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# Brook House Residential Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

This inspection took place on the 5 and 10 April 2018 and was unannounced on the first day and announced on the second day.

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

Brook House Residential Home is registered to provide accommodation with personal care for up to a maximum 32 people. The accommodation was split across two floors, each of which have separate adapted facilities. At the time of our inspection, there were 28 people living at the home, two of whom were staying there on a temporary basis. Some people were living with dementia.

There was a registered manager in post who was present during our inspection. 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.

At our last inspection in March 2016, we rated the service at Good. At this inspection we found significant failings at the service and breaches of the Regulations. We gave the service an overall rating of Requires Improvement.

Risks associated with people's needs were not always accurately assessed and managed. Where people were at high risk of falls, it was not always clear what if any action had been taken to prevent reoccurrence, this left people at risk of serious injury. The provider had not assessed the risk of entrapment to people in relation to bed rails and ill-fitting mattresses. People's medicines were not always managed safely. Infection prevention and control measures required improvement to prevent the risk of infection. The provider had not ensured a safe and hazard free environment and people were exposed to the potential risk of avoidable harm.

There was a lack of effective leadership and governance which impacted on the effectiveness of the care provided to people. The checks the provider had in place to monitor the quality and safety of the service were not effective in identifying shortfalls and driving the required improvements.

The principles of the Mental Capacity Act were not always fully understood and implemented and we were not assured decisions made on people's behalf were made in their best interest. Staff sought people's consent before supporting them and explained things to people in a way they understood to enable them to make decisions for themselves wherever possible.

While people had access to a range of activities suited to their needs and interest, staff had limited time to sit and chat with them.

Staff received training relevant to their role and to support their development. Staff felt well supported by the registered manager and their colleagues.

People were protected from the risk of abuse and discrimination by staff who had the knowledge to identify the signs of abuse and who knew how to report concerns

People enjoyed the food and were supported to eat and drink enough. Staff monitored people's health and supported them to access healthcare professionals as required.

People found staff to be kind and considerate and were involved in decisions about their care. Staff treated people with dignity and respect and supported then to remain as independent as possible.

Although people had not had cause to raise concerns they felt comfortable and able to approach staff or management should the need arise.

The provider sought people's view on the quality of the service and people found the registered manager friendly and approachable.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Risks associated with people's needs, in particular in relation to the management of people's falls were not always appropriately assessed and managed.

The provider did not ensure a safe and hazard free environment.

The provider did not ensure people were adequately protected from the risk of infection.

The provider did not ensure the safe management of medicines.

People were protected from the risk of abuse and discrimination by staff who had the knowledge to identify the signs of abuse and who knew how to report concerns.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

The principles of the Mental Capacity Act were not fully understood and followed to ensure people's rights were protected.

Staff felt supported by the registered manager and colleagues and were provided with training relevant to their roles.

People were supported to eat and drink enough.

Staff monitored people's health and supported them to access to health care as and when required.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

People and their visitors found staff kind and considerate.

People were offered choice and felt listened to.

Staff treated people with dignity and respect and encouraged them to remain as independent as possible.

Staff provided people with reassurance and support when they became distressed.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

People's care plans were not always reflective of people's needs or the support provided by staff.

People had not had cause to raise concerns but felt able to raise concerns with staff or management should the need arise.

People's wishes for the future and end of life care were established with them.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well led.

The service lacked effective leadership and governance.

The systems the provider had in place to monitor that quality and safety of the service were ineffective in identifying shortfalls in the service.

People and staff found the registered manager and provider approachable.

The provider sought people's views on the quality of the service.

# Brook House Residential Home

**Detailed findings**

## Background to this inspection

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

The inspection was prompted in part by notification of an incident that had occurred at the home. The information shared with CQC about the incident indicated potential concerns about the management of falls. This inspection examined those risks.

This inspection took place on 5 and 10 April 2018 and was unannounced. The inspection was conducted by two inspectors 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.

