Regal Healthcare Properties Limited

Brooke House

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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 22 and 25 August 2016 and was unannounced.

Brooke House provides accommodation and support for up to 35 people who may be living with dementia, with mental health support needs or with physical disabilities. At the time of this inspection there were 34 people living in the home. The service is comprised of an older unit in the main house, arranged over two floors with lift access between. The Brookefields unit is adjacent to the main home, purpose built and on one floor.

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

Some improvements were needed to the safety of the service. Increased clarity was needed to the way that risks to people's skin integrity were managed and mitigated to promote people's safety. This included improving the application of external creams and lotions to protect and maintain the health of people's skin. The provider had already identified this as an issue. Staff were very busy and sometimes stretched to respond to people promptly. The registered manager was seeking an appropriate tool to use for assessing people's dependency levels to ensure that staffing levels remained safe as people's needs changed. Staff understood the importance of their role in contributing to protecting people from the risk of harm or abuse and of reporting any concerns they had. Recruitment practices contributed to people's safety.

There were some gaps in staff training which the manager was trying to address, chasing staff to complete some of their learning in a more timely manner. We found that there were also gaps in training for them to understand their legal obligations when they were supporting people who may not be able to make informed decisions about their care. This area needed to improve and the provider was aware of this. However, staff did understand the principles of trying to gain people's consent and cooperation. The registered manager understood what action they needed to take to ensure people's liberty was not unreasonably restricted in the interests of maintaining their safety.

People had enough to eat and drink to meet their needs. However, the quality of their mealtime experiences varied. There was not always a calm and conducive atmosphere for people to enjoy their meals. Where there were concerns about people's diet or other aspects of their health, staff made sure that they sought appropriate advice from health professionals.

Staff had developed warm and caring relationships with people using the service. They took action to offer reassurance and comfort when people became anxious or distressed. They also treated people with respect for their dignity and privacy and spoke with them politely. They offered people opportunities to make choices about their care. Staff considered how people communicated and how they could adapt what they

did to ensure people were able to understand what was happening and make choices.

Staff had also developed a good understanding of people's backgrounds and histories so they knew what was important to them. They took these and people's interests into account in people's opportunities to pursue activities and hobbies as well as in the way that they delivered their care.

People were supported to express their views about their care so that improvements and changes in the service were made if it was needed. They were confident that, if they had concerns or complaints, the management team would listen to them and take their concerns seriously. Staff were also supported to express their views and found both the registered manager and deputy manager supportive if they had issues or suggestions to make.

The registered manager and the provider's representatives had systems in place for checking and monitoring the quality of the service people received. These systems were effective in identifying what improvements were needed and had already identified the improvements we considered necessary. However, we found that these improvements did not result in breaches of regulations and were confident that the management team would address them.

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 enough staff to support people safely, but their ability to intervene promptly when necessary was sometimes compromised.

Risks to people's safety and welfare were assessed. However, there was a lack of clarity about measures for preventing pressure ulcers to properly promote people's safety.

Prescribed tablets and liquid medicines were administered safely and as intended by the prescriber. However, topical creams intended to assist with people's skin health and integrity were not always applied as required.

Staff understood the importance of reporting any concerns that people were at risk of harm or abuse. Recruitment processes contributed towards protecting people from staff who were unsuitable to work in care.

Is the service effective?

Requires Improvement

The service was not always effective.

People had enough to eat and drink, although the quality of their mealtime experiences was inconsistent.

Staff had access to relevant training but did not always complete e-learning in a timely manner, as they were not paid if they needed to complete it in their own time.

Staff were not well prepared, by way of training, to understand their legal obligations when supporting people who lacked capacity to make specific decisions about their care. However, staff understood the principle of seeking consent from people where they could.

Staff supported people to access advice and treatment from health professionals if they became unwell.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and compassionate.

People were encouraged to make choices and decisions about their care and support.

Staff respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Staff delivered care in a way that took into account people's individual preferences and what was important to them.

People and their relatives were confident that concerns and complaints were properly addressed.

Is the service well-led?

Good

The service was well-led.

People were confident that the management team listened to their views about the service and made changes if necessary. The views of staff were also taken into account.

Systems for assessing and monitoring the quality of the service were effective in identifying improvements that were needed.

Brooke House

Detailed findings

Background to this inspection

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

The inspection took place on 22 and 25 August 2016 and was unannounced. It was completed by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a 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 improvements they plan to make. We reviewed the content of this. We also looked at all the information we held about the service. This included information about events happening within the service and which the provider or manager must tell us about by law. We sought feedback from the local authority's quality assurance team and two commissioners of services. We only received feedback from the quality assurance team.

