

Tuella Limited

Brookdale House Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Brookdale House is a care home accommodating up to 22 people. The accommodation is arranged over two floors with a stair lift available to access the upper floor. There is no passenger lift. There is a mature garden to the rear and a patio with seating areas. People in care homes receive accommodation and their care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection. Brookdale House is owned by Tuella Limited who, throughout this report, are referred to as the provider. At the time of our inspection there were 18 people using the service.

The service does not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager who had been in post at our last inspection left in March 2018. In August 2018, the deputy manager was appointed as manager and is applying to register as manager with the Care Quality Commission.

We last inspected Brookdale house in October 2017. That inspection identified four breaches of the Regulations. People had not always received safe care and treatment, safeguarding concerns had not always been escalated appropriately to relevant agencies. The Care Quality Commission (CQC) had not been notified of events which had occurred within the service as required by the Regulations and the governance and quality assurance arrangements were not sufficiently robust.

We also made four recommendations. These were:

- That the medicines arrangements within the service reflected best practice guidance.
- That the use of covert medicines and the assessment and documentation of mental capacity assessments. was underpinned by the principles of the Mental Capacity Act 2005.
- That staff received an appraisal to support their ongoing development.
- That the activities provision be reviewed to ensure this met the needs of people using the service.

This inspection found that some improvements had been made but that many of these needed to be embedded further. There had been a period of five months when the service had been without a registered manager and this had delayed progress with addressing some of the areas where improvements were required. There was evidence that the manager was now acting to address these.

The provider had not completed all the relevant checks before employing staff.

Improvements were needed to ensure that the premises were decorated and adapted to a consistent standard throughout and in order to meet people's needs.

We continued to find that some risks to people's health and wellbeing were not being adequately assessed.

The use of covert medicines was being reviewed but best interest's consultations still needed to be more clearly documented.

People told us the food was tasty and that there was sufficient choice. However, records did not reflect that people were always being offered regular fluids. Aspects of the meal time experience could be improved.

The cleaning arrangements needed to be more robust.

Overall medicines were managed safely, but there were some areas where further improvements could be made.

Records did not demonstrate that new staff were completing the provider's induction in a timely manner.

More could be done to ensure that each person's faith and spiritual needs were documented and catered for. Improvements were needed to ensure that people were supported to develop a personalised end of life care plan.

Improvements were still needed to ensure that people had regular opportunities for meaningful interaction and to take part in a range of social activities tailored to their individual needs.

A provider information return (PIR) had been requested, but due to an oversight by the provider, this had been prepared, but not submitted.

Notifications to the Care Quality Commission (CQC) had not been submitted in a timely manner.

Improvements had been made to the governance arrangements, but these needed to be embedded and sustained in order to be fully effective at driving improvements and identifying compliance with the Regulations.

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

Staff asked for people's agreement before providing their care and gave people the time they needed to make and express their choices.

Staff had received supervision periodically and had an appraisal of their performance. A training programme was provided.

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

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

Staff provided care in a manner that was mindful of people's privacy and dignity.

Feedback about the manager from people and their relatives was positive. The manager demonstrated a good knowledge of all aspects of the home including the needs of people living there and the staff team.

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

We found one breach of the legal requirements. You can see what action we have taken at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

The provider had not completed all the relevant checks before employing staff.

We continued to find that some risks to people's health and wellbeing were not being adequately assessed.

The cleaning arrangements needed to be more robust.

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

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

Requires Improvement ●

Is the service effective?

The service was not always effective.

Improvements were needed to ensure that the premises were decorated and adapted to a consistent standard throughout and in order to meet people's needs.

Staff asked for people's agreement before providing their care and gave people the time they needed to make and express their choices.

The use of covert medicines was being reviewed to ensure that the records relating to this were complete and demonstrated that all of the key people had been involved in the decision to administer medicines covertly. Best interest's consultations needed to be more clearly documented.

People told us the food was tasty and that there was sufficient choice. However, records did not reflect that people were being offered regular fluids. Aspects of the meal time experience could be improved.

Records did not demonstrate that new staff were completing the

Requires Improvement ●

provider's induction in a timely manner.

Staff had received supervision periodically and had had an appraisal of their performance. A training programme was provided, although some staff felt that they would value more face to face training.

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

Is the service caring?

Good ●

The service was caring.

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

Staff provided care in a manner that was mindful of people's privacy and dignity.

More could be done to ensure that each person's faith and spiritual needs were documented and catered for.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Improvements were still needed to ensure that people had regular opportunities for meaningful interaction and to take part in a range of social activities tailored to their individual needs.

People were cared for by staff who were knew them well and received care and support which suited their needs and wishes.

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

Is the service well-led?

