Brookfield Care Home Limited

Brookfield Residential Home

Inspection report

1 High Street
Somersham
Huntingdon
Cambridgeshire
PE28 3JA

Tel: 01487840900

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05 February 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Brookfield Residential Home is registered to provide accommodation for up to 13 people who require nursing and personal care. At the time of our inspection there were 12 people living at the service. The service is located in the village of Somersham close to local shops, amenities and facilities. Access to the accommodation is provided by stairs and a stair lift to the first floor. Bathing and shower facilities are available for people with this preference.

This unannounced inspection took place on 5 February 2016.

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

Staff were knowledgeable about identifying and reporting any incident of harm should this ever occur. People were cared for and looked after by enough staff to support them with their individual needs. Satisfactory pre-employment checks were completed on staff before they were employed and allowed look after people who used the service.

People were supported to take their medicines as prescribed and medicines were safely managed. An effective induction process was in place to support new staff. Up-to-date risk assessments to help safely support people with risks to their health were in place and these were kept under review according to each person's needs.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The registered manager and staff were knowledgeable about when an assessment of people's mental capacity was required. Appropriate applications had been made by the registered manager to lawfully deprive of their liberty. People using the service who currently met the criteria to be lawfully deprived of their liberty had applications