During the inspection, we spoke with ten people who used the service, two relatives and a visiting health professional. We interviewed the registered manager, deputy manager, two senior support workers and two support workers. We also spoke with the provider's director of service quality and the operations manager for the home.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed how staff interacted with people at other times. We reviewed records associated with the care of four people, including care plans, assessments and daily records. We checked systems for managing medicines in the main part of the home, including medicine administration records for five people.

We reviewed training records for the staff team, recruitment files for two staff and minutes of three staff meetings. We also checked a sample of records associated with the quality, safety and management of the service. This included the audits undertaken by the registered manager and the findings of their survey for

people's views, completed in March 2016. We also reviewed the findings of the provider's audit completed in July 2016 and the resulting action plan.

Requires Improvement

Is the service safe?

Our findings

Staff were able to deliver care safely, for example, when people needed two staff to assist with using a hoist or delivering personal care. However, there were some concerns that staff may not be able to intervene promptly when people needed this.

All but one person told us they felt there were enough staff and that staff attended to their needs promptly. One person said, "They [staff] always come when I call." A visitor told us that staffing levels were usually, "...adequate..." but that sickness was not always covered.

For further information, we reviewed the results of the provider's quality assurance surveys from March 2016. These showed that 11 people responded and eight of them felt staffing levels were sufficient. One person did not know but two disagreed that this was the case. A relative also expressed some concern about staffing levels. When we asked staff about arrangements, they explained that they had breaks in their shifts, which included a lunch break if they were working a long day. This compromised the availability of staff to intervene quickly if people needed support.

However, we noted that, throughout our two visits, staff responded to call bells promptly. They were available to provide support to people who called for assistance when they needed it. However, we also noted that there were periods of time when staff were very stretched. For example, we noted that one person needed assistance from two staff to deliver their personal care safely. They had to wait a short while before a second staff member was free to help.

While these staff were assisting in the person's room, people seated in two separate areas within the same unit, were without staff support or supervision. This included one person who became anxious and distressed and tipped their cup of tea on the floor. A short while later another person, who had been sitting in the same area, was outside on the paved terrace. They had walked from the dining room patio doors along the terrace at the back of the home. They were without their walking stick, which they said they had forgotten, and with bare feet. The person said that they did not mind walking barefoot. However, this and the lack of their stick presented the potential of injury and increased risk of falls. Staff did intervene as soon as they noticed this, but had not been able to address this promptly at the point the person left the room.

Concerns about staffing levels in the Brookefields unit were raised at a staff meeting in June 2016. This showed that a staff member expressed concerns that three staff were not enough to support people and that it was easier to support people when a 'floating' member of staff was available to assist.

We noted from the staff meeting minutes, that the registered manager explained 12 residents to three staff was a high ratio. This supported our concerns that staffing levels were based on the occupancy of the service. We discussed this with the registered manager and service quality director. The management team explained that they were attempting to source a suitable tool for assessing staffing levels based on people's dependency. However, the registered manager was aware of the importance of indicators such as accidents or complaints, which would lead to further review.

Recruitment processes contributed to protecting people from the risk of harm or abuse. The registered manager described the checks that they made to ensure staff were suitable to work in care. This included a disclosure and barring service (DBS) check and the provision of references. Recruitment files reviewed showed that these checks were in place before prospective staff members started work.

Staff managed and administered prescribed medicines in a safe way. However, creams and lotions were not always applied as intended to maintain people's skin health and condition. The provider's quality audit report from 8 July 2016 had identified some shortfalls in the way that these were managed.

The management team were seeking support from their GP practices about clarity around the application of topical creams and lotions. This was where the guidance showed staff should apply them to people's skin, "…as directed." They told us that this was so medication administration record (MAR) charts showed clearly how often staff should apply them and what for. This work was in progress at the time of our inspection visit to make the improvements the provider's audit identified.

The deputy manager told us that care staff applied moisturising and barrier creams to promote people's skin health. Care staff were expected to apply them when they assisted people with their personal care, to maintain their skin condition. People had charts for these in their own rooms so that staff could record them promptly.