Requires Improvement ●

The service was not always well led.

A provider information return (PIR) had been requested, but due to an oversight by the provider, this had been prepared, but not submitted.

Notifications to the Care Quality Commission (CQC) had not been submitted in a timely manner.

Improvements had been made to the governance arrangements, but these needed to be embedded and sustained in order to be fully effective at driving improvements and identifying compliance with the Regulations.

Feedback about the manager from people and their relatives was positive. The manager demonstrated a good knowledge of all aspects of the home including the needs of people living there and the staff team. They took an active role within the home, delivering care and serving as a role model to the staff team through their hands-on approach.

Brookdale House Care Home

Detailed findings

Background to this inspection

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

The inspection took place on the 17 and 18 October 2018 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is used by registered managers to tell us about important issues and events which have happened within the service. We used this information to help us decide what areas to focus on during our inspection. A provider information return (PIR) had been requested, but due to an oversight by the provider, this had been prepared but not submitted. A PIR is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make.

Some people were not able to speak with us and share their views about the care and support they received; however, we spent time observing interactions between people and the staff supporting them. We were able to speak with six people who used the service and two relatives. We also spoke with the manager, the provider and four care staff. We reviewed the care records of four people in detail and the recruitment records for four staff. We also reviewed the medicines administration record (MAR) for all 16 people. Other records relating to the management of the service such as audits, meeting minutes and policies and procedures were also viewed. Following the inspection, we received feedback from two health and social care professionals.

Is the service safe?

Our findings

People told us they felt safe at Brookdale House. One person said, "Yes I'm safe and happy here". Another person said, "I feel safe with the staff. ... They encouraged me not to get up on my own, I've not been well and had a fall. When I go downstairs for lunch they come and help me on the stair lift". A relative told us, "[person] is safe and secure here".

Whilst people told us they felt safe, we noted some areas for improvement.

We were not assured that the provider had completed all the relevant checks before employing staff. In the case of one person, the service was unable to provide evidence that they had made every effort to assure themselves that the staff member was of good character. In the case of another staff member, their records did not include a full employment history. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and Proper Persons employed.

Other required checks were in place. We have discussed our findings with the manager who is taking action to obtain the missing information.

Our last inspection had found that some risks had not been adequately assessed and planned for. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. This inspection found that some improvements had been made, but that there were still some areas where the management of risks to people's health and wellbeing needed to improve.

We were not assured that people's nutritional needs were always met safely. One person's care plan stated that they required a 'Thin puree' however, we observed them being given a thick puree which contained small lumps. We pointed this out to the manager who arranged for an alternative meal to be provided.

Environmental risks had not always been managed. Water sampling to detect legionella was taking place and there was a basic legionella risk assessment in place. However, the remedial actions this recommended were not in keeping with Health and Safety Executive Guidance and records did not provide assurances that these remedial checks were all being completed. We have discussed our findings with the manager. They have advised that they are acting to source a more robust legionella risk assessment. We will check to see that this has been completed.

There was a 'Disaster Box' located in the main entrance of the home which contained the personal emergency evacuation plans (PEEPS) along with other equipment which might be helpful in an emergency such as a fire. However, the PEEPs were not up to date and did not fully reflect the people using the service. This could impact on the fire service safely and promptly evacuating the service.

Bed rail risk assessments were now in place as were assessments to identify any potential risks to people from using or accessing the stairs independently. Accidents and incidents were monitored by the manager to look for trends and patterns. However, a number of the accident forms viewed lacked information or had

not been fully completed. It was not clear therefore what follow up had been undertaken and what actions had been put in place, to reduce recurrences. Staff attended to people's immediate needs following falls and if appropriate had sought advice or intervention from health care professionals to dress wounds for example. However, we found that following falls, including those resulting in head injuries, suitable post falls protocols were still not being followed. These protocols ensure that people are appropriately monitored following falls in case their condition deteriorates allowing further medical advice to be sought. This had been raised as a concern at our last inspection. The manager has now taken action to implement clear post falls protocols.

People who were at risk of choking had been identified and their care plans included information about their dietary requirements and the support they needed to eat and drink. However, the risk assessments did not include guidance for staff on how they should respond should the person experience a choking episode. One person had a risk assessment in place for self-medicating. We found that this risk assessment would benefit from being more robust and personalised and we recommend that this is reviewed in light of best practice guidance such as that from the National Institute for Health and Care Excellence, Managing Medicines in Care Homes.

