HC-One Limited

Brookdale View

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

The inspection took place on 22 and 23 May 2016 and was unannounced. This means that the service did not know we were coming in advance. At the previous inspection on 19 May 2015 we rated the home requires improvement and identified two breaches of the regulations in relation to staffing levels and the need for consent.

Brookdale View is a purpose built care home which offers accommodation for up to 48 people. There were 42 people in residence on the day of our inspection. Brookdale View provides nursing care on the ground floor and residential accommodation on the first floor. There are two lounges and a dining room on each floor, laundry facilities and hairdressing salon. There is a car park within the grounds. The home is situated in the Newton Heath area of Manchester, close to local amenities and with good transport links.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found that some improvements had been made. However, they were not sufficient enough to meet the requirements of the regulations. We also found new breaches of the regulations.

At the last inspection we identified a breach of the regulations due to the inconsistency of staffing levels and the high level of usage of agency staff.

At this inspection we found staffing levels had not improved and we noted people did not receive their care in a timely manner.

The majority of staff we spoke with felt there was a lack of leadership at the service. Overall staff morale was low. The provider was aware of this, and were working to find a way forward.

Audits on the home's quality were not accurate which meant systems to improve the quality of provision at the home were not always effective.

Policies were in place to ensure people's rights under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were protected. Although policies and procedures were in place it was clear that some staff were not aware who had a DoLS authorisation in place.

Staff training was recorded effectively and attendance was monitored. Staff received regular supervision. Recruitment procedures were thorough and ensured the staff who were recruited were suitable to work in the home.

People's needs had been assessed before they moved into the service and they had been involved in formulating and updating their care plan. The home focused on person-centred care giving people as much choice as possible, such as when to get up, and most records were reflective of individual needs. However, not all the information was current and some records needed further scrutiny on the residential unit. We were concerned as some staff told us they did not have time to read the records which could have meant incorrect care was potentially being provided.

People had access to activities; however we received mixed feedback with regards to the activities on offer. People were not always protected from social isolation. The range of activities available were not always appropriate or stimulating for people on the nursing unit.

Procedures were in place to manage people's medicines safely.

Feedback on the meals provided was varied. On the two days of our inspection we observed there was sufficient quantity and choice available.

We saw people's weight, their nutritional intake and their ability to eat and drink safely was monitored and referrals to dieticians and speech and language therapists took place when required for treatment and advice. During the day, we observed people were served drinks and snacks between meals.

People were supported by staff who were kind, caring and friendly. We observed people being acknowledged throughout the day which was an improvement from our previous inspection. Staff were discreet in offering support and worked well with colleagues to ensure people's needs were met in a timely manner.

People's privacy and dignity were respected and staff provided people with explanations and information so they could make choices about aspects of their lives. There were positive comments from relatives about the staff team.

There was an effective complaints procedure. Complaints were responded to within the stipulated time. We found the manager had archived all complaints for 2016, and we could not view them.

People's healthcare needs were met. People told us that they had access to their GP, dentist chiropodist and optician should they need it. The service kept clear records about all healthcare visits and appointments.

All areas of the home looked clean. Procedures were in place to prevent and control the spread of infection.

In relation to the breaches of regulations, you can see what action we told the provider to take at the end of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were an insufficient number of staff to provide people with safe care and protect them from harm.

People in the home felt safe and staff had a good understanding of the meaning of safeguarding.

There were effective systems in place for managing medicines and the control of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received supervision and training and an on-going programme was being developed. However, staff did not understand the principles of mental capacity or DoLS requirements.

People were provided with sufficient food and drink. They were given choices about what they wanted to eat and drank. However, we received a mixed response in relation to the food on offer.

People had access to healthcare professionals and services.

Is the service caring?

Good

The service was caring.

We observed people's choices were respected and that staff were attentive and responsive to the needs of people who required support at meal times.

Staff treated people in a caring and compassionate manner Staff agreed that this was important and spoke affectionately about the people they supported.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although people's assessed needs were met, we found care plans were not always person centred care or detailed in the residential unit.

The registered provider had not taken sufficient action to improve activities for people.

People knew what to do if they made a complaint and were confident that any concerns raised would be followed up.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had a registered manager. However, the majority of the staff we spoke with felt the leadership and direction was not always effective.

There was a quality monitoring system in place but this had not been used effectively to identify some shortfalls in the service and then take robust action to address them.

There were regular meetings for staff, people who use the service and their relatives to raise issues, provide feedback, and share information about the home.

Brookdale View

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.