The provider's audit report from July 2016, identified omissions of signatures from MAR charts for creams and lotions, not showing that staff had applied them as required. We found similar concerns. For example, one person had a cream on their topical MAR chart, staff needed to apply regularly, twice a day. We found that their MAR chart showed that staff had signed as having applied this twice daily on only one day during the month. On eight days, this was not shown as applied at all. We discussed this with a member of the management team, who agreed they could not be sure staff had applied the cream appropriately. This presented a risk that the person's skin health would deteriorate.

Staff had taken action in response to the provider's audit report to improve the way that tablets not in blister packs were accounted for. A senior staff member explained to us how they checked balances of these medicines daily to ensure that they could account for all tablets. They said they also checked there were no missing signatures or codes on the MAR charts. They were clear about their obligations to report any anomalies or missing signatures to the management team so that they could follow up any concerns promptly.

Blister packs for medicines were used correctly and in sequence when staff offered people these medicines. MAR charts we reviewed for prescribed medicines were complete with no missing signatures. They accounted for whether people had taken their medicines or had refused them. There were specimen signatures and initials so that it was easy to see who had been responsible for administering medicines on each shift. A senior staff member confirmed that they had received training in the administration of medicines. They were able to give us a clear account of the process for giving and recording medicines to ensure they followed a safe system.

We found that, where staff administered medicines using patches applied to the skin, there were records to show where they applied the patch. This enabled staff to check whether they had become detached so the person was at risk of not receiving the measured doses of medicines they needed. It also enabled staff to ensure that they removed old patches before applying a new one. The staff member gave us a clear account of how medicines were disposed of, including these patches.

There was guidance for staff about the administration of medicines prescribed for occasional use (PRN), such as to relieve pain or anxiety. We noted that one person prescribed a PRN medicine was receiving this with increasing frequency and more regularly. The staff member we spoke with was clear about the person's history. They knew that the person could become pre-occupied with their medicines. The staff member accepted that it was becoming appropriate to review this with them and their doctor.

We checked a sample of people's medicines that required additional precautions in their management. We found these were all appropriately recorded and accounted for. We saw that a designated and trained staff member retained medicines keys safely to ensure that unauthorised staff could not access them. This confirmed what the registered manager told us in the Provider Information Return (PIR) they sent to us before our inspection.

Staff assessed risks to people's safety and welfare and recorded these within people's plans of care. This included risks associated with mobilising safely, from pressure ulcers and risks associated with not eating or drinking enough. However, there were occasional inconsistencies in information. For example, one person had a summary of care indicating they needed one staff member to support them safely. Their more detailed plan said that they needed two staff. A staff member told us they were aware of this and made sure there were two staff to support the person when necessary.

Staff identified another person to us as at very high risk of developing a pressure ulcer. Staff could tell us about the risk and that they checked the person regularly. We could see that they had pressure-relieving equipment in place. However, information did not show how often staff should assist them to change position to mitigate this risk to their safety as far as practicable.

We found entries showing that staff had repositioned the person on their left side. Later, after assisting the person with their care, staff had positioned them on the same side. Two other entries showed that the person was positioned on their back twice in succession after staff had assisted them. The same person's records showed that staff had delivered, "…personal care, repositioned." They did not indicate how they had left the person. This meant that staff following on could not be sure that they alternated the person's position to manage risks to their skin integrity. We noted that the provider's audit identified shortfalls in the way that staff managed these risks by re-positioning people. The registered manager had an action plan to improve and address this.

The manager showed us how they had reviewed one person's falls to see if these were related to the condition of their footwear, dizziness or blackouts, or possibly related to their medicines. They referred the person and others with a history of falls, for specialist advice. The manager also completed an audit of incidents and accidents for the provider every month so that there was oversight about the safety of the service.

People's safety in the event of an emergency, such as a fire, was assessed. The assessments took into account their ability to understand what was happening, their mobility, and the assistance they would need to evacuate the home if it was not possible to move them to safety behind fire doors. We noted that the fire alarm system was tested during our inspection as part of the routine weekly safety checks. Staff told us that they had training in fire safety and in first aid so that they could respond in an emergency. Other issues to do with the safety of the service or urgent repairs were discussed with the maintenance person so they could be attended to promptly.

We observed that one person who was quite tall, had difficulty getting out of a low chair they were using. Another person chose to remain standing at one point and told us, "The chairs are too low." This suggested

that some review of the furniture in use would be beneficial to some people.

We checked a sample of equipment used to assist people with their mobility and found that this was tested regularly to ensure it remained safe to use. Staff were aware of risks to people's safety when they were moving around. For example, staff were aware of the small step at the conservatory door and that this could be a trip hazard. We observed that they assisted a person who was walking independently, to use another door, and explained why this would be better for them.