Our last inspection had found that potential safeguarding concerns had not been escalated to the local authority safeguarding teams. Escalating concerns is important as it helps to ensure that the relevant agencies have oversight of potential risks within the service. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

The new manager demonstrated a commitment to keep people safe from harm, but during the inspection they told us about some incidents which had occurred within the service which we felt might have met the threshold for being considered a safeguarding concern, but had not been escalated to external agencies and the CQC. The manager has, since the inspection, told us that they are to attend a detailed training course provided by the local authority that will help them to develop further their skills and knowledge in this area. Staff displayed a positive attitude to reporting any concerns they might have about people's care or wellbeing and were all confident that the manager would act upon these. People had a 'safeguarding from abuse care plan' which were designed to identify and prevent any risk of abuse within the service.

People told us they felt the home was kept clean. Staff were provided with a range of equipment to help ensure good infection control such as gloves and aprons and we observed that they were using this personal protective equipment appropriately. However, we observed that some improvements were needed. Some areas of the home were not visibly clean such as some of the carpets in the communal areas. We found used toilet paper on the floor of the downstairs toilet and the bin was overflowing with paper towels and used gloves. We pointed this out to the provider who arranged for this to be cleaned. There continued to be no cleaning staff employed to cover weekends and the weekend cleaning schedules showed that planned cleaning tasks did not take place. The local clinical commissioning group had recently undertaken a full infection control audit of the service and whilst the full feedback from this was not available, the manager had produced an interim action plan which demonstrated that they were taking prompt action to address a number of areas noted for improvement and efforts were being made to recruit additional cleaning staff.

People were satisfied with the support they received with their medicines. One person said, "Oh yes, I always get my [name of medicine] on time". Suitable arrangements were in place for ordering medicines and relevant checks were made to ensure that these were supplied correctly. People had an individual medicines administration record (MAR) which included their photograph, date of birth and information about any allergies they might have. We observed staff supporting people to take their medicines. This was

managed in a person centred manner. Staff responsible for the administration of people's medicines had received training and their competency to administer medicines was being checked on a regular basis by the manager.

However, we found some areas where improvements could be made. We saw examples where handwritten MARs had not been countersigned in line with best practice guidance. Staff were not maintaining records which clearly evidenced that each prescribed topical cream had been administered as prescribed. We found one gap in the MARs without a reason for this being recorded. Checks showed that this was likely to be a recording error. Not everyone had a personalised protocol in place to guide staff as to when PRN or as required medicines might be needed. When PRN medicines had been administered, staff were not recording the reason why on the reverse of the MAR. This is important as it helps staff recognise any trends in the use of PRN medicines that might require a referral to their GP. Whilst medicines awaiting return were stored in a locked medicines room, they were not in a tamper proof container. We were advised that the temperature of the room used for storing medicines could at times be in excess of recommended temperatures. Storing medicines at the correct temperature is important to ensure they remain effective. An action plan is being developed to address these areas.

During the inspection, our observations indicated that there were sufficient numbers of staff deployed to meet people's needs. Daytime shifts were staffed by three care workers, one of whom was a senior care worker. There was also occasionally a fourth care worker who was an apprentice. There were two waking care staff on duty at night. We reviewed the staffing rotas for a four-week period and found that the service had been staffed to these target levels. Rotas did show that care was provided by a small and consistent staff team which helped to ensure that people were cared for by staff who knew them and their needs well.

The manager kept staffing levels under review to ensure they were in line with changes in people's level of dependency. They had recently introduced a twilight shift on some days to increase the availability of staff to support people to bed at a time of their preference. Senior care workers were given some supernumerary hours to update care plans for example. People expressed no concerns about the staffing levels. One person said, "When I ring my bell, they always come quickly" and another said, "I don't ring [the bell] very often, [I] don't have to wait long". One visitor told us, "I think they are quite well staffed here, some of them have been here for years" and another said, "Yes there's always plenty of staff here". A health care professional told us, "There always appears to be a decent amount of staff on duty who are also aware of each individual's needs". Staff felt the staffing levels were usually adequate but some said that the last few months had been tough since the new head of care had left and due to sickness. Recruitment was ongoing and there was evidence that the manager was trying to address sickness levels.

Is the service effective?

Our findings

People told us they were happy with the care they received at Brookdale House. For example, one person said, "If I wasn't satisfied, I wouldn't stay here". Relatives were also largely happy with the care provided. One relative said, "We were very lucky to find this place". Although another relative told us, "When [manager] is not here, I feel it slackens off" and another felt that some aspects of the premises needed to improve. They said, "I think there are things that could be done like make a family room and make a wet room downstairs, but it is an old building".

At our last inspection, the provider told us they planned to redevelop / renovate both the self-contained bungalow and the main building in order to improve the living accommodation. We had been told that this work would be completed by the spring of 2018, however this had not yet started. The provider maintained a commitment to undertake this work and plans were now in place to start this work in January 2019, which we saw some evidence to support. Some improvement work had been completed within the main house, for example, work had begun to improve the entrance hall and dining room. The walls had been painted and the flooring replaced in these areas. Five rooms had also been refurbished. However, there remained a number of areas where improvements were needed to ensure that the premises were decorated and adapted to a consistent standard throughout and in order to meet people's needs.