This inspection took place on 22 and 23 May 2016 and the first day was unannounced.

One inspector and an expert by experience carried out the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. This expert had experience of care home services and caring for people living with dementia.

Before the inspection we reviewed the information we held about Brookdale View. This included notifications we had received from and about the home, and the minutes of safeguarding meetings. We also reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We contacted the contract officer of Manchester City Council for information about the council's recent monitoring visits. We contacted Healthwatch who held no information about the service.

During the inspection we spoke with 13 people who were living in Brookdale View and seven relatives. We spoke with the registered manager, the deputy manager and with the assistant operations director of HC-One Limited, the provider. We also spoke to one agency nurse, one nurse and twelve care staff, this included four night staff.

We conducted an observation known as a SOFI (Short Observational Framework for Inspection). This is a method of observing people and the care they are receiving, to help us understand the experience of people who may have difficulty communicating with us.

We reviewed a range of records about people's care and how the home was managed. These included six care files, staff training and supervision records, three staff personnel records and quality assurance audits

that the registered manager and assistant operations director had completed.

Requires Improvement

Is the service safe?

Our findings

We asked people living in Brookdale View whether they felt safe. Comments received were positive: "Yes I feel safe at this home, compared to where I once lived" and "The home is safe in my opinion."

At the last inspection we identified a breach of the regulations due to the inconsistency of staffing levels and the high level of usage of agency staff.

At this inspection we found the service had made progress by recruiting more permanent staff, however the staffing levels had not improved and people, their relatives and staff felt the staffing levels were not adequate.

At the time of our inspection the home was providing nursing care for 21 people on the ground floor and residential care to 21 people on the first floor. When we arrived at 6.30am on the first day of our inspection two night care workers and one agency nurse was working on the ground floor, with two care workers and one night team leader working on the first floor. We spoke to the staff on duty who felt the current staffing levels at night were adequate, but suggested the staffing levels would not be suitable if the provider made any reductions to the staffing levels during the night.

We looked at staffing levels across the home. One nurse worked alongside three care workers on the ground floor from 8am to 8pm. On the first floor one senior and three care workers were on shift from 8am to 8pm.

Additionally there was one activity coordinator on duty from 8am to 3pm. The registered manager was supernumerary and the deputy manager who was also the nurse worked eleven hours across the week to concentrate on areas such as care plans and new admissions.

At the last inspection we received varied opinions in relation to whether there was enough staff on duty, with many people having concerns about the over use of agency staff. At this inspection we continued to receive mixed comments, these included: "I'm waiting to go to the toilet, but it's always a waiting game here," "Not enough staff so some things get missed like the tea trolley has not been round today," "They never take us out because there's not enough staff" and "The staff are doing their best, but at times especially the mornings they are rushed of their feet."

Comments from people's relatives were also concerned about the staffing levels, they included: "Mum was told she couldn't go to see my dad because he was going for a shower at 10.30am. At 12.20pm he'd still not had his shower so we've brought her down to see him. They're both very upset as you can imagine and they need to be together," "There's not enough staff, that's the only problem. They can't spend quality time with them (people living at the home)" and "Some days are okay, but others you will struggle to find a staff member."

We asked day staff if they thought that staffing levels were appropriate. Comments received were negative and staff felt the staffing levels need to be increased. Comments included, "We are doing our best, but

morning support is hectic, we need more staff," "The manager knows we are short, she shuts her door and doesn't provide any assistance," "I don't think we are leaving anyone at risk, but I do feel for people at times when we can't get to them straight away," "We work long days, we are absolutely run off our feet, we need at least four care staff plus a nurse each day" and "We don't have time to even sit with our residents, and if you do sit down the manager thinks you're being lazy."

We observed that the staff were busy supporting people to get up in the morning. The nurse on the ground floor was administering medication and so was in and out of the lounge area and also taking medicines to people's rooms. This meant some people didn't have their breakfast until after 10am. Some people had got up before 7am and had been provided with one cup of tea before their breakfast was served. On the second day of our inspection we noted a similar pattern to the first day. This meant that people sometimes had to wait long periods of time for support as the staff were busy supporting other people. Staff were also very task orientated as they did not have the time to sit and talk with people. We spoke with one person at 9.30am who informed us they had been waiting two hours for staff to assist them with their personal care. This person was unable to mobilise independently and was unable to notify staff apart from shouting out. This person did not have access to the nurse call system, this had been disconnected in their room and there was no reason why this was not available. On the ground floor we noticed a further two people did not have their nurse call system connected. We immediately raised this with registered manager who was unaware the nurse call system was not in their rooms, she reported this to the maintenance worker.

