Mrs J Filsell

Brookfield Residential Home

Inspection report

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Tel: 02392581103

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Good
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 the 18 September 2018 and was unannounced.

Brookfield Residential Home is registered to provide accommodation for up to 29 older people. There were 29 people, some living with dementia, at the home at the time of the inspection. It is situated in a residential area of Alverstoke. The home is an adapted building with single occupancy bedrooms provided over two floors. A passenger lift provides access between the floors. There are three communal lounges, two dining rooms and appropriate toilet, bathing and shower facilities. At the front of the home there is a non-enclosed garden adjacent to the car park.

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

Effective quality assurance process had not identified areas for improvement found during this inspection and most quality monitoring was informal. Risks to people were not always managed effectively as not all risks had been assessed and staff did not always follow actions required to minimise risks. Some medicines were not always managed safely and systems to protect people for the prevention and control of infection were not always followed.

The manager took immediate action to assess and manage the areas of concern around risks which we identified to them.

The premises and equipment were safely maintained. Incidents or accidents were reviewed and action taken to reduce the likelihood of any reoccurrence.

Sufficient numbers of care and ancillary staff were deployed to meet people's needs. Checks were made to ensure staff were suitable to work in a care setting. Staff were trained and supervised and felt supported and valued.

People's nutritional needs were assessed and people were supported to eat and drink. There was a choice of food. Health care needs were monitored and referrals made to other services to ensure there was a coordinated approach to people's care.

People were treated with kindness, respect and compassion. People's privacy and dignity were promoted. People were supported to have choice and control of their lives and staff promoted independence where possible.

Care and support were centred on the individual needs of each person and staff responded promptly when people's needs changed. People and external health professionals were positive about the service people

received.

Staff supported people to receive end of life care that helped ensure their comfort and their dignity.

Activities were provided seven days per week offering a range of mental and physical stimulation.

There was an effective complaints procedure and people and their relatives confirmed they were listened to and changes made when requested.

Staff were organised, motivated and worked well as a team. They felt supported and valued by their managers.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Risks to people were not always managed effectively as not all risks had been assessed and staff did not always follow actions required to minimise risks.

Some medicines were not always managed safely and systems to protect people for the prevention and control of infection were not always followed.

People felt safe and staff had received training in safeguarding adults.

There were enough staff to meet people's needs and recruitment practices helped ensure only suitable staff were employed.

Is the service effective?

Good

The service was effective.

People praised the quality of the meals and were supported to eat and drink enough.

Staff acted in the best interests of people and followed legislation designed to protect people's rights and freedom.

People had access to health professionals and specialists when needed. When people were transferred to hospital, staff ensured key information accompanied them to help ensure they received ongoing healthcare support.

People received effective care from staff who were competent, trained and supported in their roles.

Adaptations had been made to the environment to make it supportive of people who lived at the home.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. They interacted positively with people and created a family atmosphere.

Staff expressed a commitment to treating people according to their individual needs, wishes and preferences.

Staff understood the importance of protecting people's privacy and dignity. They promoted independence and involved people in decisions about their care.

Is the service responsive?

Good

The service was responsive.

Care and support were centred on the individual needs of each person and staff responded promptly when people's needs changed.

People had access to a range of physical and mental activities suited to their individual interests.

Staff supported people to receive end of life care that helped ensure their comfort and their dignity.

People knew how to raise a complaint and there was an appropriate complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Effective quality assurance process had not identified areas for improvement found during this inspection. The manager responded promptly when we identified areas for improvement.

People were happy living at the home and had confidence in the management.

Staff were organised, motivated and worked well as a team. They felt supported and valued by their managers.

People described an open culture. Visitors were welcomed at any time and links had been developed with the community to the benefit of people.

Brookfield 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.

This inspection took place on 18 September 2018 and was unannounced. The inspection was undertaken by three 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 service.