Carpets in the main lounge and in other areas of the home were in places, heavily stained and sticky to walk on. This had been a concern at our last inspection. Since our last inspection, a small lounge had been converted into two rooms. One of the rooms was the new medicines room, the second was now being used as accommodation. This room was not big enough to have a wardrobe which meant the person occupying the room was having to keep all of their clothes in drawers. We found a similar situation in a shared room. One person was not able to use the downstairs adapted bath, but was also not able to safely use the stair lift to the first floor where the level access shower was located. This meant they were only able to have strip washes. A number of windows were dirty, in some cases, to such an extent that it was difficult to see out of them. There had been water damage due to a leak in one of the communal rooms in August. Whilst remedial repairs had been made, the area had not yet been redecorated. Some items of furniture were old and worn and would benefit from being replaced.

Our last inspection had commented on the need to make the environment more suitable for people living with dementia. Whilst some decorative work had been completed to the upstairs corridors, the provider acknowledged that this had not been wholly effective and the premises still needed further work to ensure it was designed or adapted for the needs of people living with dementia. This is important as it helps to create a supportive and enabling environment that helps people maintain their independence. The provider told us they planned to work with a specialist company to design dementia friendly spaces within the home, however, there had been a lack of progress with this to date and the physical environment did not match the provider's website description of Brookdale House as a 'specialist dementia home'.

Throughout our inspection we saw people were given choices about how they would like their care and support to be provided. Staff asked for people's agreement before providing their care and gave people the

time they needed to make and express their choices. For example, we heard a staff member offer people a choice of seat in the lounge and checking people had finished before removing their plate following their meal. Where able, people had signed consent forms giving permission to have photographs taken to keep in their care records for identity purposes.

We looked at how the service was acting in accordance with the Mental Capacity Act 2005 (MCA). The MCA 2005 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. We saw that some people had mental capacity assessments regarding the use of bed rails and regarding the decision to live at Brookdale House. Staff understood their responsibilities with regards the MCA 2005. One staff member said, "We have to do the least restrictive thing, we have to assume they have capacity until deemed otherwise". One of the health care professional we spoke with, told us, "[the manager] is very knowledgeable on capacity assessments",

We did, however, observe that best interest's consultations needed to be more clearly documented and demonstrate how external professionals and family members had been involved in reaching decisions about how people's care and support should be provided when they lacked the capacity to decide this for themselves.

It was positive that the manager was at the time of the inspection, reviewing the use of covert medicines within the service to ensure that this remained appropriate and was the least restrictive way in which to meet people's needs. However, we found that the records relating to the use of covert medicines remained incomplete and did not demonstrate that all of the key people had been involved in the decision to administer medicines covertly. The manager is continuing to work with local health and social care professionals to ensure that the correct procedures have been followed when medicines need to be administered without the person's knowledge or consent.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). A number of applications for a DoLS had been submitted by the home and had been authorised. The manager was able to provide reassurances that conditions attached to the DoLS had been met.

People confirmed that they were offered a choice of meals and drinks. Lunch was served at 12pm and a tea at 4pm. A light supper was available at 7pm. We observed the lunchtime meal on the first day of our inspection. People could choose to eat their meal in their room or in one of the two lounge/ dining areas. Prior to lunch people were offered a sherry or whiskey cream liqueur and water and squash was also available. The lunch time meal was a quiet occasion and there was a relaxed atmosphere. The tables were laid with cloths and serviettes although we noted that no condiments were available. The food appeared freshly cooked and looked appetising. People were offered a choice of dessert. One person had a red plate which the manager explained helped people with dementia to see their food more clearly encouraging them to eat better. In the afternoon, the cook came around to offer people tea or coffee and flapjacks. They asked people to choose what they would like for tea. They were able to choose from homemade butternut squash soup, cheese or spaghetti on toast or a range of sandwiches. One person asked for tinned tomato soup which the cook agreed to provide.

People were mostly positive about the food provided. One person said, "The cook comes around at 10

o'clock with coffee, she tells you what's on the menu and says is that alright with you? She will always offer you a choice. ...I've lost weight so they tempt you with little snacks, they are very kind". Another person said, "The food here is good but repetitive, the cook is a miracle worker, she cooks nearly everything from scratch, we can have a roast three times a week". A relative told us, "They always offer [person] a choice to encourage her, the cook always takes an interest, she brings in different fruits and juices to tempt her". Staff told us the food was generally good. One staff member felt that there should be more choice of desserts for people living with diabetes.

