Brackenlea Care Homes Limited

Brackenlea Care Home

Inspection report

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Date of inspection visit:
20 March 2017
21 March 2017

Date of publication:
27 April 2017

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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 20 and 21 March 2017 and was unannounced.

Brackenlea Care Home provides accommodation and care for up to 25 older people, some of whom may also be living with dementia. At the time of the inspection 22 people were using the service.

Brackenlea Care Home has a registered manager in post. 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.

Medicines were not stored safely. Medicines were stored in a locked medicines cupboard in a locked room. However, the key for the room and the cupboard was kept in an unlocked key cupboard in the staff room which was not locked. The index clearly indicated which key was the medicines key. This meant there was a risk that people living in the home or visitors could access the medicines and take them. The provider could not be assured that medicines were kept at a temperature which ensured they remained safe and effective. This was because the temperature in the room where they were kept was not monitored and although the fridge temperature was checked, the maximum and minimum temperatures reached were not recorded.

The provider could not be assured that medicines were administered safely. The Medicines Administration Record (MAR) chart did not record whether anyone had any allergies to specific medicines. There was a risk that people may be prescribed medicines which they were allergic to. There was guidance in place for each person that received 'as required' medicines, known as PRN; however, these were not always up to date. There was a risk that PRN medicines may not be administered appropriately. The topical MAR charts (TMAR) did not demonstrate that medicines applied topically had been applied within prescribed guidance and applied consistently.

People were protected from abuse. Staff had completed safeguarding training and were able to explain to us how they protected people from abuse. Staff told us they were aware that they could report safeguarding concerns to outside agencies such as the police, the local authority and the Care Quality Commission. The safeguarding policy was available for staff to review in the staff room and staff said they were familiar with it. Staff said they would feel able to whistle-blow, if necessary, without fear of reprisal. Whistle-blowing is where staff can raise concerns about the quality or type of care provided.

There were specific risk assessments for each person in relation to falls, malnutrition and pressure ulcer prevention. The provider had taken action to ensure staff knew how to manage these risks to keep people safe. Risks in relation to falls were carefully monitored and people were referred to the falls team if they experienced repeated unexplained falls.

There were enough staff deployed to meet people's needs. The provider used a dependency tool to

calculate required staffing numbers. This was to ensure there would always be enough staff deployed to meet people's needs.

Recruitment and induction practices were safe. Relevant checks such as identity checks, obtaining appropriate references and Disclosure and Barring Service (DBS) were being completed for staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. This assured the provider that staff were suitable for their role.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Drinks were readily available throughout the day and staff encouraged people to drink. However, for those people identified as at risk of malnutrition, records did not demonstrate this. Records about people's nutritional requirements were unclear and inconsistent and records about what people had eaten and drunk were unclear and incomplete. Due to staff knowledge, people received food consistent with their nutritional requirement in sufficient quantities and there was no impact on people.

The environment was not specifically designed to support the needs of people living with dementia. We have made a recommendation about improving the environment to support these needs.

Staff had received appropriate training to meet people's needs. Records showed that staff had received training in key areas such as fire training, moving and handling, food hygiene and first aid. Staff were supported to study for health and social care vocational qualifications. Staff told us they felt supported in their role.

Staff were knowledgeable about people's needs and how to support them. Staff said they knew about people's needs from handovers, care plans, risk assessments, people themselves and their families. We saw that staff interacted with people appropriately and kindly, appearing to know them well as individuals, and treating them accordingly.

People were asked for their consent before care or treatment was provided and the provider acted in accordance with the Mental Capacity Act 2005 (MCA). People made their own decisions where they had the capacity to do this, and their decision was respected.

People were supported to maintain good health through access to ongoing health support. Records showed that district nurses, continence and falls specialists and the GP had been involved in people's care and referrals were made where appropriate.

Staff were kind and patient with people, using gentle persuasion and encouragement to support them. They took time to listen to people and understand how they were feeling. People's dignity was respected. People were supported to be as independent as possible.

People were involved in decisions about their care and were offered choices in all aspects of their daily life. Where they had capacity, people had signed their care plans showing that they agreed with the plan of care.

People's care plans were not complete and care records included inconsistencies which may have been confusing to new staff or agency workers. However, staff were able to respond appropriately to people's needs because they knew them well and understood their care needs. Staff knew people personally so they could respond to their preferences, likes and dislikes providing personalised care. Care plans were reviewed and updated every month and when necessary to ensure that staff were always aware of people's needs.

People were able to engage in different activities, such as music, quizzes or arts and crafts. People who liked to stay in their room received one to one time with staff to reduce the risk of social isolation.

