Mr & Mrs H Rajabali

Brooklands Nursing Home

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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on the 19 and 20 July 2018 and was unannounced.

Our inspections in May 2016 and June 2017 found breaches of regulation and were rated Requires Improvement. This was because they had not sustained the necessary improvements needed to meet the breaches of regulation. We received an action plan from the provider that told us they would meet the breaches of regulations by June 2018.

Brooklands Nursing Home 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. Brooklands Nursing Home is located close to the village of Forest Row and backs on to the Ashdown Forest. The service provides nursing care and support for up to 29 people most of whom have limited mobility, are physically frail with health problems such as heart disease, diabetes and stroke. There were people at the service living with dementia and some people were receiving palliative care. At the time of our inspection there were 23 people living at the home, two of whom were in hospital.

There was a registered manager in post. 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 2008 and associated Regulations about how the service is run.

We undertook this unannounced comprehensive inspection to look at all aspects of the service and to check the provider had followed their action plan and confirm the service now met legal requirements. We found improvements had been made in the required areas.

The overall rating for Brooklands Nursing Home has been changed to good. We will review the overall rating of good at the next comprehensive inspection, where we will look at all aspects of the service and to ensure the improvements have been sustained.

People spoke positively of the home and commented they felt safe. Our own observations and the records we looked at reflected the positive comments people made.

The quality assurance system had been reviewed and areas for change had been identified and prioritised to drive improvement. Nurses were responsible for reviewing the care plans, risk assessments and daily records and, although most of these were up to date with clear guidance for staff in how to deliver safe, effective and responsive care, we also found some information that was not clear or had not been updated. This included changes to people's risk assessments when their nutritional needs had changed and food and fluid charts not being consistently recorded. Staff were aware records were not consistently up to date and the changes in the care planning process would take time to be embedded into day to day practice.

People were relaxed and comfortable with staff. They said they felt safe and there were sufficient staff to support them. One person said, "I feel safe, the staff are kind and look after me." A relative said, "I really don't think we could have found a better place, we looked at a lot of homes. Here it is always clean and never smells, my relative is kept nicely and able to do what she wants. She phoned me at 10 last night, which shows the kind of freedom she has, she uses the phone a lot." When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector. Medicines were managed safely and in accordance with current regulations and guidance. There were systems that ensured medicines had been stored, administered, audited and reviewed appropriately. Risks associated with the environment and equipment had been identified and managed. Emergency procedures were in place in the event of fire or emergency situations. Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place. Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar events happening in the future.

Staff received training in order to undertake their role. Formal personal development plans, including two monthly supervisions and annual appraisals were in place. People were supported to make decisions in their best interests. The registered manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and were aware of current guidance to ensure people were protected. The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS applications had been requested where appropriate to ensure people were safe and the registered manager was waiting for a response from local authority. People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people could give feedback and have choice in what they ate and drank. Health care was accessible for people and appointments were made for regular check-ups as needed.

People felt well looked after and supported. We observed friendly and genuine relationships had developed between people and staff. Care plans described people's preferences and needs in relevant areas, including communication, and they were encouraged to be as independent as possible. People chose how to spend their day. Activities were mixed and people could choose either group activities or one to one. People were encouraged to stay in touch with their families and receive visitors. The provider had sent CQC notifications in a timely manner. Notifications are changes, events or incidents the service must inform us about.

Staff were asked for their opinions on the service and whether they were happy in their work. Staff said the management team was fair and approachable, care meetings were held every morning to discuss people's changing needs and how staff would meet these. Staff meetings were held monthly and staff could contribute to the meetings and make suggestions. Relatives said the management was very good; the registered manager was always available and they would be happy to talk to them if they had any concerns.

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

Brooklands Nursing Home was safe.

Risk to people had been assessed. Accidents and incidents were recorded and action was taken to reduce the risk of a re-occurrence.

Robust recruitment procedures ensured only suitable staff worked at the home. There were enough staff working in the home to meet people's needs.

Staff had attended safeguarding training and had a clear understanding of abuse, how to protect people and who to report to if they had any concerns.

Medicines were managed safely. Staff had attended relevant training, there were systems in place to ensure medicines were given as prescribed and records were accurate.

Is the service effective?

Good

Brooklands Nursing Home remains effective.

People were supported to access healthcare support. People's individual needs were met by the adaptations made at the home and the design of the service.

Staff had the relevant skills and knowledge to deliver care and support to people they supported. Training was provided regularly. Consent to care and treatment was sought in line with legislation

People were supported to eat and drink enough to maintain a balanced diet

Is the service caring?

Good

Brooklands Nursing Home remains caring.