There were some aspects of the meal time experience that could be improved. There was no menu displayed in the home. At lunch time there were plenty of staff available to support people, however, we noted that this was not always done in a person-centred manner. For example, one person required assistance from staff to eat. Throughout the meal this support was provided by three different members of staff. At tea time, some people had chosen spaghetti on toast which was served in a plastic bowls, this made it difficult for some people to cut their meal up.

Our observations indicated that people were being offered regular fluids, however, the records did not always evidence this. This had been a concern at our last inspection. For example, a sample of fluid charts were viewed. On the 10 October 2018, one person was assisted with some fluids at 5pm. The next record of fluids being offered was at 10:43am the following day. On the 12 October 2018, no fluids were recorded as taken by this person between 10:25am and 16:45pm. After that, there was again no records of fluids being offered until 9:15am the next morning. The records for a second person showed similar concerns. For example, on the 14 October 2018, the person was offered fluids at 16:53pm, but not again until 09:42am on 15 October 2018. The registered manager was confident that this would be a recording issue and that people would have been offered regular fluids and that fluid intake was monitored carefully by staff and this would be in keeping with our observations. To monitor this more carefully, the manager has made arrangements to add realistic target fluid levels to each person's electronic records. If these are not met then senior staff will be alerted to this and will be able to take remedial action. We, were however, told that this facility was being implemented when we last inspected in October 2017.

Records used to monitor people's weight had improved and we were able to see evidence that people had been referred to their GP if they had lost weight and higher calorie foods and fortified drinks were being offered. A nationally recognised tool to monitor people's risk of malnutrition was being used.

New staff received a service based induction which involved learning about the care philosophy within the home, people's needs, daily routines and key policies. The induction paperwork stated that the induction should be completed within a maximum of six weeks. We looked at the induction records for three staff who had been employed at the service between April and August 2018 but none had fully completed induction records. This is an area for improvement.

The manager told us that instead of enrolling new staff on the Care Certificate, they were enrolled on other nationally recognised health and social care qualifications as was the case with three recently recruited staff. A further ten staff already had a Level 2 qualification, in health and social care, or above.

This training programme was completed via an App staff had on their smart phones. The manager advised that this allowed them flexibility about when and where they completed the training. The training covered a variety of areas such as moving and handling, the MCA 2005, safeguarding, fire training, food hygiene, infection control and first aid. The training also covers training relevant to the needs of people using the service such as caring for people living with dementia, end of life care and pressure ulcer prevention. Staff were required to repeat this training on an annual basis. Some staff felt that they preferred face to face

training and this was available in some subjects such as first aid, fire safety and moving and handling which was due to take place shortly. They felt the online training was not adequate. For example, one staff member said, [online training] is not good enough, you just try and do it to not get told off". Another staff member said of the online training, "I'm not struck on it, the first aid training was a practical and it was really enjoyable". Some staff also told us they would value specific training in managing behaviour which challenges. Completion rates of the online training were adequate. Most staff were overdue with their moving and handling training, but this had been booked to take place shortly.

Records showed that staff received formal supervision periodically and had had an appraisal of their performance in 2018. Supervision and appraisals are important tools which provide an opportunity for staff to discuss matters relating to the needs of people using the service and develop their own skills and knowledge. It also provides managers with reassurances that staff have the required skills and knowledge to perform their role effectively.

The manager understood the importance of information sharing and communicating with other organisations to meet people's needs. This was evidenced by a social care professional who told us, "[Manager] will contact the team...for advice and information when she needs it... I have confidence that she will contact one of us if she is unsure how to proceed with a case".

Where necessary a range of healthcare professionals had been involved in planning and monitoring people's health and wellbeing support to ensure this was delivered effectively. People had regular visits from their GP and from other healthcare professionals such as community nurses and mental health professionals. There was evidence that relatives were kept informed of the outcome of GP or hospital appointments. Antibiotic care plans had been introduced to help staff monitor people's recovery from infections. Hospital packs were in place and included information about people's current medicines, a care plan summary and a summary from the GP about the person's past medical history. This was sent with a person upon their admission to hospital along with documentation recording whether they had a do not resuscitate decision in place.

People who had experienced falls had been referred to the falls clinic. During our last inspection, the manager in post at the time had told us of plans to implement post falls huddles. These are a debriefing following a fall to see if any preventative actions might have been possible. The registered manager told us they were also hoping to implement a specialist tool to help recognise when a resident may be deteriorating or at risk of physical deterioration so that they seek prompt escalation of their care to relevant healthcare professionals. Neither of these tools had yet been implemented, although the current manager expressed a commitment to do so.

