. There is a mature garden to the rear with seating areas. The home does not provide nursing care. There were 18 people living in the home when we inspected, some of whom were living with dementia.

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

Improvements were needed to the governance arrangements within the service. There was a no robust programme of audit to assess and monitor the quality and safety of the service. The registered manager did not have an accurate oversight of events affecting the safety and wellbeing of people within the service.

Risks to people's safety had not always been identified and addressed. Incidents and accidents had not always been reviewed to identify trends and minimise the risk of reoccurrence.

Some aspects of medicines management required improvement.

The registered manager had failed to notify the local authority and CQC of a number of safeguarding incidents which had occurred within the service.

Consent had not always been sought in line with the requirements of the Mental Capacity. Relevant applications for a deprivation of liberty safeguard (DoLS) authorisation had been submitted by the home and had either been authorised or were waiting to be assessed by the local authority.

People told us the food was tasty and that there was sufficient choice. Where people required a modified diet, this was provided and presented in an attractive manner. However, records did not reflect that people were being offered regular fluids. Tools used to monitor people's nutritional needs were not yet being used effectively.

Aspects of the home's décor and furnishings needed to be updated or replaced and cleaning arrangements

were not always effective. The premises had not been designed or adapted for the needs of people living with dementia. The provider had plans to refurbish the premises and it was anticipated that this would start in November 2017.

There were sufficient numbers of experienced staff to meet people's needs. Staff were provided with an induction, regular supervision and training opportunities but had not received an appraisal.

Where necessary a range of healthcare professionals had been involved in planning and monitoring people's health and wellbeing support to ensure this was delivered effectively.

People were cared for by staff who were kind, caring and attentive. The atmosphere in the communal areas was good natured and people looked relaxed and happy in the company of the staff.

Overall, staff were observed to provide care in a manner that was mindful of people's privacy and dignity.

People had care plans which provided guidance for staff although these were not always updated to reflect changes in people's needs. People received care and support which suited their needs and wishes. Overall, staff were generally well informed about people's needs and how to meet these.

People and their relatives were positive about the activities provided and were encouraged to follow their interests and hobbies.

People knew how to raise concerns or complaints and records showed that complaints were dealt with appropriately.

The registered manager took an active role within the home, delivering care and serving as a role model to the staff team through their hands on approach.

We found four breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider 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 service was not always safe.

Risks had not been adequately assessed and planned for. The risk reduction measures in place were not being fully effective at ensuring that risks to people were minimised.

The registered manager had not ensured that potential safeguarding concerns were escalated to the local authority safeguarding teams.

Some areas of the home needed to be cleaner. Cleaning schedules had not always completed or were not available for the inspection team to see.

Overall medicines were managed safely, but there were some areas where improvements were required. We have made a recommendation about this.

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

Is the service effective?

Requires Improvement

The service was not always effective.

Consent had not always been sought in line with the requirements of the Mental Capacity Act 2005. Relevant applications for a deprivation of liberty safeguard authorisation had been submitted.

People told us the food was tasty and that there was sufficient choice. Whilst our observations indicated that people were being offered regular fluids, the records did not always reflect this.

Aspects of the home's décor and furnishings needed to be updated or replaced. The premises had not been designed or adapted for the needs of people living with dementia. The provider had plans to refurbish the premises and it was anticipated that this would start in November 2017.

Staff were supported through a structured induction, regular

supervision and training opportunities but had not received an appraisal.

Where necessary a range of healthcare professionals had been involved in planning and monitoring people's support to ensure this was delivered.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind, caring and attentive. The atmosphere in the communal areas was good natured and people looked relaxed and happy in the company of the staff

Overall staff were observed to provide care in a manner that was mindful of people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People received care and support which suited their needs and wishes. Overall staff were generally well informed about people's needs and how to meet these.

People and their relatives were positive about the activities provided.

People knew how to raise concerns or complaints and records showed that complaints were dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

Improvements were needed to the governance arrangements within the service. There was a no robust programme of audit to assess and monitor the quality and safety of the service. The registered manager did not have an accurate oversight of events affecting the safety and wellbeing of people within the service.

The registered manager had failed to notify the CQC of a number of safeguarding incidents which had occurred within the service.

The registered manager demonstrated a good knowledge of all aspects of the home including the needs of people living there and the staff team. They took an active role within the home,

delivering care and serving as a role model to the staff team through their hands on approach.