As part of the inspection we reviewed the information we held about the service, such as statutory notifications we had received from the provider. Statutory notifications are about important events which the provider is required to send us by law. We reviewed the Provider Information Record (PIR). The PIR is a form where we ask the provider to give some key information about the service, what the service does well and what improvements they plan to make. We asked the local authority and Healthwatch if they had information to share about the service provided. We used this information to plan the inspection.

During the inspection we spoke with eight people who lived at the home and two relatives. We spoke with the provider, the registered manager and seven staff which included four care staff, two cooks, and the maintenance worker. We viewed eight care records which related to the assessment of needs and risk. We also viewed other records which related to the management of the service such as medicine records, accident records and the recruitment records for two staff.

We observed care and used the Short Observational Framework for Inspection (SOFI). SOFI is specific way of observing care to help us understand the experience of people who were unable to talk with us.

Inadequate

# Is the service safe?

## Our findings

Risks associated with people's needs were not always assessed or guidance put in place to guide staff on how to minimise the risks. We looked at the records of three people who had a history of falls. One person's fall monitoring form recorded they had fallen on 37 occasions between November 2016 and April 2018. When we asked the registered manager what action they had taken to minimise the risk of falls, they told us they had not taken any as the person had the mental capacity to make their own decisions. They went on to explain that although staff advised the person not to mobilise without their support they continued to so. We found this person had recently had a period of ill health and their mobility had deteriorated. The provider had updated their manual handling assessment to reflect that the person now required a hoist to mobilise and a crash mat was used beside their bed at night to reduce the risk of injury. Whilst the person's manual handling plan had been updated their mobility care plan and falls risk assessment had not. When we asked the registered manager why this had not been done they said, "Time and a million of other jobs."

We looked at another person's fall monitoring forms and found they had fallen 36 times between March 2015 and August 2017. The form recorded that the person had been referred to the GP on two separate occasions and found to have low blood pressure on one of these occasions. This person did not have a falls risk assessment or a manual handling assessment in place. When we spoke with the registered manager about this person they told us that this person did not fall but tended to slip off the edge of their bed or chair and therefore they had not generated a falls risk assessment. Therefore no guidance had been put in place to guide staff how to minimise the risks of falls. The registered manager told us this person was able to mobilise independently with the aid of a walking stick and they had provided them with a pendant alarm to enable them to call staff should they require assistance.

A third person had fallen 26 times between January 2017 and March 2018. We found that this person's falls risk assessment did not contain accurate information. For example, the assessment recorded that the person had not experienced any previous falls and rated the level of risk as both moderate and high. We spoke with the registered manager to establish what action they had taken to reduce this person's falls. They told us they had oversight of all accident and incident forms and logged falls on people's individual falls monitoring form. They then analysed the information to establish if there were any patterns or trends to the falls. In the case of this person they said they had not identified any patterns to the falls. However, we found that 23 of these falls had occurred in the person's bedroom and 22 falls had not been witnessed. The registered manager said they had trialled an alarm mat but this had proved unsuccessful as the person would slip or spill things on it. They had also moved the person to a downstairs room to reduce the risk of falls. They acknowledged that they had not recorded these actions in the person's care plan or their care records. They said, "I tend to think and not write it down, which I should." This did not assure us the provider was assessing the risks to the health and safety of people living at Brook House and doing all that was reasonably practical to mitigate those risks.

The registered manager told us they had referred people to the GP and occupational therapist following falls. However, they had not considered referring anyone to the falls clinic for advice on how to reduce the risk of falls. They had also not considered latest technology such as, laser sensor alarms which would alert

staff when people were about to mobilise without support. We were therefore not assured that the provider had taken all possible action to reduce the risk of falls for people. While none of the three people had sustained any serious injuries the frequency of their falls and lack of effective falls prevention placed people at risk of avoidable harm. The registered manager committed to undertake a review of people's falls risk assessments and to make any necessary referrals to other healthcare professionals to mitigate the risk of falls.