The provider had a complaints procedure which detailed how complaints should be dealt with. This procedure had been discussed at the last residents meeting in October 2016 to ensure people knew what to do if they had a complaint. There had been no complaints in the last year.

Record keeping in the home did not meet the required standard. Individual care plans were incomplete. We found inconsistencies in record keeping across different types of records held within the home. Daily records were not always completed with accuracy. This meant there was a risk that new or agency staff would not know what care to provide or how to provide it.

The quality of the service was monitored through a series of audits and checks. Whilst comprehensive in their coverage of areas of inspection, the audits were not completely effective as they failed to pick up areas of concern identified during this inspection, in particular the unsafe storage and administration of medicines.

There was a positive and open culture within the home. Staff said they felt able to raise concerns, and were confident they would be responded to.

Feedback surveys were sent to people, staff, relatives and professionals every six months. A recent survey had been sent out but not all replies had been received as the deadline was not yet due. The registered manager told us the comments would be considered once all replies had been received.

The registered manager demonstrated good management and leadership. Staff knew what was expected of them in their role as clear guidance had been issued for daily tasks which needed to be completed. Staff told us the registered manager took responsibility for the running of the home and that they trusted her.

Policies and management arrangements meant there was a clear structure within the home which ensured the service was effectively run and closely monitored. Policies included staff recruitment, safeguarding, complaints and medicines.

During this inspection we found two breaches of regulation. You can see what action we asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medication was not stored and administered safely.

Risks to people had been recorded and actions taken to ensure these risks were managed safely.

People told us they felt safe. Staff had received safeguarding training and knew how to recognise the signs of abuse.

There were sufficient staffing levels to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Staff were aware of special diets and dietary preferences. However, records were not representative of this.

The environment was not specifically tailored to the needs of people living with dementia.

Staff had received appropriate training to meet people's needs and had detailed knowledge about people's individual preferences. Staff delivered care in line with people's individual needs and wishes.

People, who were able, gave consent to their care. For people who were unable to give consent, the provider complied with the requirements of the Mental Capacity Act 2005.

The provider knew about the Deprivation of Liberty Safeguards and had made appropriate applications in this respect.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Staff were aware of special diets and dietary preferences.

Is the service caring?

Good

The staff were caring.

Staff treated people in a kind and compassionate way. They took time to make sure that people were safe and comfortable and felt included.

Staff described how they provided care to people and respected their dignity.

Is the service responsive?

Good

The service was responsive. Staff were able to respond appropriately to people's needs due to the detailed and accurate care plans, risk assessments, daily records and handovers.

Staff had taken the time to get to know people personally so they could respond to their preferences, likes and dislikes, thereby providing personalised care.

People took part in activities of their choice.

The provider was responsive to concerns and complaints, ensuring appropriate action was taken where necessary.

Is the service well-led?

Requires Improvement

The home was not consistently well led.

We found records to be incomplete, inconsistent and not up to date. Even though current staff knew people really well, there was a risk that people would not received care which was appropriate to their needs.

The provider monitored the quality of care. However, this action was not effective as it failed to identify the concerns we found during this inspection.

There was a positive and open culture within the home where feedback was actively sought and responded to by the provider. Staff and people using the service said they felt listened to.

The registered manager demonstrated good management and leadership.

Brackenlea Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 20 and 21 March 2017 and was unannounced. The inspection was carried out by an adult social care 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 nursing and dementia care services.

Before the inspection, we reviewed all the information we held about the home including previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to send us by law. 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 used this information to help us decide what areas to focus on during our inspection.

During our inspection we spoke or interacted with most people using the service and two visitors to the home. We also spoke with the registered manager, the head of care, the cook, the activities co-ordinator and two care workers. We received feedback from three healthcare professionals who had visited the service. We reviewed records relating to five people's care and support such as their care plans, risk assessments and medicines administration records.

Some people were unable to tell us about their experiences due to their complex needs, we used other methods to help us understand their experiences, including observation of their care and support.

We previously inspected the home (under it's previous registration) in January 2014 and found no concerns.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us that people felt safe living in the home. One person said when asked if they felt safe "Yes, I certainly do." A visitor (in relation to the person they were visiting) said "I feel he is safe living here. In fact, safer than when he was at home as he fell a lot. He hasn't fallen here."