Staff provided the support people wanted, by respecting their choices and enabling people to make decisions about their care.

People's dignity was protected and staff offered assistance discretely when it was needed.

People were enabled and supported to access the community and maintain relationships with families and friends.

Is the service responsive?

Good

Brooklands Nursing Home remains responsive.

People's needs were assessed before they moved into the home and they received support that was personalised in line with their wishes and preferences.

People decided how and where they spent their time and a range of group and one to one activities were provided for people to participate in if they wished.

People and visitors knew how to make a complaint or raise concern.

Feedback from people was sought and their views were listened to and acted upon.

Is the service well-led?

Requires Improvement

Brooklands Nursing Home whilst meeting the breach of regulation was not consistently well-led.

Whilst the provider had systems for monitoring the quality of the service and driving improvement, these were not always effective at this time. Records relating to the care and treatment provided to people were not always accurate or up to date.

Staff were aware of their roles and responsibilities and felt all of the staff worked well together as a team.

Feedback about the service provided was consistently sought from people, relatives and staff.

Brooklands Nursing 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 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 service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 19 July 2018 and was unannounced. The inspection team consisted of an inspector and two experts 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 the information we already held about this service. This included details of its registration, previous inspection reports, action plans and any notifications they had sent us. Notifications are information about significant events that the provider is legally obliged to send to the Care Quality Commission. We also reviewed the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority with responsibility for commissioning care from the service to seek their views. We also spoke with and received correspondence from three visiting health and social care professionals, which included, speech and language therapists, tissue viability nurse and a social worker.

We looked at areas of the building, including people's bedrooms, the kitchen, bathrooms, and communal areas. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also used communication aids that people themselves used, to communicate with them.

During the inspection we spoke with 14 people that used the service and 10 members of staff: registered manager, deputy manager, provider, one housekeeper, activity co-ordinator and five care staff. We reviewed 6 sets of records relating to people including care plans, medical appointments and risk assessments. We also 'pathway tracked' people living at the home. This is when we followed the care and support a person has received and obtained their views. It was an important part of our inspection, as it allowed us to capture

information about a sample of people receiving care. We looked at the staff recruitment and supervision records of four staff and the training records for all staff. We looked at medicines records for all the people and minutes of various meetings. We checked some of the policies and procedures and examined the quality assurance systems at the service.

Good

Is the service safe?

Our findings

We have inspected this key question to follow up the concerns found during our previous inspection in June 2017. At that inspection we found a breach of the legal requirements. This was because the provider had not ensured essential environmental work had been addressed in a timely manner. This had meant environmental risk assessments were not up to date and accurate. At this inspection we found improvements had been made and the provider/service now met the previous legal breach of regulation.

People and their relatives told us they felt safe. One person told us, "I am really well looked after here and feel safe." Another person said, "Safe and happy." A visitor said, "I have no concerns about safety, very safe." Another visitor said, "The place is safe, always clean and staffing is good."
Risks associated with the safety of the environment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal evacuation plan.

Individual risk assessments had been implemented, reviewed and updated to provide sufficient guidance and support for staff to provide safe care. Risk assessments for health-related needs were in place, such as skin integrity, nutrition, falls and dependency levels. Care plans demonstrated how people's health and well-being was being protected and promoted. We saw detailed plans which told staff how to meet people's individual needs. For example, continence care was identified and a plan of action for staff to follow such as regular visits to the bathrooms and application of topical creams. Another care plan told staff how to meet behaviours that challenge in a way that ensured people and staff safety and well-being. We saw care plans which contained information about people's skin integrity alongside the risk assessment to identify people's individual risk to pressure ulcers. Equipment used to minimise the risk of skin damage such as pressure relieving mattresses and cushions were checked daily by staff to ensure they were on the correct setting for the individual. We found all were correct and working.

Staff took appropriate action following accidents and incidents to ensure people's safety and this was recorded. We saw specific details and any follow up action to prevent a re-occurrence. Any subsequent action was shared with all staff and analysed by the management team to look for any trends or patterns. This demonstrated learning from incidents and accidents took place.

Staff had received safeguarding training and understood their responsibilities for keeping people safe from risk of abuse. Staff could give examples of signs and types of abuse and discuss the steps they would take to protect people, including how to report any concerns. The care home had a whistle-blowing policy that provided guidance for staff on how to report concerns in the workplace. Staff told us they felt confident to whistle-blow if necessary. A member of staff said, "There is a whistleblowing policy that we are all aware of. If I reported something that was a worry and nothing got done, I would inform the local authority and CQC,

but I know the manager would listen and escalate without doubt."