Before the inspection, we reviewed information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 13 people living at the home and eight visitors. We spoke with the provider, the manager, eight care staff and ancillary staff including, two activities staff, the cook and housekeeping staff. We also spoke with two visiting healthcare professionals. We looked at care plans and associated records for six people, medicine administration records for all people, records relating to staff recruitment, training and support, records of accidents and incidents, policies and procedures and quality assurance records. We observed care, support and activities being delivered in communal areas.

Requires Improvement

Is the service safe?

Our findings

Some risks to people had not been assessed and were not being managed safely. People, including those living with dementia could access the kitchen and beverage preparation room including at times when staff were not in the immediate area. The risks presented by kitchen equipment such as knives and the hot water boiler had not been assessed. Fluid thickener powder is prescribed for people who are at risk of choking and aspiration pneumonia due to a decreased ability to swallow normal fluids. We saw an in-use tin of fluid thickening powder in the beverage area readily accessible to people. The registered manager and care staff were aware of the risks fluid thickener powder posed to people if eaten dry and not mixed with a drink. If swallowed when not mixed with drinks fluid thickening powder can form a blockage preventing breathing. The manager confirmed a risk assessment had not been completed. Within various rooms such as the beverage area and a bathroom and left unattended around the home on several occasions we saw a range of cleaning chemicals which could pose a risk to people if used incorrectly or swallowed.

We identified these concerns to the provider and manager who immediately arranged for appropriate action to be taken to assess and manage these risks. This included the fitting of locks to the kitchen and beverage room and the purchase of lockable cleaning equipment for the safe storage of substances hazardous to health and reminded staff of the need to ensure safe storage of such items.

Individual risks to people were managed effectively. Risk assessments had been completed for all identified risks, together with action staff needed to take to reduce the risks. For example, some people were at risk of developing pressure injuries and we saw special pressure-relieving mattresses and seat cushions had been provided. Advice had been sought from Speech and Language Therapists (SaLT), which was being followed, when people were at risk of choking. Where people were at high risk of malnutrition, kitchen staff were aware and were providing fortified meals as well as offering high calorie snacks.

People were protected from the risk of falling. Some people had been given walking aids. Staff prompted people to use them correctly. One person had been provided with wedges to reduce the risk of them falling from their bed, other people's risk assessment had resulted in bed rails which we saw were used appropriately. We saw movement sensor equipment had been put in place to alert staff that some people may be moving around in their bedrooms. If people sustained a head injury, staff sought immediate medical advice and monitored the person closely to check for signs of brain injury. When people experienced falls, their risk assessments were reviewed and additional measures considered to keep them safe. The manager reviewed all falls in the home monthly to identify any patterns or trends; none had been identified, but they described appropriate action they would take if a common theme emerged.

Fire safety systems were checked regularly and staff were clear about what to do in the event of a fire. Each person had a personal emergency evacuation plan detailing the support they would need if the building needed to be evacuated and staff had completed an evacuation drill. In addition, arrangements had been made to access the local parish centre should the home need to be evacuated in an emergency.

Prescribed topical creams were not always managed safely. In an unlocked bathroom cabinet, we found

various in-use prescribed topical creams in tubes and tub containers. Some had people's names on them, for others these had worn off meaning it was not possible to be sure who these creams had been prescribed for. None contained a date of opening or a date after which they should no longer be used. In bedrooms, be also found undated in-use prescribed topical creams. Once opened prescribed topical creams are only safe for use for a limited time as detailed by the manufacture. We raised this with the manager who removed all the topical creams and acted to ensure that in future these were dated and used as per the manufacturer's guidance. For one person a prescribed medicine had been crossed out on the Medicine Administration Record (MARs) there was no reason recorded as to why this was not been administered or who had made this decision. The senior staff member who was administering medicines did not know why this was not being administered.