Medicines were not stored safely. Medicines were stored in a locked medicines cupboard in a locked room. However, the key for the room and the cupboard was kept in an unlocked key cupboard in the staff room which was not locked. The index clearly indicated which key was the medicines key. This meant there was a risk that people living in the home or visitors could access the medicines and take them. The provider's medicine's policy stated 'The keys to the cabinet or trolley should always be kept by the senior nurse in charge or the manager.' However, this policy was not being followed which meant there was a risk that people were not safe in relation to access to medicines. Storage arrangements met legal requirements for the storage of controlled drugs as the controlled drugs cabinet was bolted to the wall. However, the controlled drugs cabinet key was on the same key ring, that was stored in the medicines cupboard and this meant there was a risk that people or visitors may have unauthorised access to controlled drugs. Controlled drugs are medicines which require a higher level of security, as they have the potential to be misused. Medicines which needed to be stored in a fridge, such as eye drops, were stored in a locked fridge. Fridge temperatures were recorded on a daily basis to check whether they were within safe limits. However, the records did not show maximum and minimum temperatures for the fridge, which meant the provider, could not be sure that maximum and minimum storage temperatures for medicines had not been breached in the previous 24 hours. The temperature of the room in which medicines were stored was not monitored. Some medicines are not safe to take if they have been stored at a high temperature (over 25 degrees centigrade). The provider could not be assured that the room remained at a safe temperature because this had not been checked on a daily basis. We checked records and quantities in relation to controlled drugs and found them to be accurate.

Medicines stocks were ordered monthly by the provider, apart from those which were supplied in blister packs, as the pharmacy automatically supplied these each month. A 'blister pack' is a monitored dosage system provided by the pharmacy. However, as the original prescriptions were kept by the pharmacy, staff placed the orders using the previous months MAR charts. This meant they would not be aware, from this, whether a medicine had been discontinued or whether the dosage had changed. Medicines should be prepared from the original prescription and this meant the provider could not be assured that the system for ordering medicines stock was safe.

The provider could not be assured that medicines were administered safely. Records in relation to medicines were kept for each person using the service and included a photograph of the person and their date of birth. However, the MAR chart did not record whether anyone had any allergies to specific medicines. The kardex system showed that one person was allergic to three different medicines; however this was not recorded on their MAR chart or in their care plan. There was a risk that the person may be prescribed medicines which they were allergic to. A kardex is a desktop file system that gives a brief overview of each patient and is updated every shift.There was guidance in place for each person that received 'as required'

medicines, known as PRN. However, these were not always up to date, for example, one person had guidance in place for three different PRN medicines, however one of them was no longer prescribed for the person and one of them was no longer taken 'as required' but was prescribed to be taken regularly each day. This meant there was not clear up to date guidance in place for staff administering PRN medicines. In addition one of the medicines was prescribed for pain relief, the person was living with dementia and was not able to verbalise their pain. The guidance did not give a clear description of the body language and facial experiences the person displayed when they were experiencing pain. Although regular staff knew the person well, there was a risk that new or agency staff would not be aware that the person was in pain in order to administer pain relief.

Medication administration records (MAR) were kept for each person. We reviewed a sample of the records from the day of the inspection, which showed that medicines had been administered as prescribed. It was not clear how often stocks of medicines were checked to balances recorded on MAR charts. The head of care told us she checked this every time she administered medicines, but it was not clear whether other staff carried out this check. There was no system in place to ensure this was checked regularly and no records of any checks which had been carried out. This meant the provider could not be assured there was a system in place to identify and rectify any discrepancies at the earliest date. We reviewed quantities of medicines (other than in blister packs) in relation to records and found some discrepancies. Blister packs of medicines showed that all medicines had been administered on the day of the inspection up until the time of our review.

Medicines which were applied topically, such as creams, were recorded on a topical MAR chart (TMAR). However, we found that daily records did not demonstrate that the instructions on the TMAR had been followed. For example, instructions for a particular cream stated 'apply twice daily to legs and dry areas.' Records showed that the cream had been applied once a day in the morning. One person had been prescribed pain relieving gel. The instructions from the prescribing doctor were 'when required, three times a day.' The TMAR recorded that the person should have the gel applied three times a day and did not take into account that the person only required this when they were in pain. The records showed that the person had had the gel applied once a day. The head of care was concerned that staff were not recording all the care given to a person. From the records, the provider could not be assured that topical medicines had been applied regularly and as prescribed for the person.

Staff, who administered medicines, had received training and their competency to administer medicines was checked by senior staff, following completion of their initial medicines training. We found that competencies had been re-checked where an issue had been identified, such as making a mistake with administration. However, there was no system in place to ensure that competencies were checked on a regular basis to ensure that staff competencies remained up to date.

The unsafe storage, ordering and administration of medicines were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 relating to Safe care and treatment.