We discussed with staff how they made sure people were not discriminated against and treated equally and without prejudice. A senior member of staff told us, "We treat everyone the same. Everyone should be treated the same and be treated with dignity and respect." Staff were mindful of racism or sexism and respectful of people's differences. Staff had received training in equality and diversity.

Medicine records showed each person had an individualised medicine administration sheet (MAR), which included a photograph of the person with a list of their known allergies. MAR charts are a document to record when people received their medicines. MAR charts indicated medicines were administered appropriately and on time. Records confirmed medicines were received, disposed of, and administered correctly. People told us they received their medicines on time. One person told us, "I have my pills when I need them, always on time."

There was clear advice on how to support people to take their medicines including 'as required' (PRN) medicines, such as paracetamol. It was discussed that pain relief for those who had been prescribed anticipatory medicines as they approached the end of their life would benefit from further guidance so it could be started in a timely way. The registered manager said she would seek further advice from the hospice team. People's medicines were securely stored in a clinical room and they were administered by senior care staff who had received appropriate training and competencies. We observed two separate medicine administration times and saw medicines were administrated safely and staff signed the medicine administration records after administration. A clear audit trail defined what action was taken following errors, such as medicine retraining and competency tests. When necessary, medicine errors had been reported to the local authority and the registered manager had followed the guidance for the professional duty of candour. This meant it had been disclosed to the individual or their next of kin, an apology offered and an action plan discussed to prevent a reoccurrence. This ensured as far as possible lessons had been learnt.

Robust checks had been carried out to ensure staff who worked at the home were suitable to work with vulnerable people. These included references, identity checks and the completion of a disclosure and barring service (DBS) check. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer recruitment decisions and help prevent unsuitable people from working with vulnerable groups.

Sufficient numbers of skilled and experienced staff contributed to the safety of people who lived at the home. The rotas correctly displayed those staff on duty during the inspection process. The staff skill mix and the management deployment within the service had been regularly reviewed along with the needs of the people they supported. It had been identified mornings were busier and the numbers of staff reflected this. People told us there were enough staff to respond to their needs although sometimes it was very busy. We were told, "Lovely staff, always a smile, never too busy for a chat." A visitor said, "I think there are enough staff, we visit a lot and the staff team are great." Another visitor however said, "More staff is needed because a lot of people stay in their rooms." Staff told us they thought enough staff were available.

We observed people received care in a timely manner and call bells were answered promptly. Staff told us they worked hard to ensure an immediate response and felt the number of staff on duty allowed them to do so. Staffing levels allowed for staff to support people and to take people into the garden for fresh air and to sit and chat. We also saw staff sat with people in the communal areas chatting whilst other people started to join them. The communal areas were never left unattended, if staff were called away then the manager or deputy manager would take over. The staff office was near the communal areas so staff were always in the

vicinity.

Staff told us they thought staffing levels were good and appropriate to meet the needs of the people currently living at Brooklands. One care staff member told us, "We can meet people's needs and the manager will get agency staff in if someone goes off sick. There is no problem with staffing." The registered manager completed staff rotas in advance to ensure staff were available for each shift. There was an on-call rota and staff could call the registered manager out of hours to discuss any issues arising. Feedback from people and our observations indicated sufficient staff were deployed in the service at this time to meet people's needs. Staff were available for people, they were not rushed and supported people in a calm manner.

Good

Is the service effective?

Our findings

At the last inspection in June 2017, we rated this key question as Good. At this inspection, we found this key question remained good.

People told us that staff understood them and knew how to manage their health and social needs. One person told us, "Top notch, look after me very well." Another person told us, "Oh yes, I see my doctor when I need to, no problems there, I also see a chiropodist and I went to the hospital for tests a while ago." One visitor told us, "My mum needs support and care and they are good to her."

People told us their health was monitored and when required external health care professionals were involved to make sure they remained as healthy as possible. People's health needs were supported by a local GP surgery. The community psychiatric team was involved when necessary for those who needed it and advice sought when required. One person told us, "I'm waiting to see a doctor, I think they are coming today." Where required, people were referred to external healthcare professionals; this included the dietician, tissue viability team and the diabetic team. People were regularly asked about their health and services such as the chiropodist, optician and dentist were offered. Visiting healthcare professionals told us people were referred to them appropriately. One health professional said, "They respond quickly when a health problem is noted and work well with us." Another health professional said, "They are organised and seem to know their residents well."

People's needs were assessed and care, treatment and support was delivered in line with current legislation and evidence-based guidance that achieved effective outcomes. People's skin integrity and their risk of developing pressure wounds had been assessed using a Waterlow Scoring Tool and a Malnutrition Universal Screening Tool (MUST). These assessments were used to identify which people were at risk of developing pressure wounds and action taken included appropriate equipment to relieve pressure to their skin, such as specialist cushions and air mattresses.