The Clinical Commissioning Group (CCG) had completed a medicine audit at the home in November 2017. They identified some areas that required improvement to ensure the safe management of medicines. These included the completion of medicine competency assessments on staff to ensure the ongoing safe management of medicines; the completion of risk assessments for those people who self-administered or partially administered their own medicine; the completion of protocols for people who were prescribed medicine to be taken as required (PRN). The provider had not implemented these recommendations and we found people were placed at risk of harm by the unsafe management of medicines. For example, we observed that one person's medicine was left unattended on their table in their bedroom. The registered manage told us this medicine would ordinarily be stored in the medicine trolley but the person managed this particular medicine themselves. They confirmed that they had not undertaken a risk assessment to ensure that the person could administer their medicine safely as they had not had time to do so. They had also not provided the person with a lockable cabinet to allow them to store the medicine safely. They took immediate action to remove the medicine from the person's bedroom.

In another incidence we found that staff had not followed the provider's medicine policy in regard to 'controlled drugs' ('controlled drugs' are prescription medicines which are controlled under the Misuse of Drugs legislation 2001). The policy stipulated that staff should record 'controlled drugs' in the 'controlled drugs' book which required two staff to sign when it had been administered and to complete a stock check. Although staff had ensured that the medicine was stored correctly they had not recorded the medicine in the 'controlled drug' book. The staff had instead recorded the 'controlled drug' on the Medicine Administration Record (MAR) with only one signature entered each time the person received the 'controlled drug'. In addition no stock check had been completed. The registered manager took immediate action to rectify the concern.

Some people needed to take medicine 'as required' however we found PRN protocols were not in place to guide staff when these should be administered. The registered manager told us they had not completed these as the template they were provided with required them to state when the medicine had first been prescribed but they did not have this information. They agreed to complete the required PRN protocols and confirmed these had been done following our inspection.

Staff we spoke with told us they had received training in the safe management of medicines and had their competency assessed prior to administering medicine alone. However, the registered manager had not completed subsequent competency assessments to ensure the ongoing safe management of medicines. We found some people's MAR lacked clarity about what medicine people should take and when. For example, one person's MAR record contained two entries for the same medicine and staff had signed that this had been given twice for a period of 14days and then crossed the second entry out. This caused confusion as it appeared that person had received their medicine twice. The registered manager confirmed that this was a recording issue and the person had not received their medicine twice as their medicine was administered from blister packs. Where staff had hand written instructions for the administration of people's medicine on the MARs there was not always clear guidance in place as to how often the medicine should be given. We also saw that there were gaps on two people's MAR we looked at where staff had not signed to say whether people had been offered or administered their PRN medicine. In addition we saw that correction fluid had

been used on these MARs. The registered manager told us they were unaware that staff had used correction fluid on the MARs. They went on to explain that they had experienced difficulty in obtaining blank MAR charts to enable them to record medicines that people had commenced outside the monthly medicine delivery. Staff had therefore improvised using correction fluid on unused MAR belonging to other people so they had a template for recording the new medicines. Following concerns raised by us the registered manager contacted the pharmacy. The pharmacy agreed to provide a supply of blank MAR charts each month and to also to provide printed charts with the prescriber's instructions when new medicines were dispensed by them outside the monthly medicine orders.

People were exposed to the risk of potential harm because the provider did ensure a hazard free environment. The provider had purchased low rise beds and we found that the mattresses on two of these beds were smaller than the bed frame. This left a gap between the headboard and the mattress which posed a risk of entrapment for people. The registered manager told us they did not have enough space fillers for all the beds. They took immediate action to order the pads required to fill the gaps. In the meantime they reduced the risks by filling the gap with cushions. We also found that two people had bedrails in place but that risks assessment had not been undertaken to ensure that it was safe to use these for the people concerned. The registered manager completed the required risk assessments during our inspection.

People were placed at risk of potential harm as staff did not consistently follow the Control of Substances Hazardous to Health (COSHH) policy which required them to store chemicals in a locked area. We saw there was a sign on the laundry door advising staff to keep the door locked at all times. We found that the key was attached to the door by a chain which allowed people living at the home the opportunity to unlock the door. This placed them at risk of accessing chemicals stored in this area. The registered manager took action to remove the key from the laundry door and subsequently fitted a key pad instead during our inspection. We also found a container of cleaning fluid in the hairdressing salon that was accessible to people by operating a bolt attached to the top of the door. The registered manager took immediate action to remove the cleaning fluid from the salon.