We noted the maintenance worker completed monthly checks of people's rooms, and for the audit in April 2017 confirmed the nurse call system was in the three people's rooms. Speaking to the people they were not sure how long the nurse call system had not been present or why it had been removed. The lack of available call bells places a risk to people's health and safety who may not receive appropriate assistance in an emergency or otherwise.

We noticed on several occasions that there were times when no member of staff was visible while people sat in the lounge. We observed one person becoming distressed at times and we found other people living at the home attempted to calm this person down by talking to them. We found staff were busy carrying out care tasks and struggled to make time for people.

The service used a dependency tool to determine the number of staff required based on the needs of the people living at the home. The dependency tool is designed to score each person monthly according to the level of support they needed with the activities of daily living and calculated the number of staff hours needed to provide the required level of support for all the people. We noted this dependency tool had last been updated on 10 May 2017 and at that time the provider identified the home would add a 8am to 12pm shift to assist with people's morning routines on the first floor, nursing unit, however we found the home struggled to fulfil this shift and we noted it had not always been included on May 2017 rotas as a shift that was needed.

By speaking with people, their relatives and staff, and by observing the interactions between staff and the people living at the home, it was clear that, there were not enough staff to support all of the people with activities of daily living as they needed it. In addition, staff did not have time to provide engagement and stimulus to the people living at the home.

The lack of sufficient staff was a continued breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the management of medicines at Brookdale View with a registered nurse. We were informed

that only the nursing staff were responsible for administering medicines on the nursing unit. Medicines on the residential unit were administered by senior care staff. All staff responsible for the management of medication had completed medication training and undergone an assessment of competency which was reviewed periodically. This meant staff were skilled and competent to assist people living in the home with the day to day management of their medicines.

A list of staff responsible for administering medicines, together with sample signatures was available for reference and photographs of the people using the service had been attached to medication administration records to help staff correctly identify people who required medication. We checked that there were appropriate and up-to-date policies and procedures in place around the administration of medicines and found that the provider had developed a suitable policy for staff to reference.

We checked the arrangements for the storage, recording and administration of medication and found that this was satisfactory. We saw that a record of administration was completed following the administration of any medication on the relevant medication administration record. Systems were also in place to record fridge temperature checks; medication returns and any medication errors.

Medicines were all stored in a room called a clinic. Each person's medicine was kept in a separate container with their name and room number on, to help ensure the correct medicine was administered to each person. Some medication was also stored in a refrigerator or in a locked medication trolley and where necessary in a locked controlled drugs cabinet secured to the wall. (Controlled drugs by their nature need to be stored more securely as the can be subject to misuse).

During the inspection we observed people complaining about the new chairs the home had recently purchased as part of the homes refurbishment. Comments received from people included, "It looks lovely but the chairs aren't very comfortable", "The chairs are too low now" and "I never feel completely safe when I'm getting out of these chairs." Furthermore, we found no evidence people including the staff had been consulted about the new chairs that had been purchased at the home or that their individual mobility needs had been assessed. Not having chairs that are the correct height for people could limit people's independence and/or pose an increased risk of falls. We discussed this area of concern with the registered manager who confirmed they would discuss this matter further with the design team at HC-One Limited.

People were safeguarded from the risk of abuse. The home had clear safeguarding policies and procedures in place for staff to refer to. Staff were able to explain how they would recognise and report abuse. They told us they would report concerns immediately to their manager or to the police if this was necessary. The service had a whistleblowing policy in place which gave staff clear steps to follow should they need to report poor practice. Records confirmed that all staff had received training in safeguarding adults. One care worker said, "I would report any concerns to the manager, if I feel this wasn't taken serious I would whistleblow."

Risk assessments had been completed for any areas that were considered to be of concern. We saw risk assessments for malnutrition, skin integrity, medication, mobility and the risk of falls. The risk assessments we saw in care plans had been reviewed on a regular basis to ensure they remained relevant and up to date.

We looked at the recruitment records of three staff and found that all the necessary checks had been made. The personnel files we looked at contained a copy of the original application in which any gaps in employment were explained. Each file also contained two written references obtained before the staff member started work. We saw that a certificate from the Disclosure and Barring Service (DBS) had been obtained before they started work at the home. The DBS keeps a record of criminal convictions and cautions, which helps employers make safer recruitment decisions and is intended to prevent unsuitable

people from working with vulnerable groups.