People were protected from abuse. Staff had completed safeguarding training and were able to explain to us how they protected people from abuse. One staff member told us "I've had safeguarding training and also attended meetings with adult services." Staff were also able to explain how they would recognise signs of abuse and said they would take people's concerns seriously if reported to them. A member of staff said "If I saw something that was wrong, I would report it to (the manager)." Staff told us they were aware that they could report safeguarding concerns to outside agencies such as the police, the local authority and the Care Quality Commission. The safeguarding policy was available for staff to review in the staff room and staff said they were familiar with it. Staff said they would feel able to whistle-blow, if necessary, without fear of

reprisal. Whistle-blowing is where staff can raise concerns about the quality or type of care provided. The provider's policy on whistle-blowing provided guidance about how to do this.

We saw a range of tools were being used to assess and review people's risk of poor nutrition or skin damage. There were specific risk assessments for each person in relation to falls, malnutrition and pressure ulcer prevention. Risks in relation to falls were carefully monitored and people were referred to the falls team if they experienced repeated unexplained falls. Falls action plans were followed to ensure all possible causes had been considered, for example, the person's medicine, whether they were eating well or had drunk alcohol. The person's environment was also considered in terms of lighting, positioning of furniture and the availability of the call bell. A person had experienced a recent fall and had been admitted to hospital. On their return, the person's risk assessment and care plan had been reviewed and updated taking into account their recent fall. Specific changes had been implemented to keep the person safe, which were clearly documented and staff were aware of and able to describe. The registered manager had taken action to reduce the risk of falls for people living in the home.

During each shift, notes and updates about each person's care were recorded in a kardex system. This was then used to carry out a handover between each shift which ensured staff were aware of any new risks which had been identified ensuring a consistency of care, which helped to keep people safe.

There were enough staff deployed to meet people's needs. The provider used a dependency tool to calculate required staffing numbers. The tool demonstrated that the care hours currently provided by staff exceeded those identified as required by the tool. On the day of the inspection there were five care workers on duty. There was also an activities co-ordinator, a chef, a maintenance man, a deputy manager and the registered manager. Cleaning and laundry staff were also on duty. We observed that there were adequate numbers of staff deployed to meet people's needs. Very few people were cared for in bed, but those that were, had their needs met. Everyone we spoke with said there were enough staff to meet their needs and that call bells were always answered promptly. One person (when asked if they thought there were enough staff on duty) said "Yes, it's not bad at all here." The registered manager told us that staff sickness was usually covered by permanent staff taking on extra shifts, although agency staff were sometimes used.

Recruitment and induction practices were safe. Relevant checks such as identity checks, obtaining appropriate references and Disclosure and Barring Service (DBS) were being completed for staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. This assured the provider that staff were suitable for their role.

Requires Improvement

Is the service effective?

Our findings

People were happy living in the home and said they received effective care. One person said "I'm happy here." Another person told us "I was able to say what I want them to do for me when I came here – they know what I like and don't like."

People were supported to have sufficient to eat and drink and maintain a balanced diet. Drinks were readily available throughout the day and staff encouraged people to drink. We saw people had easy access to drinks and people who were nursed in bed had drinks which were in reach. Drinks and biscuits and cakes were served mid-morning and mid-afternoon. Drinks were offered during and after lunch and a hot drink in the evening. We observed care workers offering regular drinks to people.

The head of care told us that menus were worked out in line with people's preferences, ensuring healthy balanced meals. Each day two choices of a main meal were offered and a hot supper. A visitor to the home told us "The food here is very tasty – all home cooked." The registered manager told us "We invite families to join their relative for lunch." A person said "The food's freshly cooked here and they do the vegetables how I like them."

People received the type and consistency of food they needed and appropriate support when required. The cook and care staff were knowledgeable about people's individual requirements such as those people who required a pureed diet, diabetic or vegetarian diet. This ensured people received the appropriate diet for their needs. However, records in respect of people's dietary requirements were not consistent. For example a kardex system recorded that one person required a soft diet but staff told us this was no longer required for the person. Another person required a liquidised diet; this was not recorded in the kardex system or on the notice board in the kitchen but it was recorded in the dietary requirements file and in the person's room. The dietary requirements file also recorded that the person needed support with weight management but did not record whether the person needed support to gain or lose weight. The notice board in the kitchen recorded that only person required a diabetic diet although staff told us that other people living in the home were diabetic. Vegetarian diets were not on the notice board in the kitchen or the kardex file, although we were aware that two people ate a vegetarian diet. There was not clear information in one place for staff to follow. There was no impact on people due to staff knowledge; however there was a risk that new or agency staff may serve people the incorrect food for their needs.