Brookdale House Care Home

Detailed findings

Background to this inspection

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

The inspection took place on the 2 and 3 October 2017 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 care service.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is used by registered managers to tell us about important issues and events which have happened within the service. We used this information to help us decide what areas to focus on during our inspection.

Some people were not able to speak with us and share their views about the care and support they received; however, we spent time observing interactions between people and the staff supporting them. We were able to speak with 10 people who used the service and three relatives. We also spoke with the registered manager, the registered provider, the provider's quality lead, four care staff, two maintenance staff and one member of the housekeeping staff. We reviewed the care records of six people in detail and the recruitment records for four staff. We also reviewed the medicines administration record (MAR) for all 18 people. Other records relating the management of the service such as audits, meeting minutes and policies and procedures were also viewed. Following the inspection we sought feedback from four health and social care professionals.

This is the first inspection of this service under the provider Tuella Limited.

Requires Improvement

Is the service safe?

Our findings

Whilst people told us they felt safe living at Brookdale House, we found some improvements were needed.

Care plans included basic risk assessments which detailed how risks associated with poor mobility, nutrition or poor skin integrity were to be managed. However, not all risks had been adequately assessed and planned for. For example, people administering their own medicines did not have risk assessments in relation to this. Bed rail risk assessments were not currently in place and there was no risk assessment in place to identify any potential risks to people from using or accessing the stairs independently. People who had been assessed as having difficulty swallowing did not have choking risk assessments. The falls care plans viewed were mainly generic and were not adequately personalised. They did not reflect people's specific risks. For example, one person had fallen four times in two months. All of these falls were whilst alone in their bedroom, but their falls care plan made no reference to this. The falls care plan for another person focused on their risk of falling when mobilising but did not identify they were also at risk of falling from their chair or describe how this risk might be managed. Following falls, including those resulting in head injuries, post falls protocols were not being followed. These protocols ensure that people are appropriately monitored following falls in case their condition deteriorates allowing medical advice to be sought. Records showed that one person had managed to leave the building unnoticed for a short period of time. However, following this incident, the registered manager had not ensured that an absconding risk assessment had been put in place. Following our inspection, the registered manager has told us they have taken action to either put in place or update relevant risk assessments.

The risk reduction measures in place were not being fully effective at ensuring that risks to people were minimised. A person had previously gained access to the kitchen and to equipment with which they might have harmed themselves or others. Following this incident, arrangements were put in place to put a key coded lock on the kitchen door and the person's care plan updated to state that the kitchen door should be kept locked at all times. However, on one occasion, we found the kitchen door open with no staff inside. Another person's care plan stated that they required 'pureed food and thickened fluids', however, a staff member gave them cheese on toast to eat. This was not in keeping with their dietary needs and placed them at risk of choking. Staff were not always aware which people were subject to a deprivation of liberty safeguard authorisation (DoLS). For example, staff told us one person was free to leave the building when they wished. This person was subject to a DoLS. This could have placed them at risk of harm.

The registered persons had not assessed all of the risks to people using the service, or done all that was reasonably practicable to mitigate these risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

A review of one person's care records found that there had been three incidents which raised potential safeguarding concerns but these had not been escalated to the local authority safeguarding teams. Escalating concerns is important as it helps to ensure that the relevant agencies have oversight of potential risks within the service. The registered manager has, since the inspection, discussed the incidents with the local safeguarding team and agreed a plan for how they will escalate similar concerns in the future.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

Safeguarding people from abuse or harm was discussed at staff interviews and there were posters around the service reminding staff and others of their responsibility to protect people from harm. These posters included the contact numbers for the local agencies responsible for investigating safeguarding concerns. Whilst staff had a positive attitude to reporting concerns to the registered manager, some still lacked confidence in describing the potential signs of abuse and neglect. The more senior staff understood what was meant by the term whistleblowing and told us they would not hesitate to report any concerns. Newer, less experienced staff were more uncertain about what this meant in practice and which agencies they could contact with their concerns if necessary.

Overall recruitment practices were safe and relevant checks had been completed before staff worked unsupervised. These included identity checks, obtaining appropriate references and Disclosure and Barring Service checks. These measures helped to ensure that only suitable staff were employed to support people in their homes. The registered manager had not, however, always recorded their rationale or completed a risk assessment for the employment of staff where they had disclosed previous cautions or convictions.