Each person had an up to date Personal Emergency Evacuation Plans (PEEP). The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. We saw that personal protective equipment (PPE) was available around the service and staff explained to us about when they needed to use protective equipment.

The service had a detailed contingency plan for various emergency situations, for example, fire, flood and loss of electricity supply. We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for the electrical installation, the passenger lift, mobility and bath hoists, gas equipment and fire extinguishers.

During the inspection we found the home to be clean and tidy. Relatives told us that the home always appeared clean and smelled fresh; one relative said, "The home has always been clean when I visited. The cleaning staff work hard here."

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty in order 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).

Under the legislation a provider must issue an 'urgent authorisation' when they believe they may be depriving someone using the service of their liberty. At the same time they must apply for a 'standard authorisation', to a supervisory body, in this case Manchester City Council.

At the last inspection we found a breach of Regulation 11. There was a lack of DoLS applications for people who were being deprived of their liberty. At this inspection we found improvements had been made, however there was still room for improvement.

We saw that all the correct mental capacity assessments were in place for each person and DoLS applications had been submitted to the local authority. Three care records we viewed evidenced applications for a DoLS had been submitted and granted. For example, in one person's care file a DoLS application had been granted to confirm it was in the person's best interest to have bed rails in place, to minimise the risk of this person falling out of bed.

All staff were expected to undertake training via e-learning in 'Understanding the Mental Capacity Act and DoLS.' We saw a record confirming that 36 staff (out of 42) had completed the training, four recent starters were still working through it, and two existing staff were due to complete it. The staff we spoke with had little knowledge regarding MCA and DoLS, and were not clear who had a DoLS authorisation in place at the home. However, they demonstrated that they understood the importance of consent, offering choice, and helping people to make decisions. During our inspection we witnessed this in practice as we saw staff checked people's consent to the care they were providing. We discussed this area with the registered manager who commented that the MCA and DoLS training would be re-visited to ensure staff fully understood the principles of the mental capacity act.

We saw consent forms on people's care plans varied. For example, one file contained a signed consent for use of the resident's photograph. Other files did not contain this form. On another file we saw a consent form which was incorrectly completed. One person was deemed to lack capacity and they had signed the consent form to allow the provider to use their photograph. Due to the person lacking capacity to make decisions there was a danger this person didn't understand what they were consenting to, rendering the form meaningless. We discussed the matter further with the registered manager, who explained this was an

oversight and assured us they would review this person's care records immediately after the inspection.

Staff told us they received regular training. Records showed that staff had attended various courses, including safeguarding, health and safety, food hygiene, dementia awareness, manual handling and infection control. Manual handling training was provided in a classroom setting, while other training was available on e-learning. There was a dedicated training room on the top floor of the building where staff could access the Internet. There was a wide range of other training available by e-learning.

The service was signed up to the Care Certificate for employees joining the service who were new to adult social care. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers follow in order to provide high quality, compassionate care.

Staff received regular supervision; this was often every two months and an annual appraisal. One member of staff said that supervision was a valuable opportunity to discuss their work as well as to receive information about the home and any changes in policies. This meant that the service provided support to staff with regular training relevant to their roles and relevant to people's needs.

The food served in Brookdale View was brought over from the kitchens of the neighbouring sister home, Averill House. There was a temperature chart which recorded the temperature of incoming food at the time it was served. We asked all the residents we spoke with about the food. Comments received were mixed, these included: "The breakfast's cracking, but lunch isn't so good and they sometimes forget that I've got an onion allergy. Tea's alright too but we're not allowed to have a hot drink with meals, they said it's because it's a choking hazard and fills you up. I've never had that problem ever," "The food's alright but there's not enough choice," "I find the food satisfactory, and I have been given a choice" and "The foods not bad, I enjoy it." One person's relative commented, "It's really good food here. Dad always says he's dying but he ate a full cooked breakfast this morning." We discussed with the registered manager why people could not have access to hot drinks with their meals. The manager said this should be on an individual basis if people wanted a hot drink and would look in to this further.

We observed a meal time and saw that people had different options and a soft drink of their choice. Additional refreshments and snacks were also seen to be provided throughout the day. Staff were observed to be accessible and responsive to people requiring support at mealtimes. There was a menu that was accessible to people located outside the two dining rooms providing a choice of two meals. During lunch jugs of cold squash were available on a side table. We observed staff frequently encouraging people to drink something, focussing on people who appeared reluctant to drink or had difficulty helping themselves.

