Colten Care (1993) Limited

Brook View

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service: Brook View is a care home with nursing that was providing personal and nursing care to 52 people aged 65 and over at the time of the inspection.

People's experience of using this service:
The service met the characteristics of good in all areas, and there were some aspects of practice that approached outstanding.

People told us they felt safe at Brook View. Staff felt comfortable to raise any concerns about their own or other people's safety. There were checks to ensure new staff were of good character and suitable for their role.

People praised the caring manner of staff. Interactions between people and staff were kind, respectful and unhurried. People's privacy, dignity and independence were upheld.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff involved people, and where appropriate their relatives, in decisions about their care.

Care was delivered in line with current standards and good practice. People were happy with their or their loved one's care. Medicines were managed safely. Staff liaised as necessary with people's healthcare professionals. When people were unwell, staff made timely referrals to their GP. People were supported to have a comfortable and dignified death when the time came.

Care plans varied in their completeness, consistency and level of detail. The management team had already identified care planning needed to improve and had made plans accordingly.

There was an emphasis on the importance of eating and drinking well. People enjoyed a choice of freshly-prepared meals and snacks, and people's dietary preferences and needs were catered for.

There was a range of activities based on people's ideas and interests, including regular trips out. Activities staff worked on a one-to-one basis with people who were unable to leave their rooms. There were strong

links with the local community and people who were able often went out on trips.

There were enough appropriately qualified staff on duty to provide the care and support people needed. Any gaps in the rota were covered by agency staff. Staff had the skills and competence they needed to care for people safely and effectively. They were supported through training and regular supervision. The provider's Admiral nurse, a specialist dementia care nurse, gave practical and clinical support to staff as well as people's families.

The premises were clean and well maintained. The building and garden were adapted for people with impaired mobility. There was a range of communal areas for people to spend time together and alone. Equipment was regularly serviced. Effective infection prevention and control procedures were in operation.

People and relatives told us they would feel able to raise concerns or complaints with the manager if they felt the need to do so. Staff understood their responsibility to report concerns and near misses. Action was taken to ensure people were safe and improvements made where necessary.

The provider had good oversight of the service through its established management and accountability arrangements. Although there had been changes in manager, people and staff were confident in the leadership of the service. People and staff described managers as approachable and supportive, but that they would address poor practice. Staff came across as motivated and worked as a team. People commented, "The staff seem very happy and cheerful; they do seem to like their jobs here", and, "The staff get on well together. There is a very good atmosphere".

Rating at last inspection: At the last inspection the service was rated good (report published 5 August 2016).

Why we inspected: This was a planned inspection based on the previous rating.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our Well-Led findings below.

Brook View

Detailed findings

Background to this inspection

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

Inspection team:
The inspector and an expert by experience visited the service on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case services for older people. The inspector, an assistant inspector and a specialist professional advisor were present on the second day. The specialist professional advisor was a registered nurse with expertise in caring for older people and dementia care.

Service and service type:
Brook View is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Brook View accommodates up to 56 people in individual rooms in purpose-built premises.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, this manager had recently left the service and one of the senior nurses was acting as manager for the time being.

Notice of inspection:
We did not give notice of the inspection.

What we did:
Before the inspection we reviewed information we held about the service. This included notifications we received from the service of events such as deaths and serious injuries, and the most recent provider information return. This is a compulsory return from the provider that gives us key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection we made general observations and spoke with nine people using the service, a relative, three nurses and care staff, five other staff, the acting manager, the clinical manager, the training and development manager, the operations manager and a visiting health professional. We viewed ten people's care records, medicines administration records, four staff files, records of accidents and incidents, complaints and compliments, property maintenance and fire safety records, minutes of meetings and audits and quality assurance reports.

Good

Our findings

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

Good: People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse
- People told us they felt safe at Brook View.
- Staff understood what abuse was and knew how to report it.
- Staff felt comfortable to raise any concerns about their own or other people's safety.
- The service had reported to the local authority any concerns about possible abuse or neglect, in line with local multi-agency procedures for safeguarding adults.