Staff were provided with a range of equipment to help ensure good infection control such as gloves and aprons and we observed that they were using this personal protective equipment effectively and followed good infection control practices. However, some improvements were needed. No cleaning staff were currently employed to cover weekends, although a post was being advertised. Cleaning schedules had not always been completed or were not available for the inspection team to see. Some areas of the home were not clean. We found food debris on the floor in two people's rooms, cobwebs on windows and the ensuite toilet of an empty room had dried faeces on the seat.

Checks were undertaken of the fire and water safety within the service and of the safety of equipment used for lifting, such as hoists and the stair lift. An assessment of the electrical installations within the service had recently resulted in an unsatisfactory rating, and action was being taken to address this within the next week. We have asked the registered manager to confirm that this has been completed. Whilst people had personal emergency evacuation plans (PEEPS) in place which detailed the assistance they would require for safe evacuation of their home, we noted that some of these could be more detailed and more accurately reflect people's current needs. A business continuity plan was in place and set out the arrangements for ensuring the service was maintained in light of foreseeable emergencies or challenges.

Suitable arrangements were in place for ordering medicines and relevant checks were made to ensure that these were supplied correctly. People had an individual medicines administration record (MAR) which included their photograph, date of birth and information about any allergies they might have. We observed staff undertaking a medicines round. They assisted people with their medicines in a person centred manner. The temperature of areas used for storing medicines was being effectively monitored.

We carried out a stock check of controlled drugs. Controlled drugs (CD's) are medicines which are controlled under the Misuse of Drugs Act 1971 and which require special storage, recording and administration procedures. The CD register tallied with the medicines being stored in the CD safe. Staff responsible for the administration of people's medicines had received training from the local pharmacy in how to do this safely and their competency to administer medicines was being checked on a regular basis by the registered manager. The deputy manager had recently started to complete medicines audits to assist with quality improvement.

However, we found some areas where improvements were required. We found two sets of eye drops in the fridge that had not been marked with the date they were opened. This is important as it helps to ensure the medicines are only used within their shelf life. Medicines should be stored securely with only authorised care home staff having access to these. Medicines awaiting disposal were not stored in tamper proof containers and were currently stored in the cellar. The door to the cellar was locked but the key was accessible to all staff. The deputy manager took steps to rectify this during the inspection. Some people had been prescribed 'as required' or 'PRN' medicines; however there were no personalised protocols in place to guide staff as to when a person may need these medicines. PRN protocols also help to ensure that staff administer as required medicines in a responsive and consistent manner.

We recommend that the registered manager ensure that the systems in place for the administration, storage and disposal of medicines reflect current best practice guidance.

Overall there were sufficient numbers of staff deployed to meet people's needs. In addition to the registered manager, daytime shifts were currently staffed by three care workers, one of whom was a senior care worker. There were two waking care staff on duty at night. We reviewed the staffing rotas for a four week period and found that the service had been staffed to these target levels. Rotas also showed that care was provided by a small and consistent staff team which helped to ensure that people were cared for by staff who knew them and their needs well.

A number of ancillary staff were also employed including a cook, a maintenance person and a housekeeper. The service did not employ staff specifically to oversee the laundry or to provide activities or entertainment and this remained the responsibility of the care staff. People did not raise any concerns with us about staffing levels. One person said, "I think there are enough staff and they are really good. Sometimes they are busy but I never have to wait long". A relative told us, "I feel there are enough staff because there are always two people for her personal care, Mum is happy here". This was echoed by a second relative who said, "I feel there are enough staff whenever I have been here". Some staff felt that shifts could be very busy if there were new staff on duty, for example, or at weekends when the registered manager was not working. However, we observed that staff were able to provide support to people in an attentive and timely manner and were able to carry out their role and responsibilities effectively.

Requires Improvement

Is the service effective?

Our findings

People told us they were happy with the care they received at Brookdale House. This was echoed by the relatives we spoke with who told us, "Since coming here, [the person] is a changed woman, she is getting up and joining in and eating proper meals" and "[family member] is happy here, settled". A health care professional told us, "Yes I feel that [staff] have the sills they require and are happy to take on new learning when this is offered".

People were supported by the care staff to have choice and control of their daily lives. Staff encouraged people to make choices about everyday decisions such as how they would like to take their medicines or what they would like to eat for their lunch. Care plans demonstrated an understanding of the importance of care staff involving people in decisions. For example, we saw that staff were asked to 'show [the person] a choice of two or three garments' so that they be involved in deciding what to wear. Where able, people had signed consent forms giving permission to have photographs taken to keep in their care records for identity purposes.

