Tuella Limited

Brookdale House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Brookdale House is a care home, without nursing, accommodating up to 27 people. The accommodation is arranged over two floors with a stairlift 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. Many of the people using the service were living with dementia. 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 23 people using the service.

People's experience of using this service and what we found
Some of the risks to people's wellbeing had not been adequately managed or mitigated.

Learning following a recent significant safety related incident at the service had not been sufficiently embedded.

Medicines continued to not be managed in line with best practice guidance and the provider's policies and procedures.

The provider's guidance on the use of personal protective equipment (PPE) was not consistently followed. Records did not provide assurances that cleaning schedules were completed as planned.

We were not assured that there were sufficient staff, effectively deployed, to meet people's needs.

We have made a recommendation about records relating to recruitment.

Where incidents of safeguarding concerns had occurred, these had been escalated appropriately to external agencies.
Rating at last inspection (and update)
The last rating for this service was requires improvement (Published January 2020). We found one breach of the Regulation regarding safe care and treatment. The provider completed an action plan after the last inspection to show what they would do, and by when, to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We carried out this short notice, focussed, inspection of this service on 22 September 2020 to check that the provider had followed their action plan and to confirm they now met legal requirements.

The inspection was also prompted in part due to concerns we had received from whistle-blowers about medicines management, staffing levels and staff culture. There had also been a recent safety related incident and we wanted to be assured that steps had been taken to prevent similar incidents from happening again.

We did look at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

Audits and quality assurance checks were not being fully effective at driving improvements or embedding change.

Records relating to people's care did not always support staff to meet people's needs in an effective or safe way. We were not assured that the provider had robust systems in place to always keep records securely and to ensure they are only accessed by people authorised to do so.

We have made a recommendation that the provider implement systems to ensure that the information required by the Care Quality Commission is readily available and accessible in the service in order that they can demonstrate their compliance with relevant Regulations.

Staff raised concerns about morale and told us they had lost confidence in the provider to address their concerns.

Most relatives felt the service engaged with them well, although this was not everyone's experience.

In discussions with the nominated individual they demonstrated a good understanding of their responsibility to be open and honest with external agencies and with people using the service and there was evidence that the service worked in partnership with other organisations to meet people's needs.
This report only covers our findings in relation to the key questions safe and well-led which contain those requirements. We reviewed all the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them.
The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained the same. This is based on the findings at this inspection.
We have found evidence that the provider needs to make substantial improvements. Please see the safe and well-led sections of this full report.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Brookdale House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, staffing and governance.

Please see the action we have told the provider to take at the end of this report

Follow up
We will continue to monitor information we receive about the service and we will continue to work with partner agencies. We will also request a specific action plan to understand what the provider will do immediately to ensure the service is safe. We will work alongside the provider and the local authority to

closely monitor the service. We will return to visit in line with our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 safe.	**Inadequate**
Is the service well-led? The service was not always well led.	**Requires Improvement**

Brookdale House Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

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

The service did not have a manager registered with the Care Quality Commission. A registered manager, along with the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The previous registered manager had left the service in September 2020 and a new manager had been appointed shortly after.

Notice of inspection
We gave a short period notice of the inspection. This ensured we were able to work with the provider to identify any potential risks associated with Covid19 and put measures in place to manage these.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority, clinical commissioning group and community mental health providers. This information helps support our

inspections. We used all of this information to plan our inspection. The provider had not been asked to complete a Provider Information Return. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make.

During the inspection
We spoke with three people who used the service, three members of staff, the nominated individual and the new manager. The nominated individual [NI] is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 22 medicines records, three staff files and a variety of records relating to the management of the service.