Otherwise people were supported to receive their medicines safely and as prescribed. One person told us, "I get my medication regularly, the staff do all that." There were clear processes in place to obtain, store, administer, record and dispose of medicines. Medicines were only administered by suitably trained, senior staff, who had their competence to administer medicines re-assessed every year. Staff wore a red tabard with the words 'Do not disturb' written on it, to reduce the risk of them being interrupted while administering medicines, which reduced the risk of medicine errors.

People felt safe living at Brookfield. One person told us, "I feel so safe and happy in this place. All the staff are hard-working and very kind to me and all of us here. I really wouldn't go anywhere else especially at my age. I am very well looked after here and I have nothing to complain about." Another person said, "I feel so safe and happy. I am so happy living here. I cannot fault them on anything really." A family member told us, "I feel that he [my relative] is very safe in here."

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. They told us they would have no hesitation reporting concerns to the provider or manager and were aware of external organisations, including CQC, they could go to for support. Where safeguarding concerns had been raised, we saw the manager had conducted a thorough investigation and taken appropriate action to reduce the risk of future concerns.

People commented that the home was always clean and tidy, including one person who said, "Very clean and you cannot smell anything bad about it." Staff had completed infection control training. They had access to personal protective equipment (PPE) and wore this whenever appropriate. There was a policy for the handling, storage and disposal of clinical waste. The policy stated that clinical waste should be stored in a yellow pedal type bin; bags should only be three quarters full; sealed and then stored in a large yellow container. There was deviation from this policy which increased the risk of cross contamination and infection spreading. For example, we saw two yellow clinical waste bags which were more than three quarters full and could not be fully sealed, stored in a "Clinical waste" area which had a note on the door stating the door should be locked at all times. This door remained unlocked for the duration of the inspection. The mop and bucket used for the cleaning of the kitchen was stored in this outside area alongside the unsealed clinical waste bags. Later we saw the clinical waste yellow bags were transferred to a larger blue bin in the waste compound.

Otherwise all areas of the home were clean and cleaning staff completed cleaning check sheets to confirm that cleaning had been completed to the required standard and frequency. Regular cleaning audits were conducted. Staff and the manager could describe the procedures they would employ should someone have a potentially infectious condition.

Appropriate recruitment procedures were in place and we found these had generally been followed. These

included pre-employment reference checks and checks with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. However, full employment histories had not been obtained with any employment gaps explained for all recently recruited staff. This meant the provider could not be sure that applicants had not worked in other employment during these gaps from whom references should be sought. We raised this with the manager, who amended their recruitment processes to help ensure these additional checks were conducted in future. Staff confirmed recruitment processes had been followed before they started working at the home.

There were enough staff deployed to meet people's needs. One person told us, "The staff don't keep me waiting long." A visitor also told us they felt there were sufficient staff. Throughout the inspection, we saw staff were available to support people and call bells were responded to promptly. Staff confirmed there were enough staff to provide appropriate care without being rushed in their duties. A staff member said, "There is definitely enough staff." A second staff member said, "For the residents we have there is enough staff." They went on to confirm that if it was needed more staff would be put in place. Another staff member told us the provider and manager would always help and would come in any time day or night if required.

The registered manager assessed staffing needs by observing staff and listening to feedback from people and staff. Staffing shifts were organised to ensure more staff were available when required. For example, two afternoon staff commenced work prior to lunch being served to provide additional support at this busy time. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed using overtime. The provider had signed up with a care agency which allowed additional staff to be sourced at short notice if required.

Good

Is the service effective?

Our findings

Staff had the skills and knowledge to carry out their roles and responsibilities effectively. People consistently told us they received effective care from experienced and competent staff. When asked if they felt staff were trained and knew how to support them, one person said, "I feel that they know their roles very well which I think comes with training." Another person said "I have the confidence in the members of the staff. I feel that they do a great job in this place. I don't know how they are trained but I think that from what I see, they must have good training. They are excellent in what they do."