People we spoke with who lived at the home told us that they felt safe. One person told us that they endured discomfort when moving and required hoisting for all transfers. The person said they felt safe when staff assisted them with this equipment. Another person told us that they felt well treated by staff and said, "They're very good you know."

Staff told us that they had regular training to recognise and respond to suspicions someone may be at risk of harm or abuse. We confirmed this with training records. Staff spoken with were clear about their obligations to report any suspicions people may be at risk of harm or abuse. Two staff members told us that they knew they could take concerns to the Care Quality Commission (CQC) if they needed to.

We found that induction training included the importance of reporting poor practice or concerns for people's welfare. We also noted from minutes that there were periodic group discussions about identifying various types of abuse. Staff were reminded that they were expected to report any concern they felt might be a safeguarding issue. This helped to maintain and develop staff awareness and insight into what constituted possible abuse.

The information we hold showed that the registered manager reported concerns to the safeguarding team promptly to help protect people from abuse. They also made the required notifications to CQC promptly and monitored progress of referrals and investigations. This confirmed what the registered manager told us in their PIR and which the provider found in their quality audit.

Requires Improvement

Is the service effective?

Our findings

People had enough to eat and drink to meet their needs and support with this if they needed it. However, the quality of their mealtime experiences was variable.

One person told us how much they had looked forward to their ice cream for dessert and had enjoyed this. Another person was positive about the food served and said, "Yes, it's lovely." We received comments about food from relatives who either contacted us or provided a website review. One visitor commented, "There is good home cooking, and food is linked to my [family member's] ability to eat." Another said, "The home has adapted the daily meal menu to cater for mum's requirements."

The action plan developed in response to the provider's audit, showed that one person was left with their food uneaten in front of them for two hours. The person's relative was present during the morning and told us they had no concerns that the person was not getting enough to eat. They were aware that there was a risk the person may not eat enough and told us that they were gaining weight.

The action plan in response to the provider's 'mock inspection' showed that the registered manager had reminded staff, "...not to give a meal and just leave it, to sit with and assist wherever possible. Also reminded to remove any open food within two hours." However, we noted that the person was left with food in front of them for two hours, which was largely untouched.

After our inspection, the registered manager supplied us with information indicating that, "The provider's action plan did not take into account the home's understanding of how best to support the person." The information indicated that staff should provide assistance and encouragement with eating and drinking when necessary. It also showed that the person was reluctant to accept physical help but that staff should remind and encourage the person.

We noted that staff did intervene briefly on two occasions. However, one of these occasions was just to comment that the person was, "...a sleepy lady. You have a nice piece of cake there." The staff member then left the room without making any further efforts to encourage them.

We observed that, in the main house after serving food to people in their rooms, staff served the people in the dining room. We noted that staff sat alongside people who needed assistance and encouraged them with their meals. Some staff ate with people who lived in the home, helping to create a social and homely atmosphere. This was consistent with the provider's quality assurance audit.

However, on the same day in the Brookefields unit, the mealtime routine was a little disorganised. For example, one staff member took a meal to someone in their room but then had to leave again because they had forgotten the person's cutlery. Another person, who needed some prompting and assistance, had three different members of staff supporting them during their main course. Staff regularly broke off to assist others or to intervene to deal with spillages.

People who needed their food presented in a softened form to aid with swallowing, had this provided. The chef had pureed the components of their meals separately. This enabled people to benefit from different tastes, aromas and colours. A staff member assisting one person told them what was on the spoon and explained what was on their plate. This represented good practice and enabled the person concerned to experience the different flavours. Staff assisted another person to eat at their own pace and encouraged them with their meal. However, the staff member stirred the food together into a brown uniform mix, which did not look appetising, and did not explain what it was.

One person, eating finger foods, had very dirty and unkempt fingernails during our first inspection visit. This raised concerns about the effectiveness of the support they needed with their personal care. It also potentially compromised their health. Staff had attended to this when we returned for our second visit. The person's nails were clean and tidy.

We observed that the routine in Brookefields was better organised at our second visit. We noted that the deputy manager, who was not supposed to be on shift but came in after we arrived, and a member of the housekeeping team, were providing additional assistance. We saw that staff intervened promptly when one person dropped their plate and gave them additional food. Staff told us that the person did not always react well to physical support so that finger foods were a better way for them to receive their meals and meet their nutritional needs. This came with the risk that they would drop food or their plate but staff accepted this and replaced the dropped food with fresh items if necessary.