After the inspection
We received feedback from 14 relatives about the care provided and spoke with a further seven care staff. We reviewed eight people's care records. We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question had deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.
- We continued to find examples where risks to people's wellbeing had not been adequately managed or mitigated.
- Where there were concerns about people's hydration, charts did not provide assurances that fluids were always being offered regularly.
- Food charts for a person known to be losing weight, did not show that they were being offered regular food. Similar concerns had been identified at our last inspection and insufficient action had been taken to embed improvements.
- During our last inspection we found that one person had not been provided with the correct modified diet. This inspection identified a similar concern in relation to a different person.
- Assessments regarding the risk of choking or aspiration needed to be more robust.
- One person was noted to be at risk of choking, but their nutrition care plan stated that they liked to eat in their bedroom. There was no guidance about how the risk of choking was to be managed safely in these circumstances.
- One person had a catheter. Their care plan stated that their urinary output should be monitored. This was not consistently happening. This is important as it helps staff to spot signs of potential problems which might need escalating to health care professionals.
- Risk assessments regarding people using the stairs needed to be more robust.
- Sighting charts were used by the provider to record checks on the whereabouts of people who might present risks to themselves or others. These had not always been completed as planned or stepped up following incidents.
- Learning following a recent, significant, safety related incident at the service had not been sufficiently embedded. This was of concern as there had been a recent incident at the service whereby a person had accessed the kitchen and swallowed a dishwasher tablet which had resulted in them being admitted to hospital. Whilst the lock to the kitchen had been repaired, we found dishwasher tablets had still not been locked away as advised in the provider's action plan.

We also found a razor blade in one of the communal bathrooms. There were people using the service who freely moved about the home and who were living with dementia and this therefore posed a risk of harm.

This is a continuing breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection, we were unable to review key health and safety records such as required maintenance checks, audits and environmental risk assessments. This was due to the provider being unable to locate these records. We spoke with the provider and a maintenance contractor, who assured us that required checks had been carried out. We saw invoices which showed that the provider had paid for these tasks to be completed. We continue to work with the provider to obtain assurances about the completion of these checks.
● In two previous inspections, there had been concerns raised about the systems in place to prevent legionella. At this inspection, and as a result of the missing records, we were unable to see that the regular water management tasks have been completed but continue to seek assurances from the provider regarding this.
● A legionella risk assessment had been undertaken in January 2020. Recommendations made as part of this assessment are yet to be completed, however, recent water sampling checks taken in August 2020 did not detect any presence of legionella in the water system.
● Personal emergency evacuation plans (PEEPs) were in place. They reflected the occupancy of the home and had been recently updated. This had been a concern at the two previous inspections and was an improvement.
● Staff told us there had been an increase in the numbers of people displaying challenging behaviours living at the home, and in the complexity of these behaviours. There was evidence that staff escalated concerns about these challenging behaviours to external health care professionals, but we found care plans and risk assessments relating to behaviour management needed to be more detailed about the strategies staff might use to de-escalate the behaviours.
● Records showed that people displaying behaviours which might challenge were often told to 'go to their room' or were 'taken to their room to calm down' or told their behaviour was 'Inappropriate'.
● Two relatives raised concerns about the skills of staff to manage their family members needs in relation to behaviour that might challenge others. They both raised concerns about receiving regular calls from staff asking them to speak with, or come and see, their family member as staff were finding it hard to cope with their behaviour.
● Staff told us they did not feel they had had sufficient training in the management of the behaviours or in interventions such as positive behaviour support (PBS). PBS helps staff understand the reason for a behaviour so that they can better meet people's needs, enhance their quality of life and reduce the likelihood that the behaviour will happen. For example, one staff member said, "I feel like I have gained skills in how to calm people down and what to do in those situations purely from experience, I have received no training from my manager about how to deal with challenging behaviours". Another staff member said, "It can be quite daunting, you have to walk away".
● Despite our findings, people felt safe living at Brookdale House. One person said, "It's a very nice place" and another said "Oh yes very safe… This is the best care home I've ever been in, the people are lovely, honestly, the people are beautiful".
● Whilst it was not every relatives experiences, most were, overall, confident that the service monitored the safety of their family member and supported them to stay safe. One relative said, "I feel my relative is safe and secure within Brookdale". Another relative said, "I know they are doing all they can to keep the residents safe".
● Relatives were also confident that the staff team knew their family members well and treated them with

kindness and respect and were committed to protect them from harm. For example, one relative said, "The team put the residents first and centre of everything they do". This was echoed by a social care professional who told us that a person they had supported to move into the home had "Never looked so well cared for…. they have provided him a home in which he feels safe and each occasion I have visited he is very happy which is very reassuring".

● There was evidence that staff had escalated concerns about urinary infections or weight loss to the GP so that treatment might be promptly started.

● Equipment such as alarm mats were used to alert staff that a person was mobilising and might need support.

● The provider had invested in a CCTV system to enable them to enhance the safety monitoring of communal areas.

Using medicines safely

● Medicines were not always managed in line with best practice guidance and the provider's policies and procedures.