There was a system to record the training that staff had completed and to identify when training needed to be updated. There was a plan in place to ensure all staff completed any required and supplemental training with further training booked each month to ensure staff remained up to date. Staff told us they had received lots of training and felt this had given them the skills necessary to perform their roles. One staff member said "They [managers] encourage everybody to do training. Everybody has access to the online training plus the on the job training that I find particularly useful for me. They have a very good induction training that we all went through when we started work here. It is good to train because in that way you build the confidence and knowledge of doing the job competently." New staff completed an effective formal induction into their role. This included training and time spent shadowing, (working alongside experienced staff) until they felt confident they could meet people's needs. Most training was provided via computer with limited practical training. The manager told us they provided some practical training; however, they had not completed relevant training to provide this including moving and handling, first aid and fire training. The manager told us they were aware of the need to complete training to provide these courses and would be addressing this issue. Following the inspection the manager completed specific training to enable them to provide moving and handling training.

Staff received supervision and appraisals of their work and felt supported. Staff received formal supervision every two months. Supervision is an opportunity for the manager or a senior staff member to meet with staff, to discuss their training needs, identify any concerns, and offer support. Staff who had worked at the home for over a year had received an annual appraisal to assess their performance and identify development needs. Staff members confirmed that they received supervision regularly and spoke positively about the support they received from management on a day to day basis.

Staff described how they sought verbal consent from people before providing care and support. They said they were led by the person and always acted in the person's best interests. People confirmed staff asked their consent before providing care. One person said "Yes, I get asked first before the staff do anything with me and I also ask them in case I want anything. I get my medicines regularly and they normally do ask me before they give them to me. They help me with washing, dressing and moving about." People also confirmed that staff respected their choices. One person told us "I can choose to stay in my room or come to the dining room. Yes, they do respect my wishes."

Staff protected people's rights and acted in the best interests of people. Staff followed the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making 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 decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. A formal mental capacity assessment had been completed. This covered all aspects of care required such as personal care and medicines. Where the assessment showed people lacked capacity to make decisions, for example about the use of sensor mats and bed rails used to keep them safe, there had been discussion with relevant people such as the person's relatives. The resulting best interest's decisions were recorded as required by the MCA.

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 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 the manager had applied for DoLS authorisations where needed and acted where conditions had been applied to DoLS.

Prior to admission to the home the registered manager undertook an assessment of people's individual needs to ensure these could be met at the home including any equipment or specific adaptations that may be required. Relatives told us the manager had met with them prior to their admission to identify care needs and other things which were important to the person. We saw copies of assessments in care files which showed there had been consultation with family members and health or social care staff prior to admission. This would help ensure all needs were known and met on admission.

People were supported to access healthcare services when needed and people received the personal care they required. A person told us "I don't see the doctor often but I have the confidence in the girls [care staff] that should anything go wrong with me, they would know what to do." Visitors told us they felt people were well cared for. One visitor said, "I know that my [relative] is in very good hands." Another visitor told us "My [relative] is looked after very well in this place." A health care professional said the home contacted them appropriately and the welcome and support from staff was always excellent. Care records showed staff identified health needs and sought appropriate medical care and kept family members informed when necessary. The service worked well with other organisations to provide a coordinated approach to care. Records showed there was joint working with community nurses and confirmed that people were seen regularly by doctors, opticians, dentists and chiropodists. The service was working in conjunction with the local hospital 'red bag' initiative which helped ensure that, should a person require hospital care, information relevant to the person would be provided.

People told us they enjoyed the food provided at Brookfield. One person said "The food is excellent and I do get enough to eat. I can eat or drink anything I wanted any time of day or night. Excellent service." Another person said "I get silver service at breakfast, lunch and supper. You can ask for tea or coffee any time of the day and it shall be given to you. They also give us variety to choose from." Some people needed a special diet and we saw this was provided consistently with the cook able to state who required specific diets and how these were met.