Diet notification forms were kept in individual care files and copies were kept in a folder near the kitchen. The form gave details of dietary needs – for example whether the person was diabetic – and also of their likes and dislikes. This also recorded the person who had the onion allergy. This meant that the kitchen staff could make themselves aware of people's dietary requirements and preferences.

The tables were laid with metal cutlery and glasses and tablecloths, which created a pleasant environment to eat in. People wore napkins while they were eating. Both dining rooms had recently been tastefully renovated and provided a spacious and modern look.

We found a number of food satisfaction surveys entitled 'food for thought 'completed by the people living at the home. We found a high number of these surveys were positive about the standard of food on offer. However, in light of the varied response received during this inspection the registered manager confirmed

they would revisit this area.

The people nursed in bed had food and fluid charts. We looked at three of these. Records were kept regarding the amount that people ate and drank when they were at risk nutritionally and we found that they were completed consistently and recorded the expected fluid intake for each person. We saw weights were checked weekly and records kept on care files to ensure that any rapid changes in weight would be identified. People's health needs were recorded in their files and we saw evidence of professional involvement where appropriate. Relatives we spoke with told us they were kept informed of all events and incidents and that professionals were called when required.

Brookdale View had been decorated to a high standard and was well maintained throughout. People's rooms had been personalised with memorabilia and personal possessions; they were homely and comfortable. People were also seen to have access to personal aids to help them mobilise independently and to ensure their comfort. We noted many of people's bedroom doors had not been personalised to help people orientate themselves. For example, we found signs on doors with people's names on were not easy to identify due to the small font. Memory boxes and pictures connected to the person outside their rooms will help people orientate independently.

The environment was much improved from our previous inspection as the home had undergone a significant refurbishment and the communal areas were much brighter and tastefully decorated. There was signage to the dining areas and on toilet and bathroom doors to assist people living with dementia to orientate around the home. Rails and doors had not been painted in a contrasting colour to clearly assist people living with dementia orientate themselves. We recommend the service considers the latest guidance in relation to developing dementia friendly environments to ensure that people are supported to maintain their independence for as long as possible.

We asked about the laundry service at the home and people told us, "I have no issues with the laundry, I did early on but this was sorted." Comments received from people's relatives were not so positive. "Sometimes he's wearing someone's else's clothes", "Laundry is a bit hit and miss" and "I do have some laundry issues because sometimes she's not wearing her own clothes and there's even wrong clothes in the wardrobe." We found when people's laundry had been cleaned this was left in the corridor on a rail for staff and the people who had the ability to collect their laundry. This potentially meant some items of clothing may have not returned to the correct people. We discussed the laundry and negative comments received with the registered manager who acknowledged she needed to review this area. We will check the progress of these at our next inspection.

People using the service or their representatives told us that they had access to a range of health care professionals subject to individual need. Care plan records viewed provided evidence that people using the service had accessed a range of health care professionals including: GPs; district nurses; opticians and chiropodists subject to individual needs.

We received positive feedback from three health care professionals who were visiting the home at the time of our inspection. Comments included, "I have visited many care homes and this one isn't too bad, they do keep you informed about any changes to the patients" and "The homes generally good and the care staff are approachable."

Good

Is the service caring?

Our findings

We asked people who used the service or their relatives if they found the service provided at Brookdale View to be caring.

Comments received from people using the service included: "All the carers are very friendly and kind. They're absolutely brilliant but they just don't have enough time to do everything", "The carers are really good, they're very kind but there's not enough of them to cope with the needs of everyone", "The staff are lovely", "The staff are great, they work really hard" and "I like it here."

During the inspection we observed staff supporting people at various times of the day and in various places throughout the home. We saw that staff communicated in a kind and caring way and were patient and respectful. We observed staff being affectionate and tactile with people and this often helped to reassure people when they were unsettled. The second day of our inspection was the day after the serious events that happened in Manchester on the 22 May 2017. We observed on occasions people becoming upset and confused about what had happened. We observed staff interacting with people in a kind and sensitive manner. Although staff had a number of care tasks still to complete, we observed staff taking the time to stop what they were doing to sit down and reassure those who were distressed.

Positive and caring relationships had developed between people who used the service and the staff. Staff were able to demonstrate that they knew the people they cared for well, were aware of their life histories and were knowledgeable about their likes and dislikes. Staff told us that they also observed body language and other non-verbal forms of communication, such as facial expressions to understand people's needs. One member of staff told us, "I feel we know our clients well here, we always raise the alarm if we suspect there has been a change in people's health."