The provider had not ensured that people were adequately protected from the risk of infection. While people told us and we saw that staff wore protective clothing such as, gloves and aprons when they supported them, we found some areas of the home and items of equipment were not kept clean. For example, one shower chair had staining and debris to the underside of the cushion and seat. Tap fittings and shower trays had lime scale stains. Mops were stored in the buckets and not been hung up to dry. Hoists were found to be dusty and stained. One hoist we looked at had been damaged and had been repaired with insulation tape and foam padding which could harbour germs. We found that the varnish on wooden radiator covers was peeling and these were difficult to clean. There was food debris between the joins of a dining table and stains to the underside of two lap tables we looked at. In the pantry we found dried food matter on the floor and that the hinge on the deep freeze had broken.

The registered manager told us that they did not have dedicated domestic staff and that the cleaning and laundry duties were undertaken by care staff. They said they had previously asked the provider for dedicated domestic staff but their request had been declined. They went to explain that although there were cleaning schedules in place; care staff would always prioritise people's care needs over cleaning duties. During the inspection the provider agreed to employ dedicated domestic staff to improve the cleanliness of the home and reduce the risk of infection. They also arranged for the maintenance person to re varnish the radiator guards and this work was completed during our inspection.

As well as the hazards identified within the home we found hazards in the grounds which were accessible to people living at the home. The provider had undertaken ground clearance work at the home and exposed a

pool area in the garden. Although the provider had initially put in place a fence to prevent the risk of people entering the pool, the fence was low in parts and this posed a risk of people falling into the water if they leant on it. There was a gate access to the pool in one part of the garden which had a padlock in place but this had not been locked. The provider had recently restored the bridge that spanned across the brook leading to the pool. The contractors employed to do the ground works had not reinstated the fence and this meant that people had direct access to the pool via the bridge. This placed people at potential risk of drowning if they entered the pool area.

We found a series of other hazards in the outdoor area. For example, a glass pane had broken and fallen out of the greenhouse leaving sharp edges where it had fallen from and broken glass on the floor beside the greenhouse. This placed people at potential risk of injury. The provider had put in place the foundations for a conservatory however, they had not proceeded with this work and the brickwork had become loose posing a fall hazard if anyone accessed this area.

The provider and registered manager told us there had been some difficulty with the contractors they had employed to complete the works within the grounds. The contractors were supposed to fit a gate to the bridge but they had left without completing the work required of them. Although the registered manager had completed audits on the environment they had not identified the hazards we had found. The provider took immediate action to remove the broken glass from the greenhouse on the first day of our inspection and collected fencing materials to make safe the pool area. The provider erected a new fence around the pool and secured the gates with padlocks the following day. They also put a fence up around the conservatory footings following the inspection to prevent a falls hazard.

The provider did not consistently follow safe recruitment procedures to ensure that prospective new staff were suitable to work in the home. While they had obtained references for potential new staff they had not always completed Disclosure and Barring Service (DBS) checks. In one instance they had accepted a DBS from a previous employer. The registered manager told us they had been advised that this was acceptable as long as there had not been a break in employment. The registered manager started a DBS application for this person during out inspection and in the interim completed a risk assessment on the person's employment.

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

Staff were not always effectively deployed to meet people's health and social needs. Whilst people told us staff were quick to respond to calls for assistance they did not always have time to sit and talk with them or to support them with their social needs. One person told us, "If I press my buzzer they (staff) are here like a shot." This view was echoed by another person who said, "When I press my buzzer I am never left waiting they (staff) arrive within a minute." Staff we spoke with told us it had been a difficult few months as three staff had been away from work and they had provided cover during this time. A lot of people had also been unwell and this had increased their workload. While they felt they had time to meet people's basic needs they had limited time to sit and talk with people. Throughout the inspection we saw that staff responded to people's request for support in a timely and unrushed manner.