However, improvements were needed to ensure that the principles of the Mental Capacity Act (MCA) 2005 were being fully implemented. The Mental Capacity Act 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.

Two people were receiving covert medicines. Covert administration of medicines is the term used when medicines are administered in a disguised format such as in food or drink without the knowledge or consent of the person receiving them. Covert administration should only be used as a last resort and would only be appropriate where a person has been assessed as not having the capacity to understand the consequences of their refusal and the medicine is deemed essential to the person's health and wellbeing. We looked at the records for the two people receiving their medicines covertly. There was evidence that a consultation with a prescriber and a family member had determined that the covert administration was felt to be in the person's best interests. However, we were unable to see that an assessment of the person's capacity to understand the consequences of refusing their medicines had first been carried out. This was of concern as in the case of one of these people, their care plans did not indicate any concerns about their ability to understand and consent to receiving medicines. Their consent plan said they were 'presumed to have capacity' and their mental capacity care plan said they lacked capacity to understand the risks of living in their own home, but had capacity in' all other areas of their daily routine'. We also could not see any evidence that the continued need for covert administration of medicines and the person's capacity to consent was being regularly reviewed. We discussed this with the registered manager. They have agreed to review the documentation relating to the use of covert administration of medicines to check that all relevant assessments have been undertaken to ensure that people's rights are being protected.

A number of people had mental capacity care plans within which it stated that the person had been deemed

to not have capacity to understand the risks about where they lived or the care that they received. However, in a number of the records viewed we were unable to see that, decision specific, mental capacity assessments or best interest's consultations had been undertaken to determine this. The registered manager told us they did not undertake mental capacity assessments to identify if a person using the service was able to make decisions about their care and support. They told us they would seek the relevant assessments from community health and social care professionals. However, we were unable to see that these were in place. Where the decision to be made relates to the delivery of care and support being provided by the care home, it would be appropriate for the registered manager or their staff to assess the person's capacity as long as they had undertaken the relevant training. This helps to ensure that the mental capacity assessments are undertaken by staff with relevant knowledge of the person, the care to be provided and enables the mental capacity assessment to be regularly reviewed.

We recommend that the registered manager ensures they are following best practice principles regarding the use of covert medicines and the assessment and documentation of mental capacity assessments.

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). Relevant applications for a DoLS had been submitted by the home and had either been authorised or were waiting to be assessed by the local authority.

The provider employed a full time maintenance person who carried out repairs promptly within the service and people told us that Brookdale House provided a comfortable and homely environment. However we found that many aspects of the home's décor and furnishings needed to be updated or replaced. Some of the carpets were stained and there were odours of stale urine in many areas of the home. Many items of furniture were old and worn and would benefit from being replaced. There was a general lack of storage meaning that hoists and wheelchairs were stored in lounges and corridors. The premises had not been designed or adapted for the needs of people living with dementia. This is important as it helps to create a supportive and enabling environment that helps people maintain their independence. Signage directing people to toilets was poor. People were encouraged and enabled to access the gardens for walks or to smoke, however, we found that there were a number of uneven paving stones which could cause a trip hazard. The smoking shelter was in a poor state of repair and it wooden floor was weak in places. Staff were required to work in areas which were unsuitable. Some medicines were kept in a cellar that staff needed to access via a steep set of steps. Once down in the cellar they were not able to stand up due to the low ceiling.

The provider recognised that the environment needed to be upgraded and there were plans in place to build an extension. It was anticipated that this work would start in November 2017 and be completed by the Spring of 2018. Work would then continue with adapting and refurbishing the main building. In the meantime, it was evident that the provider continued to invest in the service and was refurbishing rooms as they became vacant installing new flooring and bathrooms. Where people required additional equipment to meet their needs, this had also been purchased. For example, a number of profiling beds had been bought. A new call bell system was being installed the day after our inspection and would provide more flexibility for people to seek assistance when required. The provider was working with the Alzheimer's Society who were due to undertake an audit within the home in October 2017 to look at how the service, might be made more suitable for people living with dementia.