Is the service caring?

Our findings

People told us they were cared for by staff who were kind, caring and attentive. For example, one person said, "They [staff] are lovely, they make you laugh and they're interested in you". A second person said, "My best friends here are two of the night carers, we have a joke together". A third person said, "I'm looked after very well. I've always found the carers very nice and never seen them be nasty...they are very good if they can they'll always help you...I'm quite content here". A relative told us, "The kindness of the staff is the best thing here". A social care professional told us, "Staff which I have met always appear to be kind and supportive towards residents in the home as well as visitors". A second professional told us, "I have no concerns regarding the home and feel the staff are generally very caring".

We saw a number of friendly exchanges between staff and people. For example, we saw one staff member encouraging a person to 'dance the twist' with them whilst listening to music. We observed another person stroke a care worker's face tenderly, whilst chatting with them. Throughout our visit people looked relaxed and happy in the company of the staff. It was clear from our conversations with staff and our own observations that staff wanted to provide good care and were committed to doing so. One staff member told us, "It keeps me going seeing their faces but the hardest bit is not being able to comfort them sometimes".

The kindness of the manager was reflected in the feedback from one relative who told us how the manager had driven out to the New Forest to pick their family member up after a celebration so that they could stay on. They said, "I thought this was very kind of her".

People could express their views and were involved in their care. People told us they could make choices regarding their day to day care such as what time they got up, went to bed and how they spent their time and their personal care. For example, one person told us, "You can get up when you want to and please yourself what you do" and another said, "I can ask for a bath if I want one". A relative said, "They are very accommodating here, [person] likes to stay up late".

There was evidence that staff encouraged people to remain independent. For example, where able and following appropriate assessments, people retained control over the management of their medicines. We continued to see people get involved in daily chores such as laying the tables. A relative told us, "One guy who lived here, they got working, watering the garden, it was really good". At lunch, people were provided with plate guards and adapted drinking cups so that they would eat and drink independently. Following the meal, if they were able, people were encouraged to clear their plates to a trolley outside the kitchen.

There was evidence that staff paid attention to people's personal appearance and the people we met all looked well cared for. For example, one person returned to the lounge after having a bath, she was smartly dressed and wearing lipstick. Staff complimented the person for looking so nice which pleased the person. Following meals, people were offered assistance with washing their hands and mouth in order to promote their dignity. Staff acted quickly and discreetly to support one person who had left the bathroom without being fully dressed.

People were supported by staff who respected their privacy and dignity. One staff member said, "If I am helping with personal care, I place a towel over their lower half, If I'm helping someone to the toilet, I do this discreetly, it helps protect their dignity". One person often chose to stay in their room and staff respected this choice. One person's relative told us, "They [staff] always knock on the door and they are really lovely".

There were no restrictions on the times people could receive visitors. One person told us, "My daughter can come in and bring the dog, she's made to feel welcome. This was confirmed by a relative who told us they were always greeted warmly by staff.

Overall, people's care plans contained very little information about their religious or spiritual beliefs and whilst some people were supported to attend their chosen place of worship there were only occasional visits to the service by representatives of local churches and this is an area where we felt more could be done to help ensure that each person's faith and spiritual needs were catered for.

Is the service responsive?

Our findings

Improvements were needed to ensure that the activities provided were sufficient, varied and based on people's known interests. The service did not employ an activity lead and the activities provided during the inspection were mainly spontaneous and led by the care staff as and when they had time in between providing people's care and support. We observed staff leading activities such as singing, quizzes, colouring and hand care. People seemed to enjoy the activities provided and the staff leading these were energetic and engaged well with people.

However, there was no schedule of planned activities displayed when we inspected. Following the inspection, we were sent a four-week schedule. This showed that the weekly activities varied very little from week to week and often included repeated activities such as nail care, karaoke, 'Sherry O'clock', a visit from the hairdresser, coffee morning and quizzes. Twice a month, an external visitor came to provide 'Chair Fitness' and a jazz singer had visited. Some people attended the local church or library and were accompanied by staff on walks to the shops.

Feedback from people and their relatives about the activities provision was mixed. One person said, "Once we had an entertainer here at the same time as the hairdresser which was a shame... We have karaoke and bounce a balloon along with the music". Another person said, "I like to sit and read my newspaper and look at the crossword". A relative told us, "They could do with an activities officer and have more music and movement". All of the staff with spoke with felt there should be more activities provision. One staff member said, "Weekends are hard [to provide activities], they [people] should have more one to one time, everyone should have it". Another staff member said, "There are not enough activities, you can only do bits and pieces".