We saw that drinks were available in lounge areas for staff to offer to people and that staff thickened these where appropriate. A drinks trolley also came around and during the afternoon of our second visit, we saw that staff offered people prettily decorated cupcakes to encourage their food intake.

One person had difficulty holding the beaker staff had given them for their cup of tea. Staff agreed that they could possibly benefit from further exploration of adapted equipment to ensure they were able to manage this better.

People received support from staff with access to training to meet their needs competently. The management team supported staff in their roles to understand and meet people's needs. People told us that they felt staff were competent to meet their needs. One person told us, "Yes, they know what they're doing." A relative also commented, "[Person] needs 24/7 care, and staff are able to meet [person's] needs."

The registered manager showed us how staff learning on the computer was 'launched' for them. The e-learning covered a range of basic standards of care. This included for example, staff roles, their duty of care, privacy and dignity, safeguarding and the theory of moving and handling practices. Staff completed the work and assessments needed for their Care Certificate, representing best practice in induction, in this way.

However, we noted that some staff were delayed in completing this learning after it was allocated to them. The registered manager told us how she monitored progress and chased staff who were not completing this in a timely manner. Staff spoken with confirmed this was the case.

They told us that they largely completed this e-learning in their own time because there was little time during the working day to do so. One explained that the completion of e-learning was a clear requirement of their employment and they felt it was appropriate. The staff member told us, "It keeps us up to date and there's a test at the end." The training information showed that staff also had 'face to face' training, for example in practical moving and handling skills and in fire drills. The majority of staff had completed this training although there were some gaps, which the manager was aware of, including in first aid and health

and safety training.

Staff told us that they felt they had access to appropriate training, including training in dementia awareness. They also told us, and the training schedule confirmed, that they were able to pursue qualifications in care to enhance their skills and competence.

We noted that there was a schedule for appraisal and for supervision. Both of these are needed so that staff have the opportunity to discuss their performance and development needs. The registered manager was aware of when these were due and overdue, so that she could ensure action was taken. This included checking when practical assessments were due, for example with staff awareness of good hand hygiene to aid in infection control. The manager was taking action to ensure these assessments were renewed promptly.

Staff told us that they felt well supported by the management team. They were confident that they could raise issues with the registered manager or deputy manager. They told us they felt that the management team would do their best to address the issues they did raise. A staff member commented to us that, for some staff who were new to care, the 24 hours of shadowing shifts did not always give staff enough confidence when they needed to deliver care on their own. However, another staff member said they felt that there was a good skills mix in the staff team. They told us that the duty roster was mixed so that newer staff worked with more experienced members of the care team and could learn from them.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether there were any concerns that people may be being deprived of their liberty.

People told us that staff checked with them what they needed and asked for consent to their care. For example, one person told us that staff always asked what they needed, "…and ask me if I need anything else before they leave." We heard staff asking people if they needed help, for example to eat their lunch.

People's ability to give consent to aspects of their care was assessed within their care records. The provider's quality audit indicated that some work was needed to ensure consistency within these. For example, it identified that one person's plan said they were not able to give informed consent and make decisions about some aspects of their life, but also said they could withdraw their consent at any time. The registered manager corrected this anomaly after the audit.

There were some gaps in staff training for the completion of learning about the MCA. The provider's quality audit also identified these gaps. However, staff spoken with understood the importance of seeking people's consent to deliver their care. They told us how they varied their approach when they tried to seek cooperation from people living with dementia, who might not understand what care was essential to their welfare.

One staff member was able to describe how they asked short, 'closed' questions when they were seeking consent from a person who was otherwise likely to become confused. They were aware of the importance of being flexible and of knowing about the person. Staff were aware of the importance of involving others who knew the person well, such as family members, in decisions and what was in each person's best interests if they persistently refused personal care.

The registered manager advised us that three people had others who were legally entitled to take decisions about their health and welfare should they lose the capacity to do so. This was through lasting powers of attorney (LPA). For two of these people, copies of properly authorised LPAs were on their files. The registered manager was not able to find the document showing that the third person's relative was legally entitled to make such decisions. The registered manager undertook to arrange for a further copy.

The registered manager knew when they needed to make an application under DoLS, if people were not able to understand significant risks to their safety. They had made applications in respect of restrictions to some people's freedoms, to ensure their rights were protected. The registered manager knew the importance of using the least restrictive options to ensure people's safety pending the outcomes of applications. Two applications to deprive people of their liberty in order to ensure their safety had been authorised. The management team monitored when these were due for renewal and whether circumstances had changed. This contributed to promoting people's rights.