People told us the food was tasty and that there was sufficient choice. One person said, "The food is good…I had two boiled eggs for breakfast". Another person said, "They make lovely homemade soup here, yesterday I had lamb, tomorrow I am having gammon and I often get fish". A relative told us, "Mum has three good meals a day", whilst another said, "My mother eats and drinks well". Breakfast was either a variety of cereals

or porridge and toast or a cooked breakfast which we observed a number of people enjoying. People were given a choice between two main meals at lunchtime, or could also ask for an alternative if they wished. On one of the days we visited, one person had both of the lunch options which they told us they enjoyed. We observed lunch. It was a quiet but pleasant experience for people. Tables were laid with clothes, place mats and condiments were available. One care worker ate their own lunch alongside a person who needed some encouragement to eat. They chatted to the person about their own family life. Staff also chatted to people about the planned entertainment for the afternoon which helped to create a positive atmosphere. Where people required a modified diet, this was provided and presented in an attractive manner, with, for example, all the elements of a pureed meal served separately so that the person might still be able to taste the individual flavours. Tea or coffee was served following lunch either in the dining room or in the lounge. Supper was soup, sandwiches or a light meal such as cheese on toast.

We were concerned, however, that people's food wishes or requests might not always be responded to. We did note that in the afternoon, a person asked for some cake with their cup of coffee. The care worker responded by saying that there was only coffee and biscuits. The provider, who was visiting, overheard this and said they would fetch some cake from the kitchen which they returned with. This was shared with whoever wanted some.

A water and juice dispenser was available in the lounge and we saw staff offering regular cold and hot drinks throughout the day along with fresh fruit. Whilst our observations indicated that people were being offered regular fluids, the records did not always evidence this. For example, a sample of fluid charts were viewed. The charts regularly contained no record of people being offered fluids following their evening meal at 5pm, until breakfast time the next day. The registered manager was confident that this would be a recording issue and that people would have been offered regular fluids and that fluid intake was monitored carefully by staff. This would be in keeping with our observations of handover, during which staff were seen to share information of concern about people's food or fluid intake. We have discussed with the registered manager the importance of ensuring that people's records fully reflect the fluids they are offered.

Staff were aware of which people were not eating well and healthcare professionals had been consulted when there were concerns that people may be at risk of malnutrition. However, the records used to monitor people's nutritional needs were not being used effectively. People were routinely weighed on a monthly basis, but these records were sometimes recorded in kilograms and sometimes in stones and pounds. This made comparisons difficult. Where people had lost weight, it was evident that staff had considered whether it might be appropriate to increase the frequency with which people were being weighed. The registered manager told us that the electronic care planning system was shortly to be enhanced and would be providing alerts on each staff member's smart phone if a person's fluid or food intake was low. The service was also introducing a nationally recognised tool to monitor people's risk of malnutrition.

New staff received a service based induction which involved learning about the care philosophy within the home, people's needs, daily routines and key policies. New staff also spent time shadowing more experienced staff. Some new staff had completed the Care Certificate. This was introduced in April 2015 and sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. The registered manager told us that new staff would instead, now complete the provider's new online training programme which was delivered in line with the Care Certificate standards. This training programme was implemented in August 2017 and is completed via an App staff have on their smart phones. This provides them with flexibility about when and where they completed the training. The training covers a variety of areas such as moving and handling, the MCA 2005, safeguarding, fire training, food hygiene, infection control and first aid. The training also covers training relevant to the needs of people using the service such as caring for people living with dementia, end of life care and pressure ulcer

prevention. It will be a requirement that staff repeat the training on an annual basis. Records showed that the majority of staff had completed the new training and where necessary, the registered manager was taking action to ensure that the remaining training was fully completed by the end of October 2017. Despite completing training, our discussions with staff showed variable understanding of the MCA 2005 and of the DoLS. We recommend that the registered manager review the training provided on the MCA 2005 to ensure this enables staff to fulfil the requirements of their role.

Staff told us they felt well supported in their role and were able to seek guidance from the registered manager or the deputy manager when this was needed. Records showed that staff received formal supervision periodically but had not received an appraisal of their performance. Supervision and appraisals are important tools which provide an opportunity for staff to discuss matters relating to the needs of people using the service and develop their own skills and knowledge. It also provides managers with reassurances that staff have the required skills and knowledge to perform their role effectively.

We recommend that action is taken to provide each staff member with an appraisal so that any training, learning and development needs can be identified, planned for and supported.