There was little evidence of the activities being specifically designed to promote the physical, mental, social and creative wellbeing of people living with dementia. We also observed and records indicated that some people who were cared for in their room, were still not being provided with regular opportunities for meaningful activity in order to promote a sense of well-being and contentment. A health care professional told us, "The staff always seem busy and a small criticism would be that I would sometimes prefer to see them sitting with residents engaging in socialisation although I understand certain tasks must be completed. I believe the social aspect to be as important as the practical requirements".

We recommend that the provider take immediate action to re-evaluate the activities programme in line with best practice guidance such as that from the National Institute for Health and Care Excellence (NICE) - Mental Wellbeing of Older People in Care Homes Quality Statement 1 - Participation in Meaningful Activity. Since the inspection, the manager has informed us that they have started to develop person centred activity plans which will be used to develop the activities provision and ensure this meets people's individual needs.

People's needs were assessed before they came to live at the service to ensure that the staff would be able to meet their needs safely. Following their admission, a care plan was developed which included information about the person's needs and how these should be met. This helped to ensure people received

care and support which suited their needs and wishes. The care plans viewed contained some information about the person's life before coming to live at the service and some specific, individual information, about the person such as their preferred daily routines. Our observations indicated that staff knew people and their individual preferences well and this was confirmed by people. One person told us, "The new ones [staff] might not know you so well, but they always come around with a regular carer at first".

The care plans were created and accessed via an electronic care planning system. Staff used smart phones to read the plans which covered areas such as how the person communicated, their personal care needs, the support they needed with nutrition, their medicines and with their mobility. Where people were living with dementia, they had a care plan in place to provide some basic information for staff on how this might affect them. Where necessary people had a suitably detailed catheter care plan. People had oral care plans demonstrating that staff understood that oral care should receive the same priority as other personal care routines. The electronic care plans clearly highlighted whether people had a 'Do not resuscitate' decision or a DoLS authorisation in place. The plans were reviewed and updated regularly.

Whilst the care plans viewed generally reflected people's current needs, there was some scope for further improvement. For example, one person's diabetic care plan did not include a suitably detailed escalation plan which described the actions staff should take if the person's blood glucose levels were too high or too low.

Staff could use their smart phones to record contemporaneous updates to people's care records. The system enabled staff to easily record when personal care had taken place or how much someone had eaten or drunk. We found that some of the food and fluid charts were not always completely fully which limited their effectiveness as a monitoring tool. The manager told us they were making changes that would address this.

A detailed handover was held at the start of each shift which helped to ensure staff were kept up to date with people's changing health and welfare needs. Staff could also access an electronic handover document which allowed them to be updated about people's needs over any chosen time frame which was helpful if they had been on leave for example.

Detailed notes were kept recording the outcome of consultations with health care professionals and there was evidence that their advice was being followed. The manager kept a tracker of all health care professional advice and recommendations to ensure that this had been incorporated into the person's care plans.

The manager was developing systems to encourage people and their relatives to give feedback about the service. There was evidence that people had been consulted on the décor for the dining room and a residents meeting had taken place in June 2018. People had been asked for their views about the activities and menus. Some of the suggestions made had been acted upon, for example, it had been suggested that a TV be fixed to the wall in the newly decorated lounge/ dining room. This had been completed. Other suggestions had been part achieved or were ongoing such as revising the menus. A second meeting planned for September 2018 did not take place as some people were feeling unwell.

'Butterfly meetings' took place. These were informal opportunities for relatives to meet individually, or in a group, with a member of the senior team. One relative told us, "I have been to one butterfly meeting with my brother, it's an opportunity to ask for changes and they did listen to us". A second relative told us, "We have not been able to get to them [butterfly meetings] but we get lots of updates, emails and information, they've always got time for you".

Surveys had recently been undertaken with people to seek their feedback about aspects of the service such as the food, environment and laundry. There had been a limited response so far. The manager told us an action plan would be developed in response.

The provider had a complaints procedure in place and people and their relatives knew how to complain. The manager was accessible and we observed relatives speaking with them throughout the inspection. People's relatives told us that any issues raised were addressed promptly. For example, one relative said, "We've had one or two little problems which [manager] jumped on straight away". Another relative told us they were satisfied with the way in which their complaint was managed. They said, "If there was anything wrong, I wouldn't keep [person] here".

The manager was aware of the Accessible Information Standard (AIS) and there was information in people's care plans about their communication needs and staff were aware of these. The manager told us that staff had been using visual aids to help one person communicate but had found that the pictures were too small and so had ordered an alternative to see if this would be more effective. We did note that more could be done to make general information more accessible for people by for example, displaying large print or pictorial menus and activity schedules. At lunchtime, the use of show plates could be used, where appropriate to help people choose their preferred meal. This would help to promote people's involvement in decisions about their care. The AIS 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.