Staff were working within the principles of the Mental Capacity Act 2005 (MCA). 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 are called the Deprivation of Liberty Safeguards (DoLS).

We were made aware of people subject to DoLS authorisations. At the time of inspection, the registered manager informed us some people had been referred for a DoLS authorisation but some were still pending. A file was kept and updated when the DoLS was authorised. The service had completed appropriate assessments in partnership with the local authority and any restriction on the person's liberty was within the legal framework. The service had submitted notifications to the CQC about the decisions of applications

submitted for DoLS for people who used the service.

People commented they felt able to make their own decisions and those decisions were respected by staff. Staff had received training and understood the principles of the MCA and gave us examples of how they would follow appropriate procedures in practice. There were also procedures to access professional assistance, should an assessment of capacity be required. Staff undertook a basic mental capacity assessment for each person when they arrived at the home and this was then regularly reviewed. Staff were aware any decisions made for people who lacked capacity had to be in their best interests. There was evidence in individual files that best interest meetings had been held and enduring power of attorney consulted. During the inspection we heard staff ask people for their consent and agreement to care. For example, we heard the registered nurse say, "Are you ready for your medicine now, and have you any discomfort." Care staff asked people, "Shall I help you to the bathroom," and "Would you like another cup of tea." Staff told us they knew people's mental capacity could change quickly and so it was always important to approach people and ask for their consent.

The management team with oversight from the provider took responsibility for the induction programme, training programme and organising the supervision programme. There was an induction process for staff when they started work at the service. This included an introduction to the day-to-day routines, policies and procedures. New staff shadowed other staff to get to know people and the support they needed. During this time, staff received on-going training in line with the organisational policy.

People told us they felt staff had appropriate and relevant skills to meet their needs. One person said, "I think they are well trained, seem to know what they are doing." Staff had completed most essential training and this was updated regularly. In addition, they had undertaken training specific to the needs of people they supported. For example, dementia awareness. Registered nurses ensured their practice was current, they undertook relevant training courses and were registered with the Nursing and Midwifery Council (NMC). Staff's competency was also assessed through direct observations. For example, staff's competency with giving medicines was observed regularly through observational supervision. Staff told us they received good training which provided them with the skills required to provide effective care.

Systems were in place to support staff to develop their skills and improve the way they cared for people. Staff received regular supervision. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed and reviewed. Staff told us they felt supported within their roles and felt able to approach the manager with any queries, concerns or questions. One staff member told us, "Very supportive."

People were supported to have enough to eat and drink. People said the food was very good; they were offered choices and could really have what they wanted. Their comments included, "The food is nice. There's a choice but not a lot of choice, seems a lot of pasta to me. There is plenty of fresh fruit, and cakes if you want them. There's a choice each day for breakfast, I have my favourite breakfast things. I don't like meat and there is always a meal I like, they make things specially for me. I love puddings and those are all lovely," and "I always enjoy the meals, todays was lovely. There's always a choice, I could have had macaroni cheese. We get plenty of fresh fruit."

The mealtime experience was mixed because very few people ate in the dining area. The registered manager said over time people had chosen to eat in their rooms unless there was a special event. During our inspection only four people chose to eat in the dining room. One person said, "I could go to the dining room but I do prefer to stay in my room." People told us they discussed the food provided during their resident's meetings and if they had any suggestions they were picked up and changes were made. For example, one

person had suggested fruit should be a regular option. Fresh fruit was readily available to everyone.

The cook said people could have what they wanted and had good knowledge of people's likes and dislikes. There were two main choices and people had requested other meals. Staff asked people each morning what they wanted for lunch and evening meal for that day and said if people changed their minds they offered other meals. We observed people telling staff they did not want the meal they had chosen earlier for lunch; staff suggested alternatives and their chosen meal was made. People's specific dietary needs were met, including diabetic diet and, soft and pureed meals were provided for people who had swallowing difficulties or were at risk of choking. Records were kept of people's diet, including the amount they ate and drank throughout the day, snacks and hot drinks were available at any time and people were supported to eat a nutritious diet.

Older people and people living with dementia are at risk of malnourishment due to multi-factors such as poor mobility, physiological changes and swallowing difficulties. To mitigate risk people's weight was regularly monitored and documented in their care plan. Some people did not wish to be weighed and this was respected. Staff said, "We use different ways to monitor their weight such as clothing if they don't want to be weighed." The registered manager said, "The kitchen staff and staff talk daily about people's requirements, and there is regular liaison with Speech and Language Therapists (SALT) and GP." Staff understood people's dietary requirements and how to support them to stay healthy. The cook told us staff kept the kitchen informed of any changes to people's dietary needs and also told the kitchen staff of people who needed their food fortified.