The provider's survey of people using the service and their relatives showed that all respondents felt that staff made sure they had medical help when they needed it. Of those people, almost half strongly agreed that staff arranged medical help promptly.

We noted from people's records that staff took action to refer people for advice about promoting their health when necessary. We could see that they contacted people's doctors when they became unwell. People also had access to advice about their eyesight and dental care. Staff referred people for dietary advice if there were concerns about their weight. Where people who were at high risk of falls, referrals were also made for specialist advice about falls prevention. We noted that staff supported one person to attend a hospital appointment during our inspection visit. Members of the district nursing team also visited people regularly when this was necessary.

We noted from one person's records that they had received support and advice from a specialist social worker about their wellbeing. Signs of their deteriorating health were available to staff with guidance about how they should follow this up.

Good

Is the service caring?

Our findings

People received support from staff who had developed caring relationships with them. We saw that staff responded warmly and kindly to people who needed assistance and intervened when people were uncomfortable.

One person using the service spoke of staff as being gentle. They described how a staff member understood they were often in pain when they needed assistance to reposition themselves. They told us, "The staff member can turn me without hurting me." Another person said, "The staff are kind and considerate, nothing is too much trouble."

A relative said, "The staff are kind and caring. It's very much like home." They went on to tell us, "[Family member] gets agitated when being hoisted and hits out, but staff are very kind and spend time talking to [person] and telling her what they are doing." Another relative commented in a website review of the service that the staff had settled their family member in very well. They said, "I cannot praise the staff enough over their care and kindness to [family member]..." and, "The staff do not stint with their affection."

The provider's survey of people using the service, completed in March 2016, showed that people and their relatives valued the approach of staff. Everyone completing these surveys felt that staff treated people with kindness and compassion and were always caring. A relative commented, "All staff work very hard and have amazing attitudes."

We observed that one person, being assisted to go downstairs for their lunch, was anxious, feeling that they had lost their door key. We heard them say that they, "…might have left it in my other suit." The staff member assisting them offered reassurance that they had a spare key so would lock their door for them. We discussed with the registered manager, whether the person, if they were used to having a key previously, would feel reassured if they had one at this time. They undertook to review arrangements because the person had previously stated their wish not to have one.

We observed that one person in the Brookefield unit was unsettled and moving about a lot in their armchair. Staff understood that involuntary movements were part of their underlying health condition. Initially, we observed that staff offered them a soft toy for comfort. However, they continued presenting as unsettled. We had noted from the person's care records, that staff needed to intervene to support the person with maintaining a comfortable body temperature, as they were unable to do this for themselves. We discussed this with staff who checked and assisted the person with their clothing and provided a fan. We observed that they became less restless. We noted that staff also pulled the curtain behind another person who was sitting close to a window and in the sun. A staff member recognised that this was likely to be uncomfortable for the person.

Staff recognised that one person did not respond well to physical contact. They explained that this was why it was sometimes difficult to attend to their personal care. They described how they had acted, a little at a time and at the person's own pace, to ensure their fingernails were clean and tidy.

We observed that this person became anxious from time to time. We saw that a staff member intervened, making good eye contact with them, and speaking to them gently. The person responded well, smiling and telling the staff member, "You're lovely, you are." They became calmer as a result and allowed the staff member to assist them briefly. Another person responded well to a staff member's gentle touch and guidance to their room to find something they had lost.

Staff supported people to make decisions about their care. People, who were able to comment about their care in detail, told us that staff asked them what they needed. We observed one staff member checking with a person, whether they needed assistance and if it would be all right for them to help. We also noted that an independent mental capacity advocate had been involved in support a person with decisions about their care.

The service held care plans and records on computer. These provided prompts for staff to ensure that they had discussed people's care plans with them. For example, staff had recording having asked one person who else they would like to be involved in discussions about their care. Staff also recorded that the person was asked for their consent to sharing information about their health if it was necessary.

The provider's survey of people using the service showed that three of 11 people responding were not sure whether they were asked for their views and preferences about their daily lives. However, all of the remainder agreed that this was the case.

People's privacy and dignity was respected. One person told us how they had expressed their preference to receive care from a female member of staff where possible. However, this was not always possible during the night. The person described to us how staff had helped to change their room and moved their bed around so that they had more privacy.