Staff told us of how they respected people's privacy and dignity by knocking on their door and, where possible, waiting for permission before they entered. They also ensured that before personal care was provided, doors and curtains were drawn. We saw that when staff spoke with people about whether they needed support with personal care in the communal areas, this was done discretely.

Brookdale View operated a 'Resident of the Day' scheme. Each resident in turn was given special treatment for that day, such as having an individual choice of activity, their room being deep cleaned and the chef discussing menu preferences. This was designed to promote wellbeing and a sense of being special.

The service had enrolled on the Six Steps programme, which is designed to enable care homes in the North West to improve end of life care. There was a Six Steps checklist at the front of the people's care files, and a correctly completed DNAR form (this means "Do not attempt resuscitation" and when in place prevents paramedics or staff from attempting cardiopulmonary resuscitation).

We saw the provider's End of Life Care Policy which clearly set out their approach to providing end of life care within the home wherever possible.

On the second day of our inspection we found the registered manager had made arrangements for a married couple living at the home to be supported by two staff to a family funeral. We found staff were respectful and supported the married couple through this difficult situation.

The provider had policies in relation to equality and diversity, which included specific guidance on considerations care staff may need to be aware of in relation to care provision to people with different religious beliefs or cultural backgrounds. Training records showed the majority of staff had undertaken training in equality and diversity.

Requires Improvement

Is the service responsive?

Our findings

We looked at six care files, three from the nursing unit and three from the residential unit. We examined whether the care being provided was person-centred. Person-centred care means care which is individualised and specific to the person concerned. Before people's support commenced an assessment of people's needs was completed with relatives or people who were important to them. This meant staff had sufficient information to determine whether they were able to meet people's needs before support started. This also allowed the provider to understand the likes and dislikes of people so support packages could be tailored to meet their needs and requests.

Support needs highlighted in their assessments had not always been carried through to people's care plans. One person who had epilepsy did not have a care plan in place to provide guidance for staff in this area. The deputy and registered manager said this care plan had been completed but couldn't explain why this was not in the person's file, the deputy manager created a new epilepsy care plan on the same day. We found the level of detail in people's care plans varied on each unit, with the care planning in the nursing unit being person centred and addressing people's assessed needs. The three residential care plans we viewed were not person centred and lacked sufficient detail. For example, one person living with dementia did not have a 'dementia plan' to provide staff guidance on their support needs. We found a second person had a number of long term conditions such as chronic obstructive pulmonary disease (COPD). Again, we found a care plan had not been devised to provide staff the relevant guidance on how to manage this long term condition. This meant that the level of support required by people was not assessed and documented so that care staff would understand how to meet people's needs.

We discussed care planning with staff and asked them how often they viewed people's care plans. Comments included, "I always have a read, but it can be difficult because we don't have the time," "I rarely look at the plans, I speak to the other staff if I am unsure of anything" and "As far as I know I don't think we can look at the care plans." We discussed these comments with the registered manager who was not aware staff felt this way.

Care plans did not always meet the assessed needs of people. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

A system was in place to ensure that people's support needs were regularly reviewed. Each person had an individual dependency tool which showed how much support the person needed for specific tasks. This was reviewed monthly. When asked, people said that they were involved in these reviews.

The home employed an activities co-ordinator who worked from 8am to 3pm five days a week. There was an activity schedule on display, which was out of date by two weeks. This had been updated by the second day of our inspection, the activities co-ordinator had been absent and this was the reason. We saw a four week activity schedule which included a variety of activities. These included indoor games such as floor skittles, arts and crafts, dominoes and bingo, and armchair aerobics. The activities co-ordinator confirmed the home had links with the local community such as a youth club, primary school and the local Catholic Church who

provided a weekly Sunday service of prayer. The home also had a mini bus that could enable people to access the community, however, we found these trips couldn't be arranged regularly due to the activities co-ordinator being reliant on the activities co-ordinator from the sister home to assist with any trips.

The home subscribed to a daily reminiscence newspaper, published 365 days a year, which offers an ever-changing range of nostalgia topics and activities, geared towards stimulating the mind and improving memory. This was printed in large print, distributed around the home on a daily basis and used by staff to generate discussion. This meant that the home looked for and invested in tools to assist staff deliver meaningful activities, encouraging residents to talk and share memories.

We noted from the provider PIR, the activities co-ordinator did try to include people in activities and were proud of a recent achievement. A knitting circle was suggested to make blankets for the homeless people of Manchester. The families of people at the home also got involved and donated many sleeping bags. Together with the knitted blankets, these were taken to a homeless shelter in Manchester; the residents were very proud of themselves for such an achievement and the staff were proud of the residents for generating such an idea.