Staff were attentive to people during meals which people could eat either in the dining rooms, lounges or their bedrooms as according to their personal preference. When people did not want either of the main cooked meal options, an alternative such as an omelette or jacket potato was provided. Where people needed support to eat, this was done in a dignified way. Each person had a nutritional assessment to identify their dietary needs. Throughout the inspection we saw people had hot and cold drinks. Where needed, staff were recording all drinks some people received. These records showed people were receiving

drinks and their hydration needs were being met. Staff monitored people's weight and action was taken when people were identified as suffering from unplanned weight loss.

Staff made appropriate use of technology to support people. For example, pressure mats were used to alert staff of the need to support people when they moved to unsafe positions. Special pressure-relieving mattresses had been installed to support people at risk of pressure injuries and an electronic call bell system allowed people to call for assistance when needed. Wi-Fi had also been installed to allow people to connect to the internet.

Adaptations had been made to the home within the structural limitations of the building. A lift was provided to enable people to access the first-floor bedrooms. Bedrooms were personalised and people had their own furniture and items that were important to them on display. Hand rails were painted in contrasting colours to walls and WC and bathroom had suitable signs to help people locate these. There was a programme of redecoration in progress and we were informed this would include replacing floor coverings where necessary. There were a variety of dining and lounge areas meaning people had choice where they spent their time. There was level access to a garden at the front of the home including a patio area which we were told people enjoyed using in warmer weather.

Good

Is the service caring?

Our findings

People were supported by kind, caring and compassionate staff. Everyone we met spoke positively about the attitude and approach of staff. Comments from people included: "Everyone here is caring especially the staff and the manager. They are always there whenever I have needed them. They always check on me to make sure I am well, and not going hungry or thirsty." Another person said, "The carers are very good to me", whilst a third person said, "They do check on me day and night to make sure that I am well and comfortable and that really makes me feel loved." Family members echoed these views, including one who told us, "People are treated with respect and they get every support. Whenever I have been here I have been so impressed with the welcoming nature of the home." We saw care staff took time to ensure a person was comfortable after they were settled into a chair after lunch adjusting a cushion several times until the person felt 'right'.

Interactions between people and staff were positive and supportive. Staff engaged with people, checked they were comfortable, bent down to their level and used touch appropriately to reassure. A person told us "The staff are so kind and they do a very good job looking after us. They do everything you ask them." We saw a staff member ask a person if they were 'OK', the person replied they were "struggling [with walking]". The staff member responded empathetically saying "Oh dear, that's not good." And rubbed the person's back whilst walking with them towards the lounge. On another occasion we saw a person ask a staff member if they needed their coat on. The staff member knelt to the person and held their hand and told the person they were staying for lunch. The person smiled and said, "I like it here."

Staff expressed a commitment to treating people according to their individual needs, wishes and preferences. For example, we saw some people had been supported to apply make-up and wear jewellery as was their preference. One person told us "I am also given choices to make my own decisions. They do listen to what I say to them and respect my decisions." Staff promoted choice and respected people's autonomy by empowering them to make as many of their own decisions as possible. We heard people being offered choices throughout the inspection. Staff could tell us about people's life histories and this information was also available within care plans. Care plans also contained information as to how the person's emotional and social needs should be met and what was important for them.

People's privacy and dignity was respected and staff acted to ensure this was maintained at all times. A person told us "I feel that they respect my personal dignity and space. They always respect what I say to them or if I want something done." A staff member told us, "We shut doors and when we are washing people we keep them covered as much as possible, we make sure they are not completely naked." Confidential information, such as care records, were kept secure and only accessed by staff authorised to view it. Any information which was kept on the computer was also secure and password protected.