Assessing risk, safety monitoring and management
- People's individual risks were assessed and managed in line with their wishes. Where people were unable to make decisions about managing risks, these were managed in the least restrictive way possible.
- Risk assessments routinely covered moving and handling, malnutrition, development of pressure ulcers, and falls. People also had assessments for other risks that affected them individually, such as the use of bed rails. The findings from these risk assessments were incorporated into their care plans and staff were aware of the measures to take.
- Swallowing difficulties were communicated to nurses, care workers, kitchen and hospitality staff. Clear directions were provided in line with safe swallow plans for modifying the texture of food and thickening drinks.
- The premises were well maintained. There were dedicated maintenance staff and a regular maintenance programme, with regular health and safety and fire safety checks. Current certification was in place for gas safety, electrical wiring, portable electrical appliance testing, lift inspection, and the inspection and servicing of fire safety equipment.
- Equipment was regularly serviced and well maintained.

Staffing and recruitment
- There were always enough nurses and care staff on duty. There were ongoing efforts to recruit into staff vacancies. Any gaps in the rota were covered by agency staff.
- The service block-booked agency staff. Staff told us there were regular agency staff who were getting to know people who lived at Brook View.

● People told us they received assistance promptly when they rang their call bells. The manager monitored call bell response times.
● Staff did not rush when they were supporting people.
● There were checks to ensure new staff were of good character and suitable for their role. These included criminal records checks, obtaining an employment history and taking up references from previous employers.
● Staff had the training they needed to maintain people's safety, such as moving and handling training, and were up to date with this.

Using medicines safely
● Medicines were stored securely and disposed of safely.
● Quantities of medicines in stock were accounted for by medicines records. There were regular checks to ensure these were complete and correct.
● Staff who administered medicines were trained to do so. Their competence in handling medicines was assessed at least annually.
● One person had some medicines administered concealed in food or drink, as they lacked the mental capacity to understand the implications of refusing them. The necessary records were in place to support this, including evidence of consultation with a pharmacist.

Preventing and controlling infection
● People and visitors confirmed the premises were kept clean. A team of housekeeping staff worked to cleaning schedules that ensured each area of the home was cleaned properly.
● Staff had training in infection control, including hand cleansing techniques, and safe food handling.
● Personal protective equipment, such as disposable gloves and aprons, was readily available and staff used this appropriately.
● Alcohol hand rub was available at the entrance and around the building, for staff, people and visitors.
● The laundry was orderly. Dirty and clean laundry were kept apart. The laundry staff were aware of the procedures to follow to maintain good hygiene, such as the washing temperatures for soiled linen.

Learning lessons when things go wrong
● Staff understood their responsibility to report concerns and near misses. Individual accident and incident reports were reviewed promptly by the manager or clinical lead to ensure all necessary action had been taken to keep people safe.
● Senior staff were informed at the daily 'ten at ten' meeting of any accidents or incidents that had occurred since the meeting the day before.
● Accident and incident reports were logged on the provider's computer system, which alerted the senior management team who reviewed for possible trends across their services.
● Any learning from things that had gone wrong was shared with staff.

Good

Our findings

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

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care was delivered in line with current standards and good practice.
● Assessments were comprehensive. They covered areas such as making choices, communication, moving around, keeping safe, breathing, eating and drinking, promoting continence, washing and dressing, preventing and treating tissue damage, medical conditions and medication.
● Care plans varied in their completeness and level of detail. For example, a nurse told us there were fluid charts for all people with urinary catheters, but this was not mentioned in the eating and drinking care plan for a person who had a catheter. Another person had recently experienced a significant life event and staff told us about how they were providing emotional support; this was not reflected in the person's care plans. The management team had already identified care planning needed improvement and had plans to bring this about. They rectified any discrepancies we highlighted.
● Assessments and care plans were reviewed monthly and updated, each time someone was 'resident of the day'.