● A review of the medicines administration records (MARs) did not provide assurances that people were being administered their medicines as prescribed. We found seven gaps in the September 2020 MARs without an explanation recorded. Staff undertaking the next medicines round had not escalated the gaps to the management team for investigation.

● One person's medicine was noted to be out of stock for a period of three days, and another person's for four days. There was no evidence in either case that the prescriber had been contacted to seek advice about the impact of this. The provider told us, there had been ongoing problems with the supply of medicines and a meeting had been held with the GP pharmacist to address this moving forward.

● There were numerous examples where a medicine had been signed for on the MAR, but then the reverse of the MAR stated that the medicine was not given as not available. Staff should only sign the MAR once the resident has taken the medicines.

● The medicines trolley was kept in the dining area and was not secured to the wall. The temperature of this area was not being monitored. Action was taken to address this during the inspection.

● Excess stock was kept in a locked cupboard. The temperature of this area was being monitored but had been in excess of recommended limits every day for the last 2 months. Additional fans had been placed in the room, but this was not effectively addressing the problem. Storing medicines at the incorrect temperature can affect their effectiveness.

● Three sets of eye drops, open and in use, were being stored in the fridge but had no date of opening on them. Recording this is important as the eye drops should not be used after four weeks of being opened to help prevent the risk of infection.

● We were unable to check the homely remedies stock as this was stored in a locked box and staff did not know the combination for the lock.

● Records should be maintained of all medicines awaiting disposal. We found three large boxes of medicines that, whilst in a locked room, were not in a tamper proof container. No record had been kept of the medicines in these boxes. This means they were unaccounted for within the service. The last medicines returns had been recorded in March 2020. The provider has now made arrangements for these medicines to be recorded.

This is a breach of Regulation 12 (Medicines) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines competencies were undertaken, but the nominated individual told us, she had already identified that these needed to be more robust and has therefore booked for an independent assessor to

visit the service in October 2020 to complete these.
● There are plans to introduce electronic medicines administration records in November 2020 in a bid to eradicate medicines related concerns within the service.
● The provider had plans to convert a disused bathroom into a new medicines room.
● The administration of medicines was managed in a person-centred way. For example, we observed a care worker asking people if they required pain relief and how they would like to take their medicines.
● The use of covert medicines was taking place within the context of legal and good practice frameworks including the Mental Capacity Act 2005.
● Most of the relatives we spoke with were positive about how the service managed their family members medicines. For example, one relative said, "My relative's medicine is well managed and if there is any suggestion that something is not working or may need adjusting, they contact the GP".

Preventing and controlling infection
● The home has been free of COVID 19 for 16 weeks but during the inspection, we noted some inconsistencies in their infection and preventing practice which raised some concerns and needed to be addressed to continue to reduce the risk of covid.
● Staff told us that they wore a mask, gloves and apron when delivering personal care to all people. However, we observed that the provider's guidance on the use of personal protective equipment (PPE) was not consistently followed at all times. The provider was able to demonstrate to us that clear information about the prevention and transmission of COVID 19 and the use of PPE had been shared with staff but there appeared to be a disconnect between this and what was sometimes happening in practice.
● Whilst the home was visibly clean during the inspection, records did not provide assurances that regular cleaning was taking place. For example, we could see that the NI had requested that additional cleaning of COVID 19 hot spots was to take place 2/3 times a day. However, there were no records to demonstrate that this had in fact taken place.
● There were significant gaps in the daily cleaning schedules provided.
● The provider told us that care staff completed the cleaning when the housekeeper was not on duty. Staff told us they did not always have time to do this.

This is a breach of Regulation 12 (Preventing, detecting and controlling the spread of infections) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We did note a number of areas of good practice.
● Staff had undertaken infection control training, provider COVID 19 training and virtual training on COVID 19 provided by the local clinical commissioning group (CCG).
● Staff confirmed that there was no shortage of personal protective equipment.
● Residents admitted to the service were required to have had a negative COVID 19 test and were required to self-isolate in their rooms for 14 days.
● Staff demonstrated an understanding of how to instigate full infection control measures to care for people should they develop symptoms to avoid the virus spreading to other people and staff members.
● The home was taking part in the national care home testing programme for residents and staff.
● To help with social distancing the provider had taken the decision to make all of their double rooms into single rooms. In the main lounge, some chairs have been taken away and tables placed between them to support social distancing.
● Due to the layout / size of the home social distancing on staff breaks was difficult so the provider was purchasing a pod for the garden to provide another area for staff to take their breaks.
● The provider had kept the decision to admit visitors under constant review and in light of recent increases in the rate of new cases of COVID 19, had currently suspended visits to people from all but essential visitors.