Staff we spoke with were aware of their responsibility to report and record accidents and incidents. They said falls were also recorded in the daily record book with reference to the accident record so that staff could refer to these if they required further information. Records we looked at confirmed this.

People we spoke with told us they felt safe living at the home and with support provided by staff. One person told us, "I feel safe because they are honest people and I can leave things around even though I am

partially sighted, nothing has gone missing." Another person said, "The staff are really nice if anything does trouble me they encourage me to speak up this makes me feel safe." A staff member we spoke with told us they routinely assessed the risks as they worked with people. They went on to explain that one person was visually impaired and they ensured that walkways were kept clear to reduce the risk of falls. We saw that staff supported people to move around the home safely and where they used equipment to lift people they talked with the person and reassured throughout the procedure.

People were supported by staff who had received training on how to keep them safe from the risk of abuse and discrimination. Staff were able to tell us about the different forms of abuse and how they would recognise if people were being abused. They knew how and who to report concerns of abuse or poor practice to. One staff member told us they would report concerns to the registered manager straight away and were confident that their concerns would be addressed. The provider had procedures in place for reporting to outside agencies.

We saw that the provider had completed personal emergency evacuation plans (PEEPs) for each person. The PEEPs identified the support people would require to leave the home safely in the event of a fire or other such emergency.

Requires Improvement

# Is the service effective?

## Our findings

People's rights were not always protected as the provider did not ensure that the principles of the Mental Capacity Act 2005 (MCA) were consistently followed. The 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. One person had bedrails fitted on their bed. This person was unable to make complex decisions as they lacked the mental capacity to do so. The provider had not completed a mental capacity assessment or best interest decisions in relation to this specific decision. Therefore they had not ensured that the decision made, was in the person's best interest and there was no evidence to suggest they had considered the least restrictive options.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us they had previously applied for a DoLS for a person who lived at the home but this had not been authorised and the person had since left. In a second instance they had completed a MCA assessment for another person and deemed them not to have the mental capacity to consent to the arrangements for their care and treatment. However, they had not considered applying for a DoLS for this person. This meant the person was unlawfully deprived of their liberty. When we spoke with the registered manager they told us they had not submitted an application as the person had chosen to live at the home whilst they had the mental capacity to do so. They also questioned the relevance of doing this when it took so long for authorising body to assess people for a DoLS. This showed a lack of understanding of the MCA and DoLS legislation. The registered manager agreed to submit a DoLS application in respect of this person.

This was a breach of Regulation 11 of the Health and Social Care Act 2008(Regulated Activities) 2014.

People told us staff sought their consent before supporting them. Staff demonstrated they understood they needed to gain people's consent before supporting them. One staff member told us, "I always say do you mind if I do this or that? What would you like?" They went to explain if someone declined support they respected their wishes and went back at a later as long as the person was safe to be left. Where people had difficulty understanding the staff member told us they would explain things in a simpler way to enable them to make decisions for themselves. They went on to say that they had used picture cards with some people in the past to enable them to make their wishes known.

The registered manager told us they completed a preadmission assessment before anyone was admitted in to the home. They used the information gathered to complete risk assessments and basic care plans. Over the following four weeks they gathered further information from the person and the staff who supported them to develop a detailed care plan. Where required they said they worked with people's relatives and

healthcare professionals.

People and visitors we spoke with were confident that staff had the skills and knowledge to meet their needs. One person said, "I know they are not real nurses but they do just as well." A visitor told us, "I walk away knowing that [person's name] is safe, I feel reassured. I know they are happy here."

Staff told us although they did not receive formal one-to-one meetings; they could approach the seniors or registered manager for support when necessary. They received yearly appraisals to discuss their development needs and had been supported to undertake training to further their knowledge. One person told us they were undertaking a course on care planning and were looking forward to completing care plans for people. The registered manager showed us they had systems in place for monitoring staff training needs. Some staff were attending courses at the local college and the college also facilitated the care certificate training for new staff at the home. The care certificate is a nationally recognised training programme that teaches staff about the standards of care required of them. The provider had systems in place for monitoring staff training requirements.