Tables were laid with clean cloths and serviettes. People were asked where they wanted to sit for lunch. Food was served from a trolley by the cook, who plated up meals individually according to preferences. Some people changed their mind and were offered an alternative. The food looked appetising and freshly cooked vegetables were available. The choice was prawn curry or sausage and mash (vegetarian sausages were available). Most people did not require support to eat their meal; a few people needed support with cutting up sausages. Appropriate support was provided. Some people received their lunch on a red plate, this helped people who were partially sighted to see the food on their plate. People were asked if they wanted second helpings and condiments were available. People were offered water or squash with their lunch. Lunch time was a pleasant experience for people.

People who were identified as at risk of malnutrition, through risk assessment tools, had their weight monitored weekly. Food and fluid charts were maintained and referrals to the GP and/or dietician were made where appropriate. Some people received prescribed food supplements. Food and fluid charts were not an accurate record of people's nutritional intake. Food charts, although recording the amount people had eaten, did not record what people had eaten. The chart included tick boxes and choices included cereal, lunch, pudding and snack. This was not adequate to demonstrate nutritional intake. Fluid charts, did not always demonstrate that people had drunk sufficiently. They were sometimes not totalled and there was no target to measure against. The head of care told us that staff sometimes did not record all the fluid a person had drunk during the day. Minutes of staff meetings showed that staff had been reminded of the importance of completing records accurately and completely. This meant that, from the food and fluid charts, the provider could not be assured that people had eaten and drunk sufficiently to maintain their health. Other information obtained during the inspection confirmed that people had eaten and drunk sufficiently for example the monitoring of people's weight on a weekly basis, staff knowledge and observation of people and staff awareness of dehydration and malnutrition.

The home supported people who were living with dementia. We reviewed the environment people lived in to determine whether it was 'dementia friendly.' There were clear signs on the doors of bathrooms and toilets with a picture of a bath or toilet respectively. However bedroom door signs were not so clear, they were all the same and people's names were handwritten. Sometimes this was difficult to read. People's photographs were not on their bedroom door; this would have clearly indicated which bedroom was theirs. Areas of the home were named, for example Coronation close, Lily Lane. In combination with their room number people lived at an address, for example, 15 Coronation close. This reminded people of their life before they came to live in the home. We did not see any memory boxes or any reminiscence material. Reminiscence involves discussing and sharing memories, reviewing and evaluating those memories, and re-capturing the emotions and feelings that are an integral part of those memories. For example, clothing, photographs, furniture or equipment from a different era which might prompt people's memories. Having more access to these things may improve the quality of life foe people living in the home.

Carpets were of a colour which contrasted with the walls, which is helpful to people living with dementia, however, they were not a consistent colour. Patterned carpet can be distracting for people. The registered manager informed us that she had already ordered new carpets for the home. We noticed handrails along corridors which is useful to support people who may be unsteady on their feet however the handrails were not easy to see as they were the same colour as the walls. There was clear lighting and clearly defined areas for socialising and eating and drinking. We noticed some reproduction cinema photographs along bedroom corridors. These were colourful and depicted popular films from several decades, however, they were not accessible to everyone living in the home, only the small number of people living in rooms on that corridor.

The home was comfortable with a pleasant atmosphere; however it had not been specifically tailored to the needs of people living with dementia.

Staff had received appropriate training to meet people's needs. Staff received face-to-face and online training. Face-to-face training was provided in the home twice every month. Records showed that staff had received training in key areas such as fire training, moving and handling, food hygiene and first aid. Some staff had also received training in dementia care. Recent training included wound care and risk management and stroke awareness training had been booked. Staff told us they had received sufficient training to meet the needs of people living in the home. One staff member said "There's always time for training – I've signed up for 'awareness of mental health.'" The registered manager told us she regularly checked to ensure staff kept up to date with their training and had sent a letter to staff ensuring they were aware of the importance of keeping training up to date. Staff were supported to study for health and social

care vocational qualifications.

The provider operated a robust induction programme. All new staff completed the Care Certificate. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers. The head of care had trained to be a Care Certificate assessor. This meant they were able to assess the standard of care staff provided.

Staff had regular supervision meetings with senior staff and all staff had had an annual appraisal. Staff told us they felt supported in their role and felt able to discuss any concerns with the registered manager at any time.

Staff were knowledgeable about people's needs and how to support them. Staff said they knew about people's needs from handovers, care plans, risk assessments, people themselves and their families. Staff described people's individual needs and how they supported them. For example, one member of staff told us that one person's care plan and risk assessment had recently changed following a recent fall. Staff were aware of the new plan of care and were observed to be following it. Another member of staff described how they gave directions to a person who was registered blind. This allowed then to do things for themselves, as they wished, but kept them safe.