Where necessary a range of healthcare professionals had been involved in planning and monitoring people's health and wellbeing support to ensure this was delivered effectively. People had regular visits from their GP and from other healthcare professionals such as community nurses, chiropodists and opticians. Staff had arranged referrals to incontinence specialists and speech and language therapists in order to review people's healthcare needs. Whilst we found concerns regarding the lack of monitoring after someone had a fall, the registered manager was taking action to develop links with local healthcare professionals to look at implementing post falls huddles. These are a debriefing following a fall to see if any preventative actions might have been possible. The registered manager told us they were also hoping in the future to implement a specialist tool called the national early warning score (NEWS) within the service. This is a way of staff monitoring a range of vital signs to detect acute deterioration in a person's health so that they seek prompt escalation of their care to relevant healthcare professionals.

Good

Is the service caring?

Our findings

People told us that they were cared for staff who were kind, caring and attentive. One person said, "It's really good here….I know everyone". Our observations indicated that staff showed people kindness, patience and respect and offered people lots of praise and gentle encouragement.

We saw a number of friendly exchanges between staff and people. For example we saw one person and their care worker joking about their drink having 'bones in it' as it had caused them to cough. Following the interaction, the person stroked the care workers face fondly. People interacted well with the care workers, so much so there was a sense that they did not recognise them as staff, but more as friends.

Throughout our visit, the atmosphere in the communal areas was good natured and people looked relaxed and happy in the company of the staff who, when needed, provided comfort and reassurance to people by, for example, holding their hands and stroking their arms. Staff spoke fondly about the people they supported and it was clear they had developed a good relationship with each person and supported them in a kind and caring manner. One care worker told us, "I love working here, I would move in if I could".

Staff encouraged people to care about and respect one another also. This was reflected in a number of observations. When one person fell, another person was very concerned for their wellbeing. Staff talked to the person and explained what was happening and how they were making sure the person who had fallen was ok. This appeared to reassure them. We saw two people eating their evening meal together. One person placed their arm around the person sat next to them and encouraged them to eat a little more.

People told us their choices were respected and this was confirmed by the staff we spoke with. People were asked whether they would like the television on, and when this was declined the care worker tried to seek a consensus decision on the type of music people would prefer. Staff encouraged people to remain independent and get involved in daily chores such as laying the tables. Another person was observed to be helping the maintenance person in the garden. There was evidence that staff kept relatives informed about their family members wellbeing and the registered manager told us plans were in place to shortly enhance the electronic care planning system. This would allow family members to use their own smart phones to access their family member's real time care records to stay informed and involved in the provision of their care. This would be after relevant consent had been obtained.

Overall staff were observed to provide care in a manner that was mindful of people's privacy and dignity. For example, staff told us how they used the screens in the shared rooms for privacy and always knocked on people's doors before entering. We observed staff using a screen to protect a person's dignity when hoisting them into a chair in the communal areas. Staff quickly fetched a blanket to cover up one person's catheter. However, we also saw that staff had left an incontinence pad, ready to be used, hanging over a person's bedside chair in full view of people or visitors passing by. This was not dignified for the person. We pointed this out the registered manager who removed the pad.

People were supported to maintain their faith. There were regular church services in the home which people

were supported to attend if they wished to. The development of end of life care plans was a work in progress and the registered manager was aware that this was an area which needed to be developed.

Good

Is the service responsive?

Our findings

People, their relatives agreed that the service provided care that was responsive to people's individual needs. A social care professional told us, "They [Brookdale House] are absolutely brilliant at tailoring care to individual's needs". A healthcare professional told us, "The staff appear to be very caring when I have observed them within the home. they seem to have a good understanding of each resident".

People needs were assessed before they came to live at the service to ensure that the staff would be able to meet their needs safely. Following their admission, a care plan was developed which included information about the person's needs and how these should be met. This helped to ensure people received care and support which suited their needs and wishes. Most of the care plans viewed contained some information about the person's life before coming to live at the service and some specific, individual information, about the person such as their preferred routines including when they preferred to get up or go to bed. Care plans referred to the need for staff to be mindful of people's dignity, their choices and independence and they were written in a sensitive and respectful manner. Our observations indicated that staff acted in a manner that was in keeping with the ethos of the care plans and documents.

The care plans were now created and accessed via an electronic system. Staff used smart phones to read people's care plans which covered areas such as how the person communicated, their personal care needs, the support they needed with nutrition, their medicines and with their mobility. Where people were living with specific health conditions such as dementia or diabetes, basic plans were in place to guide staff on how to meet their needs. One person had detailed moving and handling guidance including pictures displayed in their room.