A visiting health professional confirmed that they had never heard staff speaking disrespectfully to people living in the home. However, we were later within earshot when this professional requested information about a person they were due to visit. The staff response was a little abrupt.

We observed that staff spoke to people in a respectful and polite manner and addressed them by name. We also noted that they consistently knocked on people's doors before entering their rooms. This included people who were not able to respond clearly. Staff did not just walk in but knocked and opened the door slightly to check before walking into people's bedrooms.

People were supported in a way that maintained their dignity, for example after eating. We noted that staff offered discreet reassurance and assistance for people to wipe their hands and faces if they needed it. Staff quietly offered another person assistance to change their top, on which they had dropped food. Another person was asked quietly and discreetly whether they wanted staff to assist them to the toilet. These things took place without drawing the attention of other people to each person's situation.

Good

Is the service responsive?

Our findings

People received care that took into account their individual needs and preferences. Staff spoken with were able to tell us about people's backgrounds and histories. Care plans we reviewed recorded this information in detail. This contributed to staff understanding what was important to each person and tailoring the care people received as a result.

One staff member, acting as a 'keyworker' to one person living with dementia, gave us a very clear account of their role and of the specific individual needs of that person. They told us how they spoke with the person about their care. The staff member recognised the need to talk to the person clearly, with short sentences that they could process and understand.

For one person, staff had introduced a small 'whiteboard' for writing messages so that the person was more easily able to understand staff. We saw that staff used this so they were more able to share information with the person and explain what was going on. For another person, staff were aware of their interest in sport and discussed with them what channel they would like to watch on television to meet this interest. They engaged them in conversation about how disappointed they must be that the Olympics had finished.

The people we spoke with told us that most of their preferences in relation to how they wanted to be cared for were met. For example, staff offered people a choice of meals. Where they had difficulty understanding the choices in the main home, they showed people two meals to assist them with decision-making. However, this did not consistently happen in the Brookefields unit. The registered manager told us that they knew of another of the provider's services where photographs were used to help people make choices. They were planning to make improvements at Brooke House by introducing pictorial menus.

One person told us how they had expressed their preference to receive care from staff of the same gender. They knew from the registered manager that this was not always possible if they needed support during the night, but their preference was largely respected. They told us that they valued the flexible approach of staff saying, "This is the best place I have lived in. It's homely and I can get up when I want. It's informal and staff don't wear uniforms."

We noted that one person, who was not able to eat and receiving their nutrition through a tube inserted through their stomach wall, was positioned in an area where other people were eating their meals. We discussed this with the registered manager as potentially distressing for the person, who was not able to communicate verbally. Our discussions showed that the staff team had considered the risks of social isolation and disruption if the person was moved each time meals or drinks were served. They assessed that the person's demeanour did not show they were distressed by being present. They considered that the person was better able to see what was going on in the home if they remained in the communal areas rather than being taken to their room.

We found an inconsistency in care for a person, whose records had been updated recently. However, they continued to show in some sections that they had a pressure ulcer. Staff told us that this was not the case

and the registered manager confirmed this. Their care records were updated while we were present. The registered manager told us how they generated a 'status report' from the computer system, so that they knew if people's assessments and care plans were up to date or due for review. We noted from one report that the information was shared with staff so that they were aware of the updates they needed to make to ensure people's current needs were taken into account.

There was an activities coordinator in post. On the morning of our first inspection visit, we noted that activities were not able to take place as planned. This was because that staff member needed to escort someone to hospital, another staff member having reported sick.

In the Brookefields unit it was not clear how people's recreational and social needs were met and whether this could be developed further. However, during the afternoon of our first visit, people were engaged in activities in the main dining area, with some movement of people from the Brookefields unit to the main home. We noted that staff were reminded at a staff meeting, they had a responsibility to support the activities coordinator when activities were taking place. We saw that some staff did so.

One person told us how they liked to spend their time. They said, "It's comfortable and I'm happy living here, it's just like home, I spend my time watching the birds, and they [staff] bring me books about birds." The person was happy to be visited by the resident dog. Staff were aware that dogs had been important to a person during their life and how much they enjoyed the company of the dog.

Another person told us that they were largely, "…a loner…" so did not always join in with organised activities. They enjoyed reading the paper and we saw that people who wanted these had their preferred newspaper delivered daily.

We noted that some people had books to read or a puzzle they were doing. There were books throughout the home that people could pick up and read if they wished. One person who had been sleepy earlier, responded well to an invitation to play the piano and clearly enjoyed this. Another person was drawing and said that they used to enjoy watercolour painting but could not do this any longer. We noted that it was difficult for them to see the picture in the book they were copying. However, the activities coordinator had tried to prop this at an appropriate angle for them.