Supporting people to eat and drink enough to maintain a balanced diet
● There was an emphasis on the importance of eating and drinking well. Meals and snacks looked and tasted appetising.
● People, including some who had a soft diet, were positive about the food. Comments included, "The food is good. I have a jaw problem and they make me things I can easily chew", and "The food is very nice here, good choices. And they will make me something different if I want it".
● Apart from meals, regular snacks and drinks were offered including a pre-lunch sherry round. In addition, snacks and drinks were available for people or their visitors to help themselves to when they wished, both in reception and upstairs in the café.
● The chef met people who had just moved in to discuss their dietary needs, food preferences and preferred portion sizes. The chef then monitored this as part of the monthly 'resident of the day' process.
● There was a nutrition resource folder for care, kitchen and hospitality staff. This gave information about nutrition and hydration, health and cultural dietary requirements, swallowing difficulties, and creating a positive dining experience.

● Hospitality staff were employed to help ensure people had a good mealtime experience, particularly if they ate in their room. However, any assistance to eat or drink was given by care staff.
● People we met looked well hydrated and often had drinks to hand. However, where people's fluid intake was being recorded, this was not always complete. Night staff reviewed and totalled fluid charts, informing day staff at handover if action was required, but these conversations were not clearly documented. The management team had identified that recording needed to improve and had plans to address this.

Staff support: induction, training, skills and experience
● People were confident in the abilities of the staff to provide the support they needed. Comments included, "I think the staff have the correct skills to look after me", and "Couldn't wish for better [staff]".
● Staff had the skills, knowledge and competence to carry out their roles effectively. They had access to the training they needed.
● New staff had face-to-face induction training, and those new to care were expected to attain the Care Certificate. The Care Certificate is based on a nationally agreed set of standards for health and social care work.
● Refresher training was delivered mostly through e-learning, each member of staff having a personal log in and a dashboard that showed them what training was due. This covered topics such as safeguarding adults, infection prevention and control, food hygiene, fire awareness, basic life support and medicines administration. Some updates, such as moving and handling, were delivered in face-to-face sessions.
● Nurses were supported to maintain their professional registration with the Nursing and Midwifery Council. They were subscribed to a nursing journal with activities for developing their clinical knowledge and skills. The provider held an annual clinical excellence day to update nurses with current practice.
● Staff had regular supervision meetings with their line manager to reflect on their work and discuss any concerns. There was annual appraisal to review performance and plan training and professional development.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff liaised as necessary with people's healthcare professionals, such as GPs, district nurses and community mental health nurses.
● When people were unwell, staff made timely referrals to their GP. People could choose which surgery they used but told us they tended to use the doctors who visited Brook View.
● Staff had referred someone who had cognitive difficulties and sometimes resisted personal care to the provider's Admiral nurse. The Admiral nurse had visited and assessed the person, recommending how staff might support them in a way to make distress less likely. The person's care plans were updated based on this information. Admiral nurses are specialist dementia care nurses who give practical, clinical and emotional support to families who have relatives living with dementia. They are also able to offer support and advice to staff.
● Activities included exercise classes suited to people at Brook View. For example, there was a tai chi class during the inspection

Adapting service, design, decoration to meet people's needs
● The premises were decorated to a high standard in a fresh-looking, homely and comfortable style.
● People told us they liked their rooms. A relative commented, "Whoever designed it has done a good job and it's well maintained."
● People were encouraged to enhance their rooms with their own pictures, personal objects and pieces of furniture.
● There was an attractive wheelchair-accessible garden with raised flower and vegetable beds.

● The building was adapted for people with mobility needs. For example, there were rails along the corridors for people to hold on to, conveniently placed grab rails in toilets, and specially adapted bathrooms with specialist baths. There was a passenger lift to the first floor.
● There was a range of communal areas, for people to spend time with other residents, with their visitors and by themselves. These included a café room on the first floor and smaller lounges on the ground and first floors, as well as the main lounge and dining room. There were also seats and tables in central areas upstairs and downstairs, so people could sit and talk with each other or watch what was going on.