Staff provided care and support to people with swallowing difficulties, for example following a stroke. For people assessed with a swallowing difficulty, the use of thickened fluids when drinking was required to minimise the risk of choking and aspiration as thickened fluids are easier to swallow. Staff were responsible for the management of thickened fluids and guidance was available on the required texture of thickened fluids. Input from dieticians and speech and language therapists were also sourced. Guidance was readily available in people's care plans about any special dietary requirements such as a soft diet. One person told us, "I have a problem with food getting stuck in a certain place. It was looked into in hospital and if I'm coughing, staff know to come right away, they know how to help me deal with it." We saw staff were attentive to this person's needs." Staff informed us of a person who was eating very little and how they ensured their food intake chart reflected this. Staff told us of various ways they fortified people's food, "We use cream for soups and add cream to sauces, we make milk shakes as well."

People's individual needs were met by the adaptation of the premises. The service has been consistently upgraded with a safe accessible garden area and communal areas. All communal areas of the service were accessible via a lift. There were adapted bathrooms and toilets and hand rails to support people. Visual aids in communal areas helped to support orientation of people with dementia to move around the home and increase their awareness of their environment. One person told us, "We are lucky to live here."

Good

Is the service caring?

Our findings

At the last inspection in June 2017, we rated this key question as Good. At this inspection, we found this key question remained good.

People were treated with respect and dignity. The home had a relaxed atmosphere. People responded positively when staff approached them in a kind and respectful way. One person said, "Everyone's very kind to me here. I had such a bad stroke, that's what I need. You can be talking to somebody and they have to answer the bell, but you do get conversation with staff. It's a comfortable environment. My children have made friends with the staff and manager. Staff have patience and make it a home from home. Your room is your private place. Staff always knock; the door is there for me to say "no, I don't need help now" when I choose. They respect my privacy and I like that. If I want to get up early or stay in bed late, they go along with my wishes." Another person said, "Very kind." Relatives felt staff offered the care and support people needed and wanted. One relative told us "I visit once or twice a week at different times," and said, "All the staff are kind, friendly and easy to talk to." One staff member said, "The staff team is really focussed on caring, we really want to do our best." We received some comments that indicated there were issues to be resolved and this was being dealt with by the provider and social services placement team.

People were treated with kindness and respect and as individuals. It was clear from our observations staff knew people well. Staff made eye to eye contact as they spoke quietly with people; they used their preferred names and took time to listen to them. Staff knocked on people's bedroom doors before they entered, saying, "Good morning (name) are you ready for us," and "Would you like your meal later then, we can keep it hot."

People's privacy and dignity was protected when staff helped them with personal care and bedroom doors remained closed as people were assisted to wash and get up. When staff assisted people to move using an electrical hoist in communal areas they ensured their modesty was protected and they were moved respectfully. Staff told them what was happening and explained what they were doing. One person said, "I have to be hoisted when I want to go to the lounge and never have any concerns how it's done, always make sure I'm decent. I'm not so well today and I've been looked after well." This showed staff understood the importance of privacy and dignity when providing support and care.

People's equality and diversity needs were respected and staff were aware of what was important to people. People were encouraged to be themselves. One person said, "They treat me as an individual." Another person liked to look smart and told us staff ensured their clothes were clean and pressed, we were also told, "I like to look nice especially if I am going out, I can't do it myself but staff help me."

We saw positive interactions between staff and people, staff used affectionate terms of address and gentle physical contact as they supported people, and people responded with smiles. We also saw a care staff member sit with a person during lunch and encourage them with eating independently with gentle prompting, "Can I help you" and "Shall I cut up your meat for you." This enabled the person to retain their dignity whilst accepting help. The SOFI told us staff and people engaged positively using verbal and non-

verbal communication. During the meal service staff sat alongside people and maintained eye contact whilst assisting people. The pace staff assisted people was set by the person and not the staff member, which meant the person was not rushed and enjoyed their meal.

Staff promoted people's independence and encouraged them to make choices. We saw those people who liked to move around independently were supported discretely by staff. Staff talked to people and asked them if they needed assistance, they explained to people what they were going to do before they provided support and waited patiently while people responded. One staff member said, "Shall I help you to the table, its lunchtime soon." They leant down to talk to the person face to face so they could see their expression, and waited until the person responded. Comments from staff included, "We encourage people to be as independent as they can be. We give them space and respect their independence" and, "We let people make their own decisions if they can. For example, if someone doesn't want to do something then we make sure we offer later." We observed one staff member visit a person in their room, they explained what the meal was and asked if they needed help. The person was not ready for lunch and the staff member said it was not a problem, and the meal could be kept hot. The person needed assistance for care and another member of staff came to assist, with the hoist. Both staff sustained positive conversation and showed empathy with the person's concerns, that they wished they could walk to the toilet themselves.