● When visits were allowed, clear procedures were in place to prevent relatives and friends from spreading infection when visiting the premises. These were confirmed by all of the relatives we spoke with. One relative said, '[Provider] would contact us a few days before the visit to do a health and safety form and ask the relevant covid questions such as have you had to have a test or been asked to self-isolate etc. Once that had been completed, I would turn up at the home and a member of staff in a mask, apron, gloves would see me outside to take my temperature and oxygen levels. I was then given my mask, gloves and apron before being allowed in the back garden. Once this was completed, I would meet my relative at the set chairs in the garden and be advised not to have physical contact with my relative. It felt quite safe and well managed".
● This approach was confirmed by all the relatives we received feedback from. For example, another said, "During the COVID 19 time all staff and residents have been regularly tested and [NI] has put in place a strong "protective" plan to minimise the likelihood of the disease entering the home which I am in full agreement with. I have been kept up to date regularly".

Staffing and recruitment
● There were not always sufficient staff deployed, to meet people's needs. Staff told us this impacted upon their ability to manage people's care in a safe and person-centred manner at all times.
● Each of the ten care staff we spoke with raised concerns about staffing levels. Comments included, "I'm struggling, there is an impact, activities is a big issue and baths, we can't do it", "Buzzers are going, there are more incidents, people are wandering more as there are less activities, you can't be everywhere" and "We're at breaking point, [Person] becomes more agitated, [Person] wanders more, you can't supervise the communal areas, you are running from one person to another". Another staff member told us, "It does impact on the residents, they are not getting any stimulation, one lady is constantly tearful, but is apologising to us, she is picking up on how busy we are and doesn't want to disturb us".
● Staff raised concerns about having to complete other tasks alongside their caring responsibilities. For example, the home did not have a chef which meant that staff were responsible for heating and serving the prepared meals at lunch and preparing suppers.
The home did not have activities staff and the housekeeper was part time, meaning that at weekends or when the housekeeper was on leave, staff were also responsible for the cleaning.
● Staff told us it was not possible for them to provide the level of care that they wanted to, whilst also trying to manage these other tasks. One staff member told us, "We don't get time to clean, I'm having to be taken off medications to help get people up, we can't get around to activities, they [people using the service] are mostly just left to sit there watching the TV".
● We observed that the staff member undertaking the lunch time medicines round was disturbed three times within a short period of time. On two occasions they had to intervene to prevent an incident between two people and on a third to answer the front door as the other staff were all completing other tasks. Three other staff were on duty at this time, but the senior, performing the medicines round did not know where they were to seek their support. In fact, two staff were at this point taking in the online shop which could have effectively been managed by one staff member.
● Most staff linked the difficulties they experienced directly to the recent admission of people with more complex needs including challenging behaviour. One staff member said, "The challenging behaviour at the moment is difficult" and another said, "The needs of the residents is greater, they are more towards needing nursing care".
● Staff told us that early evening was a particularly difficult time because between 7pm and 10pm, some people were still up, but others wanted to go bed and the medicines round had to be undertaken, but as there were only two staff on duty it meant they were too stretched and unable to monitor the communal areas for example.
● We reviewed incident and accident records for the months of August and September 2020. There were eight unwitnessed falls in September 2020, six of these were within the hours or 6pm and 11pm. In August

three of the six unwitnessed falls were within this time period. We are concerned that there are insufficient staff deployed during these hours to meet people's needs safely.
● The provider used a dependency tool to inform staffing levels which provided a useful framework for determining staffing levels and considered a range of factors such as the number of people who displayed challenging behaviour or needed assistance to eat and drink.
● Based on the outcome of this tool, the home was suitably staffed. However, the tool did not consider that staff were also responsible for activities, heating and serving meals and at times the cleaning which they told us impacted upon the provision of care.
● The provider told us that additional staff were rostered at weekends to consider that staff were required to complete cleaning tasks for example. Rotas showed that on two of the four weekends in September 2020, this had not been the case.