However, we saw little meaningful activity taking place during our inspection. The TVs were on in both lounges and we saw some people sat reading newspapers. At one point the activities co-ordinator attempted to play bingo outside. However, we noted the bingo machine could not be located and we found three people were sat outside for over an hour waiting for this to begin.

We observed people in bed throughout the day with no interaction or stimulation. We walked around the corridors at various times during the day and saw no sign of activities or interactions for the people nursed in bed. This could lead to social isolation and have a detrimental effect on their health and wellbeing. We spoke with one person nursed in bed who told us there was not much to do at the home, stating "Thank god I have a TV, I get frustrated at times."

We discussed the level of activities on offer at the home with the care staff. Comments received were overwhelmingly negative, "Activities, what activities? We don't have time for this," "I would love to be able to take people out, but we have no time for this," "Upstairs (the residential unit) have plenty going on, but the nursing unit activities is at times non-existent" and "People don't tend to get out much, if we have planned trips out staff are asked to come in on their days off and support without being paid, that's not right." We discussed these comments with the registered manager who confirmed staff could voluntary assist on activities, but the second day of our inspection the registered manager confirmed staff would now be paid if they assisted on activities on their days off.

Although we found some activities were positive, we found the service had room for improvement to ensure people living on the nursing unit were fully involved. This was a breach of regulation 9 (1)(a-c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's social needs were not being met.

We saw the record of formal complaints; there were six recorded in 2017. They had been dealt with promptly and in line with the provider's policy. We noted two of the complaints had raised concerns about the laundry at the home, with their family member's nightwear not being available. We noted the registered manager provided a response and actioned these concerns. We asked to view the complaints for 2016, however we were informed by the registered manager this information has now been archived and not available. We noted this was not good practise and the home should ensure their complaints are fully available for at least the last 12 months. The registered manager commented that there were no outstanding complaints for 2016, and all complaints are fully reviewed before they are closed by the assistant operations director.

During the inspection we reviewed the compliments file. We noted there had been a number of positive comments in relation to the home. One comment recorded included, "Having been a carer in various settings for 34 years, I was looking for a care home that ticked all the boxes. After looking at 7 places, we decided that Brookdale View was the right place for our mum. The staff are very good, patient and respectful of all my mum's needs. Mum seems to have developed a rapport with a certain carer who appears to have time to explain to my mum when need be. The manager is very efficient and listens to any concerns that may arise. No care home is perfect however pleased my mum is here."

Requires Improvement

Is the service well-led?

Our findings

Brookdale View has a registered manager who was responsive to requests of information and engaged positively with the inspection process. There was a residents' guide and statement of purpose available in the reception area which held clear details of the staff and service provided.

People and their relatives who we spoke with were positive about the leadership of the home. However we received a negative response from the majority of the staff. We were told, "Not good, the manager is rude and not a leader," "I don't feel confident speaking to the manager, she can be dismissive at times," "She [manager] has her door open today, this is always shut and she is putting on a front for CQC. You never normally see her interacting with the people or the staff," "We have had the bosses in from HC-One to sort the atmosphere out in the home, it's not worked. Morale is at an all-time low, staff are applying for other jobs," "I get on okay with the manager, at times she could be a bit more understanding when it comes to people's personal problems" and "I'm here to do a job, and I have no comment to make about the management."

The registered manager was fully aware the morale at the home was poor. The manager confirmed HC-One Human Recourses (HR) team visited the home in April 2017 to speak to staff individually to listen to their concerns and find a way forward. The assistant operations director also made herself available to speak with staff confidentially with any concerns they had. Staff were also asked to complete an anonymous survey entitled 'Our Voice'. We found 27 people completed this audit, including the homes registered manager, nurses, care workers and ancillary staff. We found many of the results captured in the audit appeared negative about the support and leadership of the registered manager. 40.74% of staff disagreed that they felt their manager developed their skills, 33.33% disagreed they felt valued, 40.74% disagreed they felt their job was rewarding, 14.81% disagreed the manager is approachable and available and 26.63% disagreed the manager recognise and praises my work. The operations director gave assurances that the provider was fully aware of these issues, and was still continuing to resolve this. We will continue to monitor this situation.