Staff respected and promoted independence by encouraging people to do as much as possible for themselves. One person told us, "They [staff] help me walk about on my frame and they are very supportive on anything that I need done." Another person told us "They [staff] do encourage us to do things by ourselves as much as we can but as you will have noticed most of us are old and so we tend to depend on

them on most things and they don't mind." People's care plans also included information as to what supported they needed and what parts of personal care, such as washing their own face, they could do independently. At lunch time we saw a range of adapted crockery, such as high sided plates and larger handled cutlery were provided when necessary meaning people could continue to eat independently.

Staff made people feel they mattered by creating a family atmosphere. People told us that living at Brookfield was like 'being part of a big family'. One person told us, "I have been living in this home for nearly three years and I really like it here so much. It feels like home. Everyone here is so helpful to me. I get help with most things because I no longer walk by myself but I do try and do the rest myself." Another person said, "The place feels like home and we all get on very well with one another and with the staff."

Staff supported people to build and maintain relationships that were important to them. A family member told us, "I do come here to see my wife every single day and they treat me as their own. They make me feel very welcome. I know that she is in very good hands and that makes me feel better. They are absolutely caring people. I can't ask for anything better than this." We saw the provider and manager as well as staff greeting visitors by name and advising them where in the home their relative was at the time they visited. The home had several dining and lounge areas meaning space for private visits could be arranged when required. Staff explained how when one person's relative visited they always arranged for them to spend some time away from other people to enjoy each other's company, as they had expressed a wish to do this.

People and relatives told us they were involved in discussing the support they wished to receive. A family member told us, "My [relative] has not been here long but I am always consulted on his welfare. They discuss his care plan with me and they also consult me on anything. They wouldn't do anything without consulting us and without asking for his opinion." Information in people's care records confirmed that they, and family members where appropriate, were consistently involved in developing their care plans. At lunch time we saw people were asked if they would like clothing protectors and these were provided when people responded 'Yes'.

During pre-admission assessments, the manager explored people's faith needs and staff supported people to follow their faith. The manager told us they explored other aspects of people's cultural and diversity needs during ongoing discussions with people about their backgrounds, interests and beliefs. Staff expressed a commitment to treating people according to their individual needs, wishes and preferences, including their specific communication needs.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs. Staff provided flexible and individualised care and support to people. One person told us, "I am not good at moving about but they do encourage me to do exercises." A family visitor said, "They keep me informed all the time for example when my [relative] was unwell last week, they kept me informed and I felt so reassured with that."

Care and support were centred on the individual needs of each person. Assessments of people's needs were completed by the manager before people moved to the home. This information was then used to develop an appropriate care plan in consultation with the person and their relatives where appropriate. Care plans contained detailed information to enable staff to provide care and support in a personalised way according to people's individual needs. They included people's normal daily routines, their backgrounds, hobbies, interests and personal preferences, for example how and where they wished to receive personal care.

Staff told us they found the information within the care plans useful and that it helped them understand the person and their needs. They demonstrated a good awareness of the individual support needs of people living at Brookfield, including those living with dementia. They knew how each person preferred to receive care and support; for example, staff told us how they cared for a person including assisting them to change their position, what topical creams needed to be applied and what music the person liked to listen to. One staff member told us, "We can always look at the care plans." Another staff member said, "I've got to know people and what they like and what they need."

Staff responded promptly when people's needs or preferences changed. For example, staff could tell us what may indicate that a person was developing a urine infection or other common health problems and described appropriately the action they would take. The manager described action they had taken in response to incidents and accidents to reduce the risk of recurrence. Records of the daily care provided confirmed that people had been supported in accordance with their identified needs. For example, where people needed to be supported to reposition in bed. turning charts confirmed this was done regularly. We joined staff for the handover between the morning and afternoon staff team. Appropriate information was passed on showing that staff had responded to people's wishes and needs. For example, afternoon staff were told a person had turned down the offer of a bath in the morning and afternoon staff said they would try later and if not wanted then by the person they would try again the following day. We observed the provider responding to a person. Their communication skills were excellent and they protected the person's privacy and dignity. The person was concerned about the distance required to walk to the dining room so she found him a wheelchair instead. The person was clearly appreciative of her efforts and responsive nature.