This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection, we were told that a new chef had been appointed and will be starting in early October. A new maintenance person had also been recruited and was undergoing pre-employment checks. The new manager had also instigated a 'twilight' shift between the hours of 6pm – 10pm to support staff during this busy time. Moving forward, these appointments assure us of the provider's commitment to address the concerns and keep staffing levels under review to ensure peoples safety.

Learning lessons when things go wrong
● As noted above, learning following a recent significant safety related incident at the service had not been sufficiently embedded.
● Records were kept of incident and accidents that had occurred within the service. These had mostly been reviewed by a manager to help ensure that appropriate action had been taken in response. Following most falls we were able to see that actions taken had included checking for urine infections, requesting referrals to the fall's prevention teams, and putting alarm mats in place.
● The provider's system allowed sophisticated data to be collected, and regular reports produced, about the nature and frequency of incident and near misses. There was evidence that information relating to individual incidents was analysed by the nominated individual and used to inform incident management and support learning. However, this approach would be strengthened by the leadership having a system to show what actions have been taken in response to key themes and trends from the overall data regarding falls, for example, their frequency, location and the time they occurred.

Systems and processes to safeguard people from the risk of abuse
● Where incidents of a safeguarding nature have occurred, these had mostly been escalated appropriately to external agencies. We did see one incident where this was not the case and we are seeking further assurances regarding this.
● Staff displayed a commitment to protect people from harm.
● The provider and staff have worked hard to ensure that people have been able to maintain contact with their relatives and friends during the COVID 19 pandemic. For example, additional lap tops were purchased to facilitate video calls and family members were able to book visits to see their relatives in the garden. Relatives were encouraged to send in parcels or letters for staff to read to their family members. This helped to ensure that people did not become isolated or suffer psychological harm.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- We acknowledge that our inspection has taken place within the context of the service responding to the COVID 19 pandemic and the difficult circumstances and challenges this presented to staff and providers. This has been considered when reaching the judgements outlined in this report.
- The inspection found a number of areas where the quality and safety of the service was compromised.
- Audits took place each month in areas such as infection control, care plans, medicines management, mealtime experience and dignity. However, we were not assured that these audits were being fully effective at driving improvements or embedding change. For example, following a medicines audit in July 2020 a 'gap analysis' process had been introduced to investigate missing signatures on the MARs. None of the missing signatures on the September 2020 had been investigated or escalated by staff to the leadership team. The care plan audits for July 2020 and August 2020 did not identify any concerns with the completeness of monitoring charts which we have highlighted elsewhere in this report.
- The providers electronic records system allowed them to have a good level of oversight of risks within the service. This included information about all of the incidents or near misses that occurred within the service and the number of people experiencing falls, weight loss or pressure ulcers for example. Each month the NI collated the data relating to these clinical risks and provided a summary as to the actions which were being taken. We were not assured, however, that the provider's checks were being effective as they had not identified the concerns we found.
- Throughout this report, we have identified a number of areas where some of the records relating to people's care and support and those relating to health and safety checks were incomplete or not available for us to view. We were not therefore, always assured that records relating to people's care supported staff to meet people's needs in an effective or safe way.
- Some records also contained contradictory or inaccurate information about people's needs. For example, one person's nutrition plan stated that they were both at risk of choking and then later not at risk of choking. In another example, one person's communication plan gave conflicting information as to whether they could express their needs. In a third person's it said they were both at risk and not at risk of leaving the building unnoticed.

The failure to have effective systems in place to assess, monitor and mitigate risks to people using the service, to securely maintain accurate and complete records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

● We were not assured that the provider had robust systems in place to always keep records securely and to ensure they are only accessed by people authorised to do so. There had been a recent incident whereby confidential personal information was accidentally shared with a third party. We were appropriately notified of this and it was escalated to other relevant bodies such as the Information Commissioners Office. However, during the inspection, we were made aware of two further breaches of data protection legislation which we had not been informed about.
● The provider had put in place an electronic system for storing recruitment records. It was not possible during the inspection to be assured that all of the required recruitment checks had been completed due to the way in which this system stored information. We have since the inspection been provided with additional information.

We recommend that the provider implement systems to ensure that the information required by the Care Quality Commission is readily available and accessible in the service in order that they can demonstrate their compliance with relevant Regulations.