When people reached the end of their life, staff worked closely with the GP and community nursing team to meet their needs. Our last inspection had found that the development of end of life care plans was an area where further work was needed. This was still the case. The manager acknowledged this and confirmed this would form part of their on-going improvement plan.

Is the service well-led?

Our findings

This inspection found a breach of the legal requirements. Alongside some additional concerns noted below. This has meant that the rating for the well led key question cannot be rated better than requires improvement.

Our last inspection identified that the registered manager had failed to notify the Care Quality Commission (CQC) of certain incidents which had occurred within the service. This is required as it enables the CQC to effectively monitor the safety and quality of the service provided. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009. Notification of other incidents. This inspection found that improvements were still needed with regards to this. Throughout the early part of 2018, when the service was without a registered manager, a number of Deprivation of Liberty Safeguards had been authorised. Such authorisations have to be notified to the CQC without delay. This had not been done until some months later. We have discussed this with the current manager to ensure they understand their responsibility to make such notifications without delay moving forward.

Our last inspection found that the governance arrangements within the service needed to be more robust. Audits had not been taking place to assess the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008. This inspection found that some improvements had been made.

There was evidence that a more robust programme of audit had been put in place. For example, the provider had completed an audit in June 2016. This had identified a range of areas where improvements were needed and an action plan was developed to achieve these. Some of these had been completed. Some remained a work in progress. Nutrition and basic care plan audits were undertaken as well as hand hygiene, kitchen and health and safety audits. The manager had developed links with staff from the clinical commissioning group who were assisting with infection control and medicines audits. However, the implementation of this more robust programme of audit was in its infancy and would benefit from being more clearly baselined against the Fundamental Standards in order to be as effective as possible at driving improvements and identifying compliance with the Regulations. We did find that the manager understood the importance of good governance arrangements to monitoring the ongoing safety and quality of the service.

Feedback about the manager from people and their relatives was positive. One person told us, "[manager] I can talk to her she's very nice, she's full of ideas and tries them out". Another person said, "She's lovely, I don't know what I'd do without her". A relative told us, "[manager] leads from the front". Another relative had recently written to the provider to share their feedback about the manager. They had written, that they were "Increasingly impressed by [the managers] abilities, skills and compassion... [The manager] is genuinely capable and totally professional at all times...[manager] is an absolute credit to Brookdale House. Since her appointment we have witnessed so many positive actions, she can certainly multi-task and to a high level, always busy, but always available... In short, [manager] is proactive and uses her acquired and innate skills well".

Staff were positive about the manager. They all felt well supported and able to approach the manager with any concerns or problems. One staff member said, "[Manager] is very fair, they have made a lot of changes... they always try to act on things, communication is good".

Improvements were needed to ensure that staff meetings happened on a regular basis. Staff meetings are important as they allow staff members to focus on issues that are not easily conveyed in the everyday running of a busy care home. They support effective communication of changes, learning from incidents, introduce new members, and allow the team to raise any issues or concerns and to look forward.

Throughout the inspection, the manager demonstrated a good knowledge of the needs of people living in the home. They took an active role within the home, delivering care and serving as a role model to the staff team through their hands-on approach. This had been commented on by a relative who had written to the provider saying, 'We inadvertently saw [manager] demonstrating to one of the care staff how to deal with a resident with dementia... This lady was very agitated/distressed... [manager] intervened as the situation was escalating. [manager] gently and calmly sat down next to the resident with the staff member. We then saw how she made this task into a 'fun game' allowing the resident to in fact wash her hands in the small bowl of water... Within a few moments the whole situation was turned around, the resident was giggling and allowing her hands and face to be cleaned'. A health care professional told us, "Their manager [name] is very aware of details of individual residents".

Throughout this inspection the manager remained open to receiving feedback. Where the inspection identified areas where improvements or actions were required, these were acted upon promptly wherever possible. Whilst it was clear from both our own findings and the feedback received, that the manager was making improvements, we did note that over the last four weeks, it had often been necessary for them to cover care shifts due to staff sickness or shortages. We were concerned that this had, and would continue to, impact on their ability to carry out their own managerial duties and dedicate the time required to driving improvements within the service. This was summed up by a member of staff who told us, "They [the manager] are a one-man band, with another trained person to support them, this place could thrive". We discussed this feedback with the manager. They told us of plans to develop the role of senior carer and delegate more tasks to these staff members. They were also in discussions with the provider to recruit a head of care and an administrator.

People were encouraged to maintain links with the local community. People were supported to attend their church if they wished or to go to the local shops and visit their doctors if they were well enough. One person enjoyed visiting a local pub.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider could not evidence that all of the required pre-employment checks had been completed. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and Proper Persons employed.