During the afternoon of our second visit, we saw a small group of people taking part in a reminiscence session. They were enthusiastically engaged, using books and pictures, to discuss their wartime experiences. This was consistent with the activities programme we saw displayed.

A relative told us how much people living in the home enjoyed the regular music sessions. They described other organised activities included a barbecue and summer fete. A staff member also commented about a group who brought in different animals for people to see and handle if they wanted to.

There were photographs of events taking place displayed in the home. We discussed with the registered manager that they could better demonstrate what happened on a regular basis, if they dated displays to show they were recent events rather than historical ones.

People were able to raise a complaint or concern if they needed to. Guidance about how to make a complaint was displayed at various points around the home. This showed who people could talk to and timescales for when they could expect to receive a response.

One person told us, "I'm outspoken and will tell them if something is not right but it couldn't be better."

Another person told us how the deputy manager visited them in their room regularly. They said, "If there was anything bothering me, I'd talk to her." A relative told us that they felt comfortable raising concerns. They told us how they frequently spoke to the manager, "…not to complain just to discuss issues and they get sorted."

The provider's survey for people's views showed that two respondents did not know how to make a complaint. However, the remaining nine people agreed they were told how to raise a concern if they needed to. Ten of the 11 people who responded also agreed that they had the opportunity to speak to the management team in private if they needed to.

No complaints or concerns about the service had been raised directly with the Care Quality Commission. The registered manager was able to show us how they had investigated and followed up a complaint that had been raised with them.

Good

Is the service well-led?

Our findings

People were empowered to express their views and suggestions about the quality of the service. We noted that 11 people who used the service completed the provider's surveys in March 2016. A relative confirmed that the provider had recently sent them a survey to ask for their views.

We asked the registered manager how they informed people of the outcomes of the survey and the action they took to address findings. They described the process as, "You said – we did." We saw that the registered manager shared this information with people and family members at meetings. Minutes showed these had taken place in January, February and April 2016. They also showed that the meetings provided people and their family members with the opportunity to comment about the service.

Staff spoken with told us that they felt the registered manager or deputy manager were both approachable if they wanted to express their views or make a suggestion. They told us that they were able to discuss their views at staff meetings if they wanted to, or to speak to the management team at other times.

The registered manager told us how they had introduced a "ten at ten" meeting for staff from all departments within the service, to improve communication. We observed one of these meetings, which took place for approximately ten minutes at 10am. Staff from cleaning, catering and maintenance sections were involved as well as senior care staff from the main house and Brookefields unit. This helped to ensure all staff were aware of what was due to happen in the home that day.

The provider had introduced a further system for gathering people's views, including those of professionals, using a tablet computer. They discussed with us how people completed these anonymously but wanted this to be amended. We discussed this with the provider's service quality director, operations manager and registered manager. This may not be conducive to some people expressing their views if they were not able to do so anonymously.

The registered manager and deputy manager demonstrated good leadership skills.
During our inspection visits, people were clear who the manager and deputy manager were. People, who were able to tell us, could name them. Two people told us that a member of the management team, "… comes up every day and chats to us. If there are any problems we can discuss them." Another person told us, "The home is efficient and well run." We observed that he had a friendly and chatty relationship with the manager. We observed that one person asked for the manager by name to talk to during our second inspection visit.

The registered manager understood the requirements of registration. This included the need to notify the Care Quality Commission about specific events taking place in the service.

We noted that the management team made commitments to senior staff to support them if there were issues about teamwork affecting the consistency of care. A staff member described how matters were usually, "…nipped in the bud." Staff told us that generally teamwork was good.

There were systems for assessing and monitoring the quality of care. The registered manager completed regular audits of the service and reported findings to the provider. Where appropriate, action plans were developed and monitored to ensure that improvements were made. This had led to improvements in furnishings and lighting within the main home, to ensure the quality of the environment was improved.

The provider's team completed checks on the service on a regular basis. We noted that they carried out a 'mini-inspection' on 8 July 2016, looking at the same key questions the Care Quality Commission (CQC) addresses at inspection.

The findings within their report were consistent with what CQC inspectors found. This indicated that the processes were working effectively to identify where improvements needed to be made. Although the action plan developed did not always indicate the timescales for making improvements, it did show what the registered manager was expected to do. We were able to see that some improvements had been completed and others were in progress.