People we spoke with told us they were supported to access healthcare professionals as and when necessary. One person told us the district nurses visited them twice a week to tend to their skin care. Another person said that when they complained of back pain staff arranged and escorted them to have a scan. They went on to tell us that staff arranged appointments with the GP for them when required. The registered manager confirmed that the district nurses visited the home on a daily basis to support people who were living with diabetes. One person had been discharged from hospital the day prior to our inspection and staff found them to be unwell on their return. They contacted the district nurses straight away and the person was re admitted to hospital.

The provider was undertaking ongoing refurbishment at the home to meet people's needs effectively. Since our last inspection they had installed new baths, purchased some low rise beds and intended to purchase some new chairs for the main lounge. In addition to this they were due to have a new kitchen installed in the coming weeks.

People were supported to eat and drink enough. One person told us, "I've never had so much food I can't eat it all." They went on to say, "The chef knows how to serve food it's all fresh and well cooked." We spoke with two kitchen staff who told us they were aware of people's dietary needs and had a list of people likes and dislikes. The registered manager explained that the menu was derived through the quality assurance questionnaires completed by people and their relatives. If people did not like what was on offer on certain days they were offered and provided with alternatives. When there were concerns about people's weight or about what they ate or drank staff told us they completed food and fluid charts to monitor their intake. Records we looked at confirmed this.

Requires Improvement

# Is the service caring?

## Our findings

People and visitors we spoke with found staff to be caring and kind. One person told us, "They (staff) are naturally kind, if they weren't, I would notice it, I do not take this level of kindness for granted. Another person felt staff were gentle in their approach. A visitor we spoke with told us staff always found time to listen to them, they said, "If you phone they (staff) find time for you, they do not fob you off." One staff member told us how they enjoyed chatting to people and their relatives about their past histories and life experiences. We saw that staff interacted warmly with people and their visitors and that people were comfortable in the company of staff. There was laughter and friendly banter between people and staff.

While people were positive about staff and their approach they found staff had little opportunity to spend one-to-one time with them. One person told us, "They (staff) can't stop with you long but they listen if they have time. I feel well looked after though." Staff we spoke with confirmed that they did not always have time to sit with people because of competing demands on their time which included both caring and domestic duties. They strove to meet people's care needs but struggled to pay the same level of care and attention and to their living environment and their social needs. In addition the provider had not ensured that people's falls and risks associated with their needs and their environment had been managed effectively to protect them from avoidable harm. This demonstrated a lack of regard for people's holistic needs and wellbeing.

People were supported to be involved in decisions about their care and support and felt listened to. They told us they were offered choice such as, whether they would like a bath or a shower and when they liked to get up and go to bed. One person told us they had been fully involved in planning their care as had their visitor. Staff told us they recognised everyone as an individual and always offered them choice in their daily routine. We saw that people were able to choose where they took their meals and where they wished to spend their time.

Staff provided support and reassurance when people became anxious. One person told us they had become upset when a healthcare professional visited them and the registered manager promptly intervened to support them. We observed that when one person became disorientated and anxious a staff member approached them and calmly redirected them to where they wanted to go.

People told us they found staff to be respectful towards them. One person told us, "They (staff) always knock on my door before entering treating me with dignity and respect." All the people we spoke with said they were able to meet with their visitors in privacy. Staff told us they were mindful of people's dignity and protected their modesty by ensuring doors and curtains were closed when helping them with personal care. One staff member explained they were careful to be discreet when asking people if they needed help with personal care when they were in communal areas. Staff also promoted people's independence by encouraging them to do as much as they could for themselves. One staff member explained that they encouraged people to maintain their mobility by getting them to walk as much as possible. They said, "It may take longer but it is taking away their independence by putting them in a wheelchair."