We saw that staff interacted with people appropriately and kindly, appearing to know them well as individuals, and treating them accordingly. For example, one person in the lounge asked to be supported to the toilet. A care worker asked them if they would like to walk to the toilet next door to the lounge or the ensuite toilet in their room. The person said "I'd prefer to go to mine upstairs; I can then take my time." They were accompanied to the lift and their room.

People were asked for their consent before care or treatment was provided. We observed staff asking for consent such as when accompanying people to the toilet, the dining room or people's own rooms. One member of staff said "I always ask them, but I also watch their body language and am aware of their care plan." Another staff member said "I ask them if they would like any assistance." People had signed their care plan to consent to their written plan of care where they had the capacity to do so.

Where people lacked capacity to make specific decisions, the home acted in accordance with the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the 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. Where they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Mental capacity assessments had been completed for people which were decision specific. For example, a mental capacity assessment had been carried out for one person in relation to their decision to live in the home. We found that staff had received training in the MCA and were able describe the principles. People were supported to make their own decisions where appropriate. We observed a care worker asking people individually what they would like to eat for lunch and supper. They were not rushed to make a choice and when a person didn't want any of the items, sandwiches or an omelette were offered as an alternative. One person said "I don't want any of that." They chose an omelette instead. This is an example of people making decisions and staff respecting their decisions.

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. We found that the registered manager understood when an application should be made and relevant applications had been submitted for people.

People were supported to maintain good health through access to on going health support. Records showed that district nurses, the GP, continence nurses and an occupational therapist had been involved in people's care and referrals were made where appropriate.

We recommend that the provider seek advice and guidance from a reputable source, about providing an environment which is specifically designed to support the needs of people living with dementia.

Good

Is the service caring?

Our findings

We observed a person smile and reach out to a care worker saying "We get on alright don't we?" They received a smile and a hug back. A relative said "The carers are nice and they work hard here, and they are nice to me as well, they make me welcome and I can come in as often as I can."

Staff were kind and patient with people. We observed staff speaking to people in a friendly way, using first names and speaking politely. Staff demonstrated they were aware of people's preferences. Staff showed kindness to people, we saw a member of staff offer to clean a person's spectacles, sitting next to a person and patting them gently on the arm and dancing with people.

Staff respected people's feelings. A member of staff told us they visited the home on their day off to support a person to visit the local supermarket. The member of staff told us they did this because they knew the person needed a trip out to support their wellbeing. They were unable to do this during working hours because the home did not own its own transport. One member of staff said "I treat people how I would like to be treated myself; I build up a rapport with them, and adapt myself to fit with them."

Staff were caring and understanding. One member of staff told us about a person who didn't like the light on in their room. They told us they always asked the person before putting the light on to support them with personal care (with the curtains closed) and always turned the light off again as soon as they were able. Another person only liked to receive their care from female staff and this was respected. Another member of staff told us they always prepared everything before supporting a person to wash, this ensured they were undressed for the least time possible and didn't get cold.

There was a pleasant, homely atmosphere which made people feel at home and supported people's relationships with their family. The registered manager said "We encourage families to come in, invite them to lunch and to activities, they can come at any time, with no restriction." There was a parrot in the hallway, which sometimes spoke and people (and visitors) enjoyed interacting with. People's birthdays were celebrated with a cake and photographs of people enjoying their birthday were displayed on the wall.

We saw that people's bedrooms held items of furniture and possessions that the person had before they entered the home and there were personal mementoes and photographs on display. People were supported to live their life in the way they wanted in a homely environment.

People were involved in decisions about their care and were offered choices in all aspects of their daily life. The registered manager told us that care plans were discussed and agreed with people before they signed them and that relatives were also included in the process. Staff told us they always gave people choices. Where people weren't verbally able to choose, staff said they used other ways of understanding people's choices. We observed a member of staff communicating with a person by showing them pictures in a book.

People were supported to be as independent as possible. Staff said they encouraged people to do as much for themselves as possible. One member of staff told us about a person who was encouraged to shave

themselves rather than let staff do it. They explained to the person how important it was to move their arms and maintain their co-ordination. Another member of staff described how they "passed people the flannel so they wash what they can reach." The registered manager said "If they can do it, they are encouraged to do it, we are there to assist and encourage." She gave an example of a person who received regular encouragement to use the bathroom.