There was a formal comprehensive quality monitoring system in place and regular audits had been undertaken, but we found aspects of the programme were not effective. For example, we found the staffing dependency tool did not accurately provide assurances the staffing levels were adequate and where additional staff had been identified as needed the service had not implemented this consistently if at all. We noted from our observations and the comments received from the people, their relatives and staff whilst people's basic care needs were largely being met, there were not enough staff to support all of the people as they needed it. Call bells had been removed from peoples rooms which meant that people could not summon support as needed and the service's manager could not provide an explanation as to why or for how long they had been missing. Furthermore, we found the auditing of care plans on the residential unit did not identify the shortfalls we found. Staff struggled to understand the principles of the MCA, and the majority of staff were not aware who had a DoLS authorisation in place.

The service had been rated requires improvement at the previous inspection in 2016 which identified 2

breaches of the regulations. At this inspection these two breaches continued and we found other breaches in regulations. The provider's quality and governance systems had not been effective in remedying these areas or driving improvements.

Not ensuring the service had an effective quality monitoring system was a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

HC-One has a corporate management system within its homes. This is called Cornerstones. It is a combination of practical tools such as, a manager's daily diary, guidance and corporate documentation. The manager's diary contained eight core daily activities that they needed to carry out. These were; walk about, activities and life in the home, daily briefing for staff, enhancing the meal service, welcoming prospective new residents, care plan audits, supporting and developing the staff team and effective management systems. The completion of the diary provided an on-going account of life within the home that could be audited as part of the company's internal quality assurance system.

The registered manager told us she conducted daily walk rounds to help identify any areas for action and to keep in touch with all of the people living in the home and staff. We found these daily walk arounds were logged by the manager. During the first day of our inspection we noted a bedroom on the first floor was being used to store confidential information such as archived care plans. We found this information had been left on the floor and the room was unlocked. We pointed this out to the registered manager who immediately locked the room. This was meant confidential information was not protected and posed a potential trip hazard.

The registered manager completed a monthly audit and report on falls; pressure sores; weight management; accidents; hospital admissions and infections; and any other incidents which occurred during the month. Incidents were monitored for trends so that methods for reducing incidents reoccurring could be identified.

The assistant operations director continued to conducted monthly visits and produced a 'home visit report'. She spoke with residents, relatives and staff, observed manual handling and the dining experience. She wrote a summary of the visit, and an action plan with timelines. The detail in the reports showed that the visits had been thorough, and that the assistant operations director did not hesitate to draw attention to issues which could be improved.

In addition to these audits the provider had its own quality inspection team that had inspected Brookdale View in May 2017 and given an overall rating of requires improvement. This audit tool looked at the same key line key lines of enquiry used by CQC. One of the areas picked up in this inspection was the staff team's lack of understanding of the mental capacity act. The registered manager had an action plan that they were working through.

The registered manager or nurse in charge held a 'flash' meeting which took place every morning at 11am, involving all available staff. The meeting highlighted current issues, needs and discussed any health concerns requiring closer monitoring or a GP visit. This meant that staff were kept informed of any immediate needs.

Staff meetings were held on a monthly basis. Minutes from meetings showed they were well attended and used to discuss best practice, the policy of the month and any issues staff wanted to raise.

The last resident and relatives meetings took place in February 2017. We noted eleven people living at the

home attended. Resident and relatives meetings were advertised on the notice board in the main area of the home with the meeting scheduled for May 2017. We noted many of the comments recorded were in relation to the activities on offer at the home. It wasn't clear from these meetings that people's suggestions had been actioned. People who used the service and their relatives were also involved in completing questionnaires about their experience of the service and any improvements they would like. We found recent surveys were in the process of being analysed.

Organisations registered with the CQC have a legal obligation to notify us about certain events. The registered provider had not understood the need to notify us in relation to two safeguarding incidents that had occurred, in accordance with the requirements of registration. We had been notified of one of the safeguarding's by the local authority, however we were not aware of the second one. This meant we could not check that appropriate action had been taken at the time. The registered manager commented that she thought the provider didn't need to notify CQC because the local authority had made CQC aware already.

Failure to report safeguarding incidents to CQC was a breach of Regulation 18 (2) (e) of the Care Quality Commission (Registration) Regulations 2009.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had failed to notify CQC in relation to two safeguarding incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Although we found some activities were positive, we found the service had room for improvement to ensure people living on the nursing unit were fully involved.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Care plans did not always meet the assessed needs of people. And Effective systems or processes to assess, monitor and improve the quality and safety of the services provided and mitigate risk had not been operated fully.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing By speaking with people, their relatives and staff, and by observing the interactions between staff and the people living at the

home, it was clear that, there were not enough staff to support all of the people with activities of daily living as they needed it. In addition, staff did not have time to provide engagement and stimulus to the people living at the home.