People's preferences were recorded in their care plans and staff had a good understanding of these. There was information about each person's life, with details of people who were important to them, how they spent their time before moving into the home, such as looking after their family or employment, hobbies and interests. Staff said they had read the care plans and told us each person was different; they had their own personality and made their own choices, some liked music and noise while others liked to sit quietly, and they enabled people to do this as much as possible. People chose how and where they spent their time. People, who wanted to sit and read, rather than participate in activities, were supported to do so.

People's rights to a family life were respected. Visitors were made welcome at any time. Lounge areas were welcoming and we saw people enjoying spending time in this area with visitors during the days of our visits. There were items of interest from the provider, such as their vision and values, newsletters, details of events that had taken place, the weekly activities programme, health information booklets and advice about advocate services. There was also a staff photo board so people could recognise key staff. Information on the use of advocacy services was available and the registered manager confirmed the home worked in partnership with Independent Mental Capacity Advocates (IMCA) when required. 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. One relative told us, "We are always welcomed and feel at home, tea, coffee and cake is always offered."

People could express their views and were involved in making decisions about their care and support and the running of the home. Residents' meetings were held on a regular basis. These provided people with the forum to discuss any concerns, queries or make any suggestions. We saw ideas and suggestions were taken forward and acted on. For example, menus, activities, trips out and laundry services.

Care records were stored securely in the staff offices. Information was kept confidentially and there were policies and procedures to protect people's confidentiality. Staff had a good understanding of privacy and confidentiality and had received training.

Good

Is the service responsive?

Our findings

At the last inspection in June 2017, we rated this key question as Good. At this inspection, we found this key question remained good.
People were involved in developing their care, support and treatment plans as much as they wished to. A senior staff member said, "We try to involve people all the time in how they want their care delivered, sometimes we have to rely on families." One person said, "Yes I know I have a care plan because staff have told me and my family." Another person said, "Staff sit and discuss what is happening, they make sure I see a doctor immediately when I feel poorly."

People's needs had been assessed before they moved into the home, to ensure they could provide the support and care needed to meet their needs. The information from the assessment was used as the basis of the care plans and there was evidence these had been written with the involvement of people, and their relatives if appropriate. Records confirmed people and their families or representative had agreed with the information recorded, as well as consent for photographs, sharing the information with external professionals and for reviews of their care plan.

Staff undertook care that was suited to people's individual needs and preferences. The care delivery was person specific and in line with people's preferences. For example, what they preferred to eat and drink, what time they got up and what time they returned to bed. For people unable to tell staff their preferences, we saw staff had spoken with families and friends. Staff told us, "Care plans change with the persons' needs. From the records reviewed care plans had been reviewed regularly and updated when people's needs changed. A person's profile was at the front of each care plan and the individual folders. This was a precis of people's specific needs, including their medical and social history; their medicines and specific needs including communication, personal care, diet and mobility with risk of falls and aids used. It also contained food and fluid charts that staff completed over 24 hours of care. Staff said this information was easily accessible because it was in a locked cupboard near people's rooms. If staff had been absent from work they could catch up quickly with any changes by discussing the records with people, or their relatives. One member of staff told us, "The folders are really good, they are reviewed regularly and when people's needs change and they keep us up to date with the support people want." Relatives told us when they visited they had seen that the meals were appropriate, medicines were given and the care provided was what had been discussed and agreed.

Each care plan looked at the person's individual needs, the outcomes the support and care aimed to achieve and the action staff had taken to achieve this. For one person who had become increasingly frail and at risk from falling out of bed, staff had lowered the bed and placed a crash mat with a sensor mat by their bed to alert staff. Staff reviewed these strategies regularly to ensure they remained appropriate. Staff demonstrated a good understanding of this person's changing needs, both in terms of health and socially. One member of staff said, "If someone becomes confused or appears unwell we look for a cause, such as a urine infection and immediately encourage fluids and contact the doctor." Another staff member told us they monitored people's weights and immediately sought advice if a person was losing weight. This meant care delivery was responsive to people's individual needs.

Staff were kept up to date with changes in people's needs and the services provided through the handovers at the beginning of each shift. In addition, any significant information was recorded in a log that was passed on to the next staff team. Staff recorded the support offered in the daily records kept in people's rooms and these were checked daily by senior staff to ensure they reflected the support provided.