People's privacy and dignity was respected. Staff were courteous, we heard them knocking on people's doors and waiting for an answer before entering. Staff told us they shut the door and pulled the curtains before supporting people with personal care. They also said they took people to another room if they needed to discuss anything private with them, to ensure they could not be overheard. People were appropriately dressed. Staff had taken time to know people, which showed they respected them as individuals.

Good

Is the service responsive?

Our findings

Staff were able to respond appropriately to people's needs because they knew them well on a personal level and understood their care needs. Staff knew people personally so they could respond to their preferences, likes and dislikes providing personalised care. A member of staff told us about a person who required repositioning every four hours. They told us the person liked to speak with staff and they described the person as "lovely."

Care plans contained information about people's abilities, their desired outcomes and the support they required to achieve them, including any identified risks. People's choices and preferences were reflected. Where other people had been involved in discussing a plan of care, this was recorded. Whilst staff were knowledgeable about people's individual care needs and provided care which appropriately responded to those needs, we found that care plans were not a complete record of everyone's care needs. For example, one person had returned from hospital with a wound. A body map showed the location of the wound but there was no plan of care in place for treatment of the wound and it was not clear from the records whether the wound had healed. The registered manager assured us that the wound had now healed and no further treatment was required. Another person was recorded as registered blind, but there was no plan of care in place to address this need, they were also recorded as displaying challenging behaviour but there was no plan of care in place for staff to follow should the person behave in a way which was challenging to others. Another person's care plan recorded recent episodes of behaviour which may challenge others. Staff had dealt with the incident by holding the person's hands but there was no plan of care in place to tell staff whether this was the most appropriate way to deal with the incidents. There was no record of whether professional advice had been sought to support an appropriate plan of care. The lack of documented care planning was not a reflection of the care provided to people living in the home. We observed that staff knew and understood people's needs and were able to describe the individual care that people needed to maintain their health and welfare. Where the provider had determined that the home was no longer suitable to meet a person's needs, they had taken appropriate action in seeking a more suitable placement.

Staff were knowledgeable about people's needs and preferences, for example, whether they preferred to stay in their room or access communal areas, how they liked to spend their time and what they liked to eat. One member of staff told us about a person who like to eat their cereal with a soup spoon. They told us they always ensured the person had a soup spoon so they did not have to continually ask for it.

Care plans were reviewed every month and updated where necessary. Comments were recorded as part of the review showing that each part of the care plan had been considered individually. Shift handovers ensured that key information was recorded and passed on to ensure a consistency of care for people. There was evidence that where people's needs had changed, their care plan had been reviewed and updated. For example one person's needs changed following a fall and a hospital admission. On return to the home, the person's care plan had been updated to record their changed need.

People were able to engage in different activities. Each day activities was displayed on a board. These included music and singing, board games, arts and crafts, exercise to music and pet therapy. A monthly

newsletter was produced which listed the activities for the next month, and showed photographs of the previous month's activities. For example, the March newsletter showed photographs of people making their valentine hearts. On the first day of the inspection the morning activity was a quiz. The quiz covered many topics and there appeared to be something for everyone. At first only a few people answered questions but as time went on, more and more people shouted out answers. Two people sat next to other were conducting a friendly rivalry. The activities co-ordinator was very inclusive in her approach ensuring everyone had a chance to answer. In the afternoon, a singer came to Brackenlea. She sang popular music from a wide variety of decades. People were asked what they wanted to hear. Two people called out Vera Lynn as they had been talking about her 100th birthday with the activities co-ordinator. One person jumped up to dance to Buddy Holly songs and staff joined in with both the singing and dancing at times. The singer wore a flared dress with several petticoats underneath. She used this to good effect swirling her skirt to the music which made people smile.

The activities co-ordinator explained how she met the needs of people who preferred to stay in their rooms, to reduce the risk of social isolation. She said "I am able to build one to one sessions into the weeks' timetable. I visit people in their rooms to tell them what activities are planned that week. One lady doesn't leave her room but likes art so I give her some to do. We hold pamper sessions weekly, people can have hand massage and their nails painted." People living in the home loved to see children and the activities co-ordinator told us she was planning an Easter egg hunt involving children. Children from the local school also visited the home to sing. Special days were also celebrated such as St George's day and St Patrick's day. The activities co-ordinator said "We celebrate things like St Patricks day. We served Guinness and some Irish music. On St George's day we have fish and chips from the chip shop, wrapped in paper." An Anglian service was held in the home once a month and bibles and hymn books were available to people if they wanted them.