People were supported at the end of their lives to have a comfortable, dignified and pain-free death. At the time of the inspection two people were receiving care towards the end of their lives. Their care records included an end of life care plan detailing specific individual wishes as to how they would like to be cared for. Staff had sought guidance from health care professionals and medicines to manage any symptoms were available. We observed staff throughout the inspection to be highly responsive to the person and their

visiting family. Care staff ensured the person was comfortable and assisted them to change their position, applied skin barrier cream to prevent skin damage and provided mouth care to keep their mouth moist. Staff offered the person food and drink as they could be tolerated and spoke with the person throughout care interactions. One person's full care plan had not been updated since their condition had deteriorated the previous day and the manager stated they intended to update the care plan on the day of our inspection. However, the person was receiving all the care they required. The manager described how they also cared for the relatives and visitors of people receiving end of life care. We saw staff frequently offered relatives refreshments and kept them informed about what they were doing to keep the person comfortable.

People had access to a range of activities which they told us they enjoyed. Two activities organisers were employed covering seven days a week up to 7:00 pm. They included a range of activities to provide both mental and physical stimulation including chair exercises, bingo, singing, crafts and board games. In addition, there were two volunteers who attended the home twice a week to provide a range of craft and social activities. One person told us, "We are encouraged to play games, listen to music and do crafts, well for those who can anyway. Yes, they keep us busy and that is nice. They don't force you but they try and encourage us to take part." A visitor told us "I know that my [relative's] ability to engage is very limited now due to her illness. But this home is very good at involving its residents in a number of things but of course it comes down to individual ability." We saw that where people remained in their bedrooms, either by choice or due to their level of frailty, appropriate music or television was provided. Care plans contained information about people's previous hobbies and interests to help staff understand what people may be interested in participating in.

There was a complaints procedure in place, which was advertised on the home's hallway. People and family members said they felt confident to complain about the service but had not had cause to. One person said, "I really can't think of anything to complain about in this place – the place feels like home and we all get on very well with one another and with the staff." Another person said, "I have no complains whatsoever." People were confident any complaints would be listened to and acted upon. One person said "If there was anything I needed done, I would speak to the carers here and the managers but I have never had anything to complain about. Oh yes, I believe that they will listen to me." No formal complaints had been recorded in the previous year. The manager described the action they would take should a complaint be received. This would include a comprehensive investigation and response provided to the person who had raised the concern.

Requires Improvement

Is the service well-led?

Our findings

There was limited quality monitoring of the service and this was not always effective. We found areas where monitoring systems had not identified concerns we found which placed people at risk. These included that risks to people were not always managed effectively as not all risks had been assessed and staff did not always follow actions required to minimise risks. Also, that some medicines (prescribed topical creams) were not always managed safely and systems to protect people for the prevention and control of infection were not always followed. We identified that the home was not always following their own policies and procedures or ensuring they were up to date with best practice changes. For example, the provider's guidance for infection control used to support the home's policy was not consistent with current supporting guidance. The manager said that as they were present every day there was no need for recorded assurance and audit programmes. However, she recognised that this was not appropriate and would need to change procedures to assess and monitor the quality of the service provided and the delegation of more tasks to senior care staff.

Providers are required to display the ratings from previous inspection in a prominent position within the home. The provider had failed to ensure this was done and they and the manager were unaware of the need to display their previous ratings. We identified this to the manager who acted promptly to ensure this was displayed within the home's entrance hallway.

During the inspection each time we informed the manager of our findings of an area that required improvement they were responsive and acted to address our concerns. Following the inspection, the manager sent us additional information detailing the action they had taken. For example, they had acted to review recruitment procedures to ensure full employment histories were obtained and that any gaps were discussed during pre-employment interviews. They also acted promptly to address concerns we raised in respect of managing risks posed by the kitchen and beverage area. This demonstrated that the provider and manager reacted when shortfalls were identified. However, they did not always have effective systems in place to ensure that they were able to proactively prevent shortfalls in the service from occurring.