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

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

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

Ensuring consent to care and treatment in line with law and guidance
● Staff had been trained and prepared in understanding the requirements of the MCA, including the DoLS.
● Where people were able to give consent to their care, this was obtained. People confirmed that staff always got their permission before providing assistance.
● Where people had given lasting power of attorney for health and welfare, delegating decisions about their care to a trusted person, the service obtained details and proof that this had been registered. The service obtained consent from those who held lasting power of attorney. One person's care records contained inconsistent information about whether someone held lasting power of attorney for care and welfare. This was corrected during the inspection.
● Where people were unable to consent to their care and did not have a lasting power of attorney for health and welfare, staff provided care in their best interests. Best interests decisions were made in consultation with family or friends who were close to the person, to provide care that was consistent with the person's known preferences in the least restrictive way possible.
● The service had identified that continuous supervision and control combined with a lack of freedom to leave the service indicated that some people were deprived of their liberty. These were people who lacked the mental capacity to consent to living at Brook View. The service had applied to the appropriate supervisory body (local authority) for this to be authorised.
● The service had recently learned that a person's deprivation of liberty had been authorised with conditions. These conditions were being met, although the person's care plan and other documentation for staff did not clearly reflect these. This was corrected during the inspection.
● The service had a system for identifying when DoLS authorisations were due to expire, enabling them to submit fresh applications in good time.

Good

Our findings

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

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

Ensuring people are well treated and supported; respecting equality and diversity
- People praised the caring manner of staff. Their comments included, "The staff are caring and supportive of me and always treat me with respect", and "The staff are very caring towards me, very kind".
- Interactions between people and staff were kind, respectful and unhurried.
- People and staff knew each other well, calling each other by name and looking comfortable with each other.
- People were treated as individuals. Their care records contained information from them or their families about their personal history, preferences and people and things that were important to them.
- Staff had training in equality and diversity. There were plans to build staff understanding of issues that can affect lesbian, gay, bisexual and transgender people who receive care.

Supporting people to express their views and be involved in making decisions about their care
- Staff involved people in decisions about their care, and where appropriate, their families and friends. A person told us, "My care plan is done by my [relative]. She has control and the home contact her regularly." Another person said, "My [relative] looks after things like my care plan for me."
- Relatives confirmed staff kept them informed about any changes affecting their loved one.
- Staff were aware that people's wishes may differ from their relatives' and that what the person using the service decided, or what was in their best interests if they were unable to decide, must be respected.
- Staff had requested external assistance where they had identified a possible clash between a person's and their family's wishes. The person's care plan made it explicit that the person's wishes must be upheld.

Respecting and promoting people's privacy, dignity and independence
- People's dignity was upheld. Staff offered intimate care discreetly and respectfully. This all took place behind closed doors.
- Care plans reflected what people were able to do independently. People told us they had the support they needed and that staff did not try to do too much for them.
- People were encouraged to maintain relationships with their social networks. Visiting was unrestricted.

Good

Our findings

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

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

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
● People were consulted in planning their care and their care was tailored to their needs. People got the right care, even though some care plans were incomplete.
● People and relatives were happy with their or their loved one's care.
● Activities coordinators organised an extensive range of activities, including visiting speakers and entertainers and regular outings. Ideas for activities came from people themselves, for example discussing in residents' meetings what they would like to do. The gardener ran garden-based activities, and the chef, a monthly chef's club. As well as providing group activities, the activities staff worked one-to-one with people who stayed in their rooms.
● People valued the range of activities they could choose to take part in. Comments included, "I do get involved with some of the activities, I like it when animals are brought in", "I do like the activities very much. They also take me out and we go to Wimborne - I like to do that", and, "They always encourage me to get involved in the activities that are taking place". Another person told us how they loved the craft workshops.
● There were strong community links, which were fostered and encouraged. People regularly visited facilities such as shops, cafes, the library and churches, as well as to local events. For example, some people went out to quiz evenings, and six people went to a nearby church café nearby during our visit.
● The service met the Accessible Information Standard. This is a legal requirement for providers to ensure people with a disability or sensory loss are given information in a way they can understand and have the communication support they need. People's communication needs were identified, recorded and highlighted in care plans and people got the support they needed. Communication needs were shared appropriately with others, for example, when people went into hospital.

Improving care quality in response to complaints or concerns
● People and relatives told us they would feel able to raise concerns or complaints with the manager if they felt the need to do so.
● Information was readily available about how to make a complaint.
● Any known complaints or compliments that day were highlighted at the daily 'ten at ten' meeting.
● The management team reviewed complaints each month. However, there had been no formal complaints in the last six months.

End of life care and support

● People were supported to have a comfortable and dignified death when the time came.