Requires Improvement

# Is the service responsive?

## Our findings

People and the visitors we spoke with were positive about the care and support they received from staff. However, we found that people's care plans were not kept under regular review and did not always reflect their needs or the support provided by staff. For example, one person's mobility had recently deteriorated and their mobility care plan had not been updated to reflect this. Staff told us they referred to people's care plans and talked with people and other staff to establish if there had been any changes in people's needs. They also had had staff handovers on each shift where they were informed of any changes or about any key events that had happened. There was a static staff group in the home and staff we spoke with demonstrated that they knew people and their preferences for care delivery well. However, it was not always evident that people and where relevant their relatives had been involved in planning and reviewing their care.

Staff routinely monitored people's skin care using a recognised screening tool. Staff told us they reported any concerns to the senior on duty who would liaise with the district nurse. However, we found that the required frequency of these checks was not recorded on the screening tool or in people's care plans. It was therefore unclear how often people should be checked. Likewise we saw that the district nurses supported some people with their skin care but this also was not always recorded in their care plans. The registered manager told us the district nurse kept their own records and wound management plans. They agreed to update people's care plans to incorporate support provided by both the care staff and the district nurses to guide staff about how to support people inbetween visits by the nurses.

As care plans were not always accurate this meant there was a risk that staff did not have access to up to date information about how to meet people's needs. We discussed our concerns with the registered manager who told us they had fallen behind with reviews of people's care plans and would take action to make the necessary improvements. During our inspection visit the provider agreed extra staff resource to support the registered manager in this process.

People told us they that they were provided with opportunities to partake in a range of activities. These included, cinema nights, memory lane sessions, singing, carpet bowls and trips out in the mini bus. The provider did not employ an activities coordinator and care staff were expected to facilitate activities. People talked positively about one of the care staff who undertook most of the activities they took part in. People told us and we observed that staff were responsive to people's requests for support. One person told us they wanted a haircut and staff had arranged this for them. We saw that the registered manager utilised the 'This is me' tool to capture details about people's life histories and their interests.

Since August 2016 all providers have a legal duty to meet the Accessible Information Standards (AIS). The standards set out the requirements for all providers of National Health Services care and or publicly-funded adult social care to identify record, flag, share and meet the information and communication needs of people with a disability, impairment or sensory loss. The registered manager told us they were not aware of the standards but assessed people's communication on an individual basis and referred people to sensory services as and when required. Where people were unable to read their care plan they explained that they would read this to them to ensure they agreed with it. One person who was partially sighted told us they

were provided with a memory stick every week containing local news articles. They also had a talking clock, a walking frame and a riser chair to aid their independence and well-being.

The provider did not have an equality and diversity policy in place that represented people who lived or wished to live at the home. They also did not provide specific training in this area. However, some staff had covered this as part of their care qualifications and had a good understanding of what this meant for their practice. One staff member explained that it was about treating everyone as an individual and not discriminating against them because of their race or disability. Another staff member stated that every individual was different and that you should treat them as they wanted to be treated.

People we spoke with had not had cause to complain but were happy to raise any concerns with staff should the need arise. The provider had not received any complaints since our last inspection but had systems in place to report and respond to complaints.

We saw that the provider had systems in place to establish people's wishes for the future including their end of life care. The registered manager told us that they linked in with the district nurse and GP service to ensure pain free and dignified deaths for people. They went on to explain that one person had recently returned home from hospital for end of life care to enable them to be supported by the staff that they knew well. Likewise another person's health had recently deteriorated and the registered manager liaised with the GP surgery to ensure the person had the necessary support should they deteriorate further. The registered manager showed us thank you cards from the relatives of people who had passed away at the home. The relatives expressed gratitude for the care and support extended to both them and their family members during this sensitive time. One card read, "Words cannot express how grateful we are for the kindness and compassion we received from you (registered manager's name) and your loyal and hardworking team during out [family member's] stay with you. We were so grateful they were able to stay in their beautiful room until they died gently and peacefully."

Requires Improvement

# Is the service well-led?

## Our findings

The service was not well led and we found breaches of the Regulations. The governance systems the provider had in place to monitor the quality and safety of the service were ineffective and had not identified significant shortfalls in the safety of the service.