The failure to operate effective systems to assess, monitor and improve the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Management systems were in place to monitor some aspects of the service. For example, the manager could provide assurance around falls and bruises (as reported on body maps). These showed there were appropriate reasons as to why someone may have been bruised. For example, for one incident there was evidence of engagement with the GP who confirmed bruising to be associated with anti-coagulant therapy. Health and safety risk assessments had been reviewed and updated on a regularly basis and a Health and Safety review of the home had been commissioned and completed in February 2018 by an external professional. This had identified there were no immediate areas for action. There was a maintenance schedule for the service which included identifying specific risks from legionella. Gas and electrical appliances were serviced routinely. The maintenance folder included monthly jobs which included checks of water outlets and temperatures being completed which showed that temperatures were in line with the

required values.

The service was operated by a sole provider who was in day to day contact with the home. They were present throughout the inspection and demonstrated an understanding of people's individual needs and how the service was run. There was a manager employed who was in day to day charge of the home with the provider. The manager had recently completed their level seven management qualification and told us they were planning to become the home's registered manager with the provider stepping back from day to day contact with the home. 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 and associated Regulations about how the service is run.

People were happy living at Brookfield and felt the service was well-led. One person said, "This is the only place I know of apart from my own home but I can say that this place is well run." Relatives also felt the home was well run. One relative said "I don't know where my [relative] would be without this home. The whole place is like home. Very clean and you cannot smell anything bad about it. I really like it here and would recommend it to anybody any time." Another relative said "I cannot complain about anything whatsoever. The service that they give to my [relative] and I guess the other residents is what I would expect and wish for anybody. It just feels like home and everybody is so good and helpful." A health care professional told us their relationship with the manager was excellent and the manager was always responsive to suggestions and ensured people received "really joined up care".

Staff were also positive about the home's management team and described good morale amongst the workforce. One staff member said "I am very happy working here; the managers are excellent and very supportive people. You can talk to them about anything and they will listen to you and offer support where need be. I and all the workers here are well supported and we get regular training including the online one. I cannot think of anything else to add or recommend." Another staff member said "I have only been working here for a period of five months and I love it. This is the best place I have ever worked. The managers are excellent and the other workers are great. Everyone is so supportive to each other and that makes work not only enjoyable but also very interesting." Care staff told us there had not been any recent staff meetings which was confirmed by the manager. Staff did identify that they felt staff meetings may have been beneficial following a safeguarding investigation in November 2017 which would have provided staff with consistent information about the situation and allayed some of their anxieties about the situation.

The provider and manager were fully engaged in running the service and their vision and values were built around providing people with care that was specifically tailored to people's wishes and needs, promoting independence and treating people with respect. The manager told us their goal was for people to receive the best possible care in a friendly and homely home. Staff understood these values. When we spoke with them, they demonstrated a shared commitment to supporting people in a person-centred way and to the best of their abilities.

People and relatives described an open and transparent culture within the home, where they had ready access to the management. Visitors were welcomed at any time and links had been established with the local community. This included local schools who had visited the home and involvement as requested by people with local churches and religious groups. The manager understood their responsibilities under the Information Accessibility Standards and stated they would make all reasonable adjustments to ensure people were able to receive information in a suitable format. The registered manager worked in partnership with other health and social care services. The provider notified CQC of all significant events. The manager was aware of duty of candour requirements and these were being followed; these required staff to act in an

open and transparent way when accidents occurred.

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 17 HSCA RA Regulations 2014 Good governance The registered person has failed to ensure systems have been developed and operated effectively to monitor and ensure the quality of the service provided. Regulation 17 (1)(2)(a)