The staff team had a good understanding of the Accessible Information Standard and discussed ways that they provided information to people at Brooklands. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Staff told us of pictorial methods used for some people and of how this enabled people to make choices. For those who had a visual impairment staff used large print and said they could provide information on tape so people could listen to the information.

Managers and staff worked with other healthcare professionals to ensure people could remain at the home at the end of their life and receive appropriate care and treatment. This included having 'anticipatory medicines' available, so people remained comfortable and pain free. End of life care plans were in place for people, which meant staff had the information they needed to ensure people's final wishes were respected. Where people had chosen not to engage in these conversations, with the person's permission, discussions had been held with family and those closest to them. We looked at the care plan for one person who was approaching end of life care. The documentation had reflected care had been adjusted for this stage of their life. It emphasised the need for constant monitoring of pain and of ensuring food and fluids should be offered regularly in small amounts. On discussion the RN stated, "We know we need to improve aspects of our care documentation and are continually doing so and end of life is one area we will be focusing on."

Activities at Brooklands were planned and tailored to meet peoples' preferences and interests as much as possible. We were told that the format of activities may change on the day depending on who chose to attend and how many. A programme of events was displayed in the communal areas of the home. These included one to one sessions, quizzes, craft sessions and musical and film sessions. During our inspection we saw a number of activities taking place and enjoyed by people.

The provider employed an activities co-ordinator. As a large proportion of people were cared for in their beds we saw they spent their time moving around rooms sitting and chatting with people. People who were more mobile spent time in communal areas and activities were available. For example, film afternoons, tea parties outside in the garden and quizzes. When the activities person was not working, care staff took the lead in ensuring people's social needs were met. Staff told us they sat and chatted to people, did mini pampering sessions and people told us they were happy with how they spent their time and the interaction they had. People spoke very highly of a multi-faith chaplain who visited the service two weekly and spent time with people in their rooms. The chaplain also visited people when they were approaching end of life.

There was good interaction seen from staff as they supported people with activities throughout the home. We received positive comments from staff and visitors about activities and the one to one sessions being undertaken for people who preferred or needed to remain on bed rest or in their rooms.

Regular staff and resident/family meetings were held, times of meetings were displayed and details of suggestions and discussion points were recorded and actioned. For example, meal choices. The action plan included surveys and regular meetings with the kitchen team. The minutes of meetings were shared with people and families and displayed in the home.

The provider had established an accessible effective system for identifying, receiving, recording, handling

and responding to complaints. A complaints procedure was displayed in the reception area of the home and in other communal areas. The complaint system was also available on the website for the service. People told us they felt confident in raising any concerns or making a complaint. One person told us, "Yes I know how to moan and make a complaint." Another said, "I would tell one of the staff and I know it would be taken seriously." Complaints were recorded and responded to as per the organisational policy. A complaints log was kept and monitored by the registered manager. There was evidence complaints were fully investigated, responded to and apologies given if there was a need to with actions they were going to take.

When compliments and thank you cards had been received these were shared with staff at meetings and showed staff they were appreciated.

Satisfaction surveys had been sent out regularly in respect of getting feedback on the service. These were collated and the survey outcomes shared with people families and staff. The actions to be taken were also shared and people confirmed their comments had been taken forward.. One visitor said, "I have been asked to complete forms about food - I give feedback all the time."

Requires Improvement

Is the service well-led?

Our findings

We have inspected this key question to follow up the concerns found during our inspection in July 2017. At that inspections we found a breach of the legal requirements. This was because the provider had not ensured an effective quality assurance system was in place and the provider had not maintained complete and contemporaneous records in respect of each person.

At this inspection we found improvements had been made and the provider met the legal requirements. However, additional work was needed to ensure the improvements were embedded into day to day practice.

People said Brooklands was very comfortable and staff provided the care and support they needed. One person said, "This is my home, I am quite happy here." People and relatives said the staff and management were approachable and they could talk to them at any time. Relatives told us, "If we have any questions or we want to check on anything there is always staff around to talk to" and, "When we visit staff always ask us if everything is ok, if we want a drink and if they can do anything. We see staff and the manager talking to residents and checking they are ok." People said, "Staff come in to just say hello and see how we are quite often" and, "They check that we have everything we need." Staff told us they worked well together as a team, "Including the manager" and they were confident they provided the care and support people needed.

At the last inspection it was identified a business continuity plan was needed. This had been developed and was available to view. It was also identified that the provider had failed to take action in a timely manner to address environmental improvements to the service. There were now clear systems that ensured the service was safe and issues dealt with in a timely manner. The registered manager told us the provider had been made aware of the above areas. The provider visited the service at least once a week to meet with the registered manager and these were now recorded.