The provider listened to and responded to concerns and complaints raised by people, staff or relatives. The provider had a complaints procedure which detailed how complaints should be dealt with. The complaints procedure had been discussed at the last residents meeting in October 2016 to ensure people knew what to do if they had a complaint. People said they were aware. There had been no written complaints in the past year. When we asked people about complaints during our inspection, they told us they didn't have any. A relative told us "No, I've had no complaints in the past year." Staff confirmed they would go to the manager if they had any concerns. People were given opportunities to raise concerns either through residents meetings or just by talking with staff. There was evidence that the registered manager had responded to a concern raised at a staff meeting. At a meeting in January 2017 senior staff had complained they were rushed and unable to complete paperwork, this issue had also been raised through a staff survey on October 2016. It was agreed by the registered manager that an extra member would be on duty for a day shift to enable senior staff to complete paperwork. The rosters reflected this.

Requires Improvement

Is the service well-led?

Our findings

Record keeping in the home did not meet the required standard. Individual care plans were incomplete, for example, not including key areas of care such as challenging behaviour, how to support people who were registered blind, wound care planning and stoma care. We found inconsistencies in record keeping for example there were differences between MAR charts and the kardex system, care plans and the kardex system, the kardex system and the dietary requirements folder, the kardex system and dietary requirements noticeboard. We found that the TMAR did not accurately reflect the way some creams and gels had been prescribed for use. In addition daily records were incomplete and did not accurately reflect the care given. For example creams prescribed to be applied three times daily, were recorded as being applied once daily. Some fluid intake charts recorded a worryingly low fluid intake which was not reflective of the health of the person they were in relation to. Staff did not record all of the fluids offered to a person during the day. This is important to ensure the person's hydration levels are maintained. A complete and contemporaneous record in respect of each person, including a record of the care and treatment provided, was not kept. This meant there was a risk that new or agency staff would not know what care to provide or how to provide it. The lack of daily records in relation to food and drink and the application of creams meant it would have been impossible to base any decisions about people's care on those records. There was also a risk that staff might carry out care that had already been provided by another member of staff, but not recorded.

People's records were not accurate, complete and contemporaneous. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 relating to Good governance.

The quality of the service was monitored through a series of audits and checks. These included covering each key line of enquiry inspected by CQC during this inspection. For example, safeguarding, risk, nutrition, personalised care. Whilst comprehensive in their coverage of areas of inspection, the audits were not completely effective as they failed to pick up areas of concern identified during this inspection, in particular the unsafe storage and administration of medicines. Any actions which were identified during the audits were collated onto an action plan. For example an audit identified that staff were not using the correct codes on the MAR charts. A system was now in place for this to be checked daily. Due to various issues the registered manager had not received as much support as she would have liked from the provider. This had been rectified shortly before our inspection. We were assured that the registered manager was now receiving the support she required to rectify the issues identified during this inspection.

There was a positive and open culture within the home. Staff said they felt able to raise concerns, and were confident they would be responded to. The head of care told us "If people (staff) bring new ideas, I try to get them out." In the living area there was an inscription on the wall 'Residents don't live in our work place, we work in their home.' This was reflective of the culture we found in the home which was caring and respectful to people in their own home.

The atmosphere in the home was friendly and easy going. There was a family feeling amongst staff who were keen to ensure people were happy and well cared for. Staff felt valued and involved in decision-making and this reflected in the care delivered. One member of staff told us "The manager's on our side."

Feedback surveys about the home were sent to people, staff, relatives and professionals every six months. A recent survey had been sent out but not all replies had been received as the deadline was not yet due. The registered manager told us the comments would be considered once all replies had been received. Replies so fare indicated that staff were friendly and professional. One person said they would like some different entertainment introduced. Feedback from professionals included that consideration should be giving to planning weekly shopping trips for people and that people could contribute to the daily tasks of living.

The provider shared activities and photographs with families via social media. They sought consent for this from people and their families. Staff told us that families liked this and they were able to receive regular updates and see photographs of their relative even when they weren't able to visit. People liked having their photograph taken because they knew their family were going to see it. This supported the warm and inclusive atmosphere in the home.

The registered manager demonstrated good management and leadership. Staff knew what was expected of them in their role as clear guidance had been issued for daily tasks which needed to be completed. Staff told us the registered manager took responsibility for the running of the home and that they trusted her. The registered manager was knowledgeable about the notification requirements for the Care Quality Commission (CQC) and appropriate notifications had been submitted. A notification is an important event which the service is required to tell us about by law.

Policies and management arrangements meant there was a clear structure within the home which ensured the service was effectively run and closely monitored. Policies included staff recruitment, safeguarding, complaints and medicines.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure the proper and safe management of medicines. Regulation 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17(2)(c)