Whilst the care plans viewed generally reflected people's current needs, there was some scope for further improvement. For example, two people who could display behaviour which might challenge others did not contain a care plan which described the strategies and interventions staff should follow when responding to the incidents of agitation. Some moving and handling assessments did not reflect the complexity of people's needs. We found two examples where the care plan contained information about the wrong person.

Staff were able to use their smart phones to record contemporaneous updates to people's care records. The system enabled staff to easily record when personal care had taken place or how much someone had eaten or drank. In addition a detailed handover was held at the start of each shift which helped to ensure staff were kept up to date with people's changing health and welfare needs. Detailed notes were kept to record the outcome of consultations with health care professionals and there was evidence that their advice was being followed.

Overall, people and their relatives were positive about the activities provided. Two care staff were allocated six hours between them each week to provide activities and entertainment. In addition a small number of outside entertainers also visited the home. During the inspection, we saw people enjoying a game of giant skittles and enjoying a sing song led by staff who were encouraging people to do solos and join in the songs

or to dance. We noted that one person who had been anxious throughout the morning when spending time in their room, was persuaded by staff to join in this activity and appeared to really enjoy this. The activity was successful in distracting the person from their worries and anxieties.

People were free to take walks in the garden or to use a shelter in the garden for smoking. One person told us, "I go to the local shops and bring back whatever I want". Another person told us, "I do some exercises and I do singing with the other residents and there is also a church service every week when I can sing hymns. There is entertainment two or three times a week. There is a carer who gets people doing karaoke and bingo, I am encouraged not to stay in my room". A relative told us, "There seems a lot to do, a couple of days ago I came in to visit mum and her hands were purple". Their family member explained that they had been out picking blackberries with a staff member. Twiddlemuffs were available for people living with dementia. These are knitted woollen muffs with items such as ribbons, large buttons or textured fabrics attached that people can twiddle in their hands. They provide a source of visual, tactile and sensory stimulation. The registered manager had agreed that one person who was new to the service could bring their much valued collection of trains with them. To facilitate this, a shed was being built in the garden. Being able to continue to enjoy their hobby had been an important factor in the person making the decision to live in a residential home and showed a commitment on behalf of the registered manager and provider to be responsive to people's needs and wishes. The provider and other visitors brought their dogs to the service which people appeared to enjoy petting and interacting with. We did note that where people were cared for in their room, records did not demonstrate that they were provided with opportunities for meaningful activity that might help provide a sense of well-being and relaxation in people who perhaps were not able to communicate their needs and wishes. One of the healthcare professionals we spoke with felt that more could be done to provide more regular and stimulating activities. Visits by the provider had also identified that staff did not always use every opportunity to interact and engage with people. We therefore recommend that the registered manager review the activities provision to ensure this meets the needs of all people using the service.

The registered manager was developing systems to encourage people and their relatives to give feedback about the service. Surveys had been developed to seek people's views about the quality of care provided and these were due to be sent out next week. Resident meetings were held intermittently with the last one being in May 2017. The minutes show that people were encouraged to raise any concerns they might have or make suggestions about how the service might improve. We were able to see that some of these had been acted upon such as the development of a library within the service. People knew who to speak with if they needed to make a complaint or raise a concern. One person said, "I would complain to the boss". A relative said, "I would speak with the registered manager if I had any issues, there have been no issues, the staff here are fantastic". Another relative said, "I have found some clothes in Mum's room that were not hers, other clothing was missing, some were never found. I complained to the manager, the missing clothes were replaced". Information about how to make a complaint was available within the service and within the service user guide. There had been one complaint within the last twelve months. Records showed this had been investigated and responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

Throughout the inspection, the registered manager demonstrated a good knowledge of the needs of people living in the home. They took an active role within the home, delivering care and serving as a role model to the staff team through their hands on approach. The registered manager had received a number of positive comments about their leadership from local health and social care professionals. Comments included, 'I have always found you to be well informed about the residents and their medical and social problems, you are always approachable, available and very helpful, positive and efficient' and 'I have always found you to be extremely helpful…you always go the extra mile and are willing to stick up for what is right….I can truly say that if I ever need a favour or have an emergency, I would always come to you first'. A social care professional had thanked the registered manager for visiting a person living in the community and providing them with some emergency care when no community care at home could be found. A health care professional told us, "The manager seems very engaged with the home and does contact me if he has any concerns that he feels I can help with. He appears to have a vision for the future within the home and is very approachable, I am always made welcome". These comments demonstrated that the registered manager was well respected by health and social care professionals and placed the care and wellbeing of people at the centre of the way in which they practised.