● The service obtained guidance and advice from the local palliative care team regarding symptom management during the last days of people's lives.

● Family and friends were supported emotionally and practically before and after a person died. This was reflected in compliments the service had received.

● The manager told us how within the past year the chef had been about to go home after work but reopened the kitchen to cater for the family of someone who was dying.

● Some nurses were qualified to verify death, which helped avoid a sometimes prolonged wait for a paramedic or doctor to attend.

● The provider had established an end of life steering group to drive developments in its end of life care, such as devising a new advance care plan, and developing kits containing things that people and their families might appreciate while the person was dying, such as a CD player and music, soft blankets and poetry.

Good

Our findings

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

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

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

- People were positive about the way the service was run. Comments included, "This home is very well run. Whoever comes to live here will be very happy", "I do think this home is well organised. It runs smoothly as far as I can see", "It does run well at this home, but it has had a few managers", and, "This home must be well managed. It runs very well, and I have no complaints".
- The service had a relaxed, warm and friendly atmosphere. Staff had 'Warm Welcome' customer care training. They understood and upheld the provider's values of "friendly, kind, reassuring, individual and honest" and its promise of "cherishing you". People commented, "The staff seem very happy and cheerful; they do seem to like their jobs here", and, "The staff get on well together. There is a very good atmosphere".
- Staff came across as motivated and there was a sense of teamwork. Staff talked about enjoying their work and having a "good team" to work in.
- The manager and senior staff were readily available if people, relatives or staff needed to talk with them. A member of staff described managers as "very informal, very easy to talk to them all".
- People, relatives and staff all felt able to raise concerns with the manager in the confidence these would be addressed. There was a whistleblowing helpline for any staff who wished to raise concerns directly with the provider.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider had good oversight of the service through its established management and accountability arrangements.
- There had been changes in the management of the service and the registered manager had left before the inspection. Staff acknowledged this had caused some colleagues to feel unsettled. However, they voiced confidence in the current manager of the service. A member of staff said, "[Manager] has been fantastic. She's really pulled the team together." They also commented, "When [operations manager] visits, she's very

approachable."
● The service manager and the provider's management teams monitored the service's performance to identify possible improvements and bring these about. This happened through the regular review of accidents and incidents as well as a programme of audits.
● The operations manager, clinical manager and quality manager visited regularly, who spoke with people and staff, observed what was going on and reviewed records.
● Audits within the service and overseen by the manager covered areas such as health and safety, infection control, medicines, care planning, wounds, infections, weight loss, housekeeping and laundry.
● Action plans were drawn up where these checks identified any shortcomings or areas for improvement. These processes had identified the areas for improvement that we found at the inspection. There were plans in place to address these, such as providing training about care planning.
● Managers and staff understood their roles and responsibilities. These were reinforced through supervision and appraisal, at which they discussed their performance.
● A member of staff explained that the manager, although supportive, did address poor performance effectively.
● Legal requirements were met. The previous inspection rating was displayed prominently in the reception area and on the provider's website. The service had notified CQC of significant events, such as deaths and serious injuries. The management team took their data protection responsibilities seriously and ensured confidential personal information was treated properly.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider valued people's feedback about the service. An annual survey was sent out to people, relatives and staff. Results from the most recent surveys to people and relatives, and the provider's response to themes raised, were displayed in reception in a "You said we did" format.
● There were regular residents' and relatives' meetings at which people voiced their views, for example concerns that the new manager would be well supported.
● There was regular consultation with staff through supervision and staff meetings, as well as through the annual survey.
● Staff told us the manager was aware of their concerns about management and staff changes and was supportive of them. For example, in response to staff concerns the manager had taken steps to ensure shifts were not left short staffed and had block-booked regular agency staff who were getting to know people.
● Daily 'ten at ten' meetings between senior staff from each department promoted good communication, helping ensure that everyone had the information they needed that day to help the service run smoothly.
● Training in equalities was mandatory for staff. Staff respected diversity, amongst people who used the service and amongst their colleagues.

Working in partnership with others
● The service had developed collaborative working relationships with other organisations to support the provision of care. It sought specialist advice where necessary from the palliative care team, tissue viability nurses and other health professionals, such as speech and language therapists and dietitians.