● At the time of our inspection, there was no registered manager in post. A new manager had been appointed and had started the week before we inspected. They have applied to be registered with CQC.
● During the inspection we highlighted to the nominated individual [NI] that the homes website was not displaying the current CQC rating which they are required to do. We asked them to rectify this immediately. This request was met and therefore we did not take any further action.
● The previous registered manager had started at the service in April 2020 and left in September 2020. This was at the height of the COVID pandemic. During their management of the service, they were required to spend much of their time supporting the staff team with provision of care and so they were not always able to commit time to their management responsibilities. At the same time, the NI and other key maintenance personnel were not able to visit the service in order to prevent the risk of transmission of COVID 19. This impacted upon the provider's ability to ensure that staff understood and were following best practice guidance and policies and procedures at all times.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff understood the importance of person-centred care, their comments included, "It's important to me to make sure the residents are happy and settled" and "Making their day, making them smile, makes my day". This person-centred culture was also commented on by many of the relatives with one saying, "The team at Brookdale care for residents and treat them like extended family members, all staff go the extra mile".
● Each staff member told us how coping throughout the COVID 19 pandemic had brought them closer together and of how they had worked really well as a team to meet people's needs and maintain a positive culture. Comments included, "In the crisis we gelled", "I love the team, we work well together".
● However, during the inspection, a large number of staff told us they now felt less positive about their role. They raised concerns about staffing levels and told us they felt "Burnt out", "Undervalued and unappreciated". One staff member said the team was "Breaking up a bit".
● A number of staff told us they had lost confidence in the provider to address their concerns relating to staffing levels and poor morale. For example, one staff member said, "We have been promised more staff since your last inspection".
● Prior to the inspection, CQC had received three whistleblowing concerns raising concerns about staffing, medicines management and culture.
● We discussed this feedback with the NI. They explained that staff were supported daily by either visits,

telephone or zoom calls. They said that the senior team had been involved in decisions regarding staffing levels and new procedures, and no concerns were raised about there being a lack of support.

● The NI confirmed the provider had supported staff by providing pay rises and interest free loans and bonus during the pandemic period. The NI confirmed that staff surveys had been sent out in July 2020, but none had been returned. They were therefore surprised by this feedback and felt it was not a fair reflection of the support that had been, and continued to be, offered to staff.

● Over the last six months, the nominated individual, although unable to visit the service, maintained visibility and contact with relatives through daily virtual meetings. These meetings focussed on the particular efforts being made to keep the home safe. Feedback from relatives regarding the effectiveness of these meetings was positive. Comments included," I feel that [NI] has been extremely proactive and visible…. I feel I can talk to [NI] about any issue I have or advice I need and she always listens" and "They have gone above the call of duty. We have video chats with the management, they send us emails every day, we also have a WhatsApp group as well. Impossible to improve on… We have been asked our views and opinions about almost everything, as they tell us what is going on we have the opportunity to give our views".

● This was not everyone's experience, however, and some relatives raised concerns about poor communication, not being told about incidents or changes to medicines.

● Resident meetings were held to seek people's views about the care they received, and surveys had been sent to relatives in July 2020. Those returned had all been positive about the support being provided and needed no further action.

Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● In discussions with the nominated individual they demonstrated a good understanding of their responsibility to be open and honest with people.

● Investigations or root cause analyses had been completed following significant incidents demonstrating that the provider has taken these concerns seriously. Remedial actions were identified and shared with staff, relevant persons and external agencies, although elsewhere in this report, we have raised concerns about how sometimes learning had been embedded within the service.

● A health care professional told us the nominated individual was "Very good at coming to me to ask for advice and has put things into place as I or the infection control team have suggested".

● A contingency plan was in place to manage ongoing or future outbreaks of COVID 19 effectively.

Working in partnership with others

● The service worked in partnership with other organisations to meet people's needs and develop its staff. For example, the leadership team joined the twice weekly CCG calls aimed at supporting services with responding to the COVID 19 pandemic.

● Staff had worked with community nurses, mental health nurses, pharmacists and the CCGs nurse facilitator for the benefit of people using the service.

● The nominated individual responded in an open and transparent way to requests for information or for investigations into incidents and accidents to support this inspection and organisational learning.

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the care and treatment was provided in a safe way. Regulation 12 (1) (2) (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems to assess, monitor and mitigate risks to people using the service and to securely maintain accurate and complete records relating to people's care and treatment. Regulation 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient staff deployed at all times.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the care and treatment was provided in a safe way. Regulation 12 (1) (2) (a) (b)

The enforcement action we took:

We have issued the provider with a warning notice.