The registered manager had fostered a homely and friendly culture which was commented on by a number of staff and relatives. One staff member told us, "The best thing about here is the homely environment, the residents love it and the families do too". This was echoed by a second care worker who told us, "I like working here because of the homely environment and long standing staff". A relative told us, "It is not regimented, [it's] more like being at home". The registered manager clearly knew people well and had developed good relationships with each person. They spent time chatting with people and taking people out for walks. This was always conducted in a kind, natural and relaxed manner. People responded well to the registered manager and seemed completely at ease with them. A social care professional told us that the registered manager had set aside space in his office for one person, who enjoyed getting involved in the running and organisation of the home. After seeing the registered manager support another person, one person told us, "See, that is an example of the special care that he gives to people". The provider also visited the service most weeks and often brought his dog which was a great favourite with people. He appeared to have a good relationship with people whom he knew by name.

Staff were positive about the registered manager. They all felt well supported and able to approach the registered manager or their deputy with any concerns or problems. Staff meetings were held intermittently and were an opportunity to discuss issues affecting people's care or staffing matters. Staff were being encouraged to become champions in a range of areas, such as activities and dementia care and to lead on modelling best practice in these areas.

However despite the positive comments and observations about the registered manager, we found there were shortfalls in the way the service was being managed and in the degree of oversight the registered manager had of aspects of the care provided. For example, between September 2016 and September 2017, there had been no robust programme of audit to assess and monitor the quality and safety of the service.

This had, within the last month, been introduced by the provider but the audit programme was in its infancy and so we were unable to assess whether it would serve as an effective tool at identifying where safety and quality were being compromised.

The lack of effective care plan audits between September 2016 and September 2017 meant that none of the significant shortfalls in care plan documentation and risk assessments that we found had been identified by the provider's quality monitoring systems. Therefore action had not been taken to make the required improvements and reduce the risks to people's safety. The lack of infection control audits meant that the registered manager had not identified that the cleaning arrangements within the service were not being fully effective.

A record had been maintained of some of the incidents and accidents that had occurred in the service; however, this was not complete. From reviewing people's care plans and notes we found that a number of falls, or other events of concern, had occurred but no incident form had been completed. This meant that the registered manager did not have an accurate oversight of events affecting the safety and wellbeing of people within the service. It was not evident that the registered manager had reviewed any of the completed incident forms to ensure that appropriate remedial actions were in place. The forms were not audited or analysed to help identify themes or trends that might require other remedial actions to be taken.

The registered manager did not have a service improvement plan against which they were monitoring progress with improving the quality and safety of the service.

The lack of a robust system to assess, monitor and improve the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

In the course of this inspection we identified that the registered manager had failed to notify the Care Quality Commission (CQC) of a number of safeguarding incidents which had occurred within the service. This is important as it enables the CQC to effectively monitor the safety and quality of the service provided. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009. Notification of other incidents.

Throughout this inspection the registered manager remained open to receiving feedback. Where the inspection identified areas where improvements or actions were required, these were acted upon promptly wherever possible. Whilst demonstrating a commitment to making improvements, the registered manager was also keen to maintain the friendly and homely culture within the home. They told us, "It's a home, comfortable, happy, I want to look after people and make them feel at home…I care about the wellbeing of everyone that works and lives here". They told us that the provider shared these values and although there were plans to extend the home, they too wanted to maintain the homely nature of the service. The registered manager told us that it was very important to them that people maintained links with the local community. People were supported to attend their church if they wished or to go to the local shops and visit their doctors if they were well enough. Staff at the service had recently become dementia friends and so there were plans to start holding coffee mornings for the local community for people living with dementia and their carers.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had failed to notify the Care Quality Commission (CQC) of a number of safeguarding incidents which had occurred within the service. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009. Notification of other incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had not assessed all of the risks to people using the service, or done all that was reasonably practicable to mitigate these risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered manager had not escalated three incidents which raised potential safeguarding concerns the local authority safeguarding team in order that they might have oversight of potential risks within the service. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding

service users from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of a robust system to assess, monitor and improve the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.