The provider was not proactive in their approach. Whilst they took prompt action to address immediate risks we identified, we considered this as reactive to our observations. We were therefore not assured that the concerns we had raised would have been identified or actioned without our intervention. For example, people's risk assessments and care plans were not accurate and did not ensure that staff had up to date information about how mitigate risks and meet people's needs. The provider had not ensured the safe management of medicines and did not effectively analyse and manage the risk of falls. These shortfalls placed people at potential risk of avoidable harm.

The provider lacked knowledge of key areas of legislation that informs their practice. For example, they had not ensured the principles of the Mental Capacity Act were fully understood and implemented. We were therefore not assured decisions made on people's behalf had been made in their best interest to protect their human rights.

The provider conducted their own environmental checks but had not identified environmental hazards we had identified during our inspection. This included the lack of appropriate fencing around the pool to prevent people accessing this area which placed them at risk of drowning if they entered the pool. They had not assessed the risk of entrapment to people in relation to bed rails and ill-fitting mattresses. Adequate measures had not been taken to prevent people accessing the laundry and the hairdressing salon where chemicals were in use. We were therefore were not confident in their ability to identify and manage risks.

We found that the provider had not ensured there were policies and procedures in place to support all key areas of legislation. For example, while the provider had an equality and diversity policy that related to staff employment they did not have one that related to people living at the home. We also found that policies that were in place were not always current or specific to Brook House Residential Home. For example, they followed the Health and Safety Executive Control of Substances Hazardous to Health (COSHH) policy 2012 which did not detail the COSHH systems the provider had in place at the home and we found that chemicals were not always stored safely. Likewise the medicine policy used was generic and correction fluid had been used to remove detail of where the policy had originated from and replaced this with Brook House details. The infection control policy was dated 2003 and did not reflect current practice and we found that infection prevention and control systems within the home required improvement.

The registered manager had fallen behind in reviewing people's care plans and risk assessments and told us, in an 'ideal world' they would update these documents as soon as changes occurred. They explained that they had previously been supported by a member of staff that had experience of completing care plans and risk assessments. However, the provider had allocated this staff member to another role and replaced them with another worker who did not yet have experience to support in this area. In view of the concerns

raised the provider agreed to revoke their decision and allow the staff member with care planning experience to support the registered manager in reviewing people's care plans and risks assessments.

The registered manager and provider told us they met on a weekly basis to discuss the running of home. However, they did not record the contents of these meetings to evidence what had been discussed and agreed to drive improvements in the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

The provider had not informed us of all the significant events that had occurred within the service which they are required to do so by law. Whilst they had notified of deaths within the service they had not notified us one person had sustained a serious injury and of an incident that involved the police.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Despite the concerns we identified, people we spoke with felt that the home was well run and had a warm and friendly atmosphere. One person told us, "This is my place if I had to live here all the time." Another person said, "I am happy because it all runs well." We saw that people were comfortable and happy in the company of the registered manager. While the provider did not hold staff meetings staff told us they felt able to approach the registered manager should they have any concerns or if they had ideas for improvement.

The registered manager showed us that people and their relatives were asked to complete questionnaires to gain their views on the quality of the service and any suggestions for improvements. We saw that people were positive about the service they received.

The registered manager told us they maintained links with the local community. A representative from the local church visited the home on a monthly basis to complete a Holy Communion service for those who wished to participate. They also accessed training through the college and other local resources. The provider had appropriately displayed their ratings from their previous inspection at the location.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider failed to ensure decisions made on behalf of people were made in their best interest. |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider did not ensure that they informed us of all the significant events that occurred within the service which they are required to do so by law. |

**The enforcement action we took:**

No further action in this instance

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider failed to ensure that risks associated with people's needs, in particular in relation to the management of people's falls were appropriately assessed and managed. The provider had failed to ensure a safe and hazard free environment. |

**The enforcement action we took:**

We served a Warning Notice on the provider to be compliant with the Regulations by 1 August 2018 .

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>There was a lack of effective systems in place to monitor the quality and safety of care people received. |

**The enforcement action we took:**

We served a Warning Notice on the provider to be compliant with the regulations by 1 August 2018.