The quality assurance system had been reviewed and a number of audits had been introduced to assess the services provided and drive improvements. Weekly and monthly audits had been completed to look at all aspects of the services provided. These included care plans, medicines, accident and incidents, complaints, catering, housekeeping and maintenance.

We found overall the audits had identified areas where improvements were needed and actions had been taken to rectify these. However, reviewing and updating the care plans was one area where additional work was needed. We found some of the information was not consistent and had not been updated promptly when people's needs changed. For example, in one person's profile it stated they were 'Able to use call bell to ask for assistance', but in the care plan it stated they 'Cannot reliably use the call bell'. We were told that this had only recently changed and they had not had time to update the risk assessment. In another care plan and risk assessment, it was not clear how staff managed the person's complex health needs which involved specific dietary and nutritional needs. As required protocols were in place but needed to be developed to give guidance as to when it may be required. For example, pain relief especially for those who had been prescribed anticipatory medicines as they approached the end of their life. The impact on

people's care at the time of the inspection was low; because staff demonstrated a very good understanding of people's specific needs and spoke knowledgeably about how they supported the people whose care plans had not contained clear guidance for staff. It was acknowledged by the management team that some areas of people's documentation required improvement.

The registered manager had been in post for 18 years and was supported by a deputy manager. Everyone we spoke with knew who the registered manager was and felt that she was approachable and the service was well-led.

Effective management and leadership was demonstrated in the home. The registered manager was knowledgeable, keen and passionate about the home and the people who lived there. The use of agency had reduced since the last inspection and this had ensured safe consistent care delivery.

Staff told us that the philosophy and culture of the service was to make Brooklands a home. Staff of all denominations had contributed to developing values for the home. Brooklands values statement was "Our aim is to offer the highest standard of nursing care and provide the best possible quality of life for our residents, At Brooklands we strive to provide this with patience, empathy, understanding and a caring approach." Staff spoke of the home's vision and values which governed the ethos of the home. The ethos of the home was embedded into how care was delivered and the commitment of staff to provide good quality care and person specific care. The registered manager and staff had a strong emphasis on recognising each person and their identity. Staff wanted to provide care that was individual to that person and it was clear staff recognised each person in their own entity. From observing staff interaction, it was apparent staff had spent considerable time with each person, gaining an understanding of their life history, likes and dislikes. Care was personal to each person and staff clearly focused on the individual and their qualities.

The registered manager took an active role within the running of the home and had good knowledge of the staff and the people who lived there. There were clear lines of responsibility and accountability within the management structure. The culture of the service was described as open, honest and friendly, by people and staff. The registered manager said their door was always open if staff, people and visitors wanted to have a chat with them. One member of staff said; "I feel valued and part of a team," Staff were happy to challenge poor practice if they saw it and would contact the registered manager or other senior staff immediately if they had any concerns.

Staff said the morale of staff was strong and they worked as a team. All the staff spoken with were enthusiastic and felt Brooklands was a good place to work. One staff member said, "The manager really supports us, fair but honest and will compliment us when we do well." Another staff member said, "We are encouraged to develop our skills, and the manager ensures we get the training we need."

Systems for communication for management purposes were established and included handover meetings. Each shift change also had a handover meeting so staff changing shifts shared information on each person. Staff told us they were involved in discussions about people's needs and were encouraged to put forward suggestions and opinions during the daily meetings and the monthly staff meetings. Staff said, "We are involved in developing the service here," "I think the management is really approachable" and, "We feel listened to."

People, staff and visitors were regularly asked for their feedback about the service. This happened informally throughout each day when staff spoke with people whilst supporting them and formally through surveys. People were also involved in meetings with families where they could discuss their experiences at the service and highlight areas, which could be improved. Staff attended regular staff meetings to discuss the

service, people and training needs. Relatives felt they could talk to the manager and staff at any time and the relatives' meetings provided an opportunity for them to discuss issues and concerns with other relatives, friends and management on a regular basis. One relative said, "If I have a problem I just talk to the staff or manager and they deal with it."

The provider had notified CQC of significant events which had occurred in line with their legal obligations. The registered manager was aware of their responsibilities under Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to, it requires providers to be open and transparent and sets out specific guidelines providers must follow if things go wrong. Staff told us they were open about all aspects of the support provided and they contacted relatives or their representatives, with people's permission, to inform them of any concerns they might have. For example, if a person's health needs had changed and their GP had been contacted.

The registered manager had an understanding of General Data Protection Regulation (GDPR) which came into effect in May 2018. GDPR was designed to ensure privacy laws were in place to protect and change the way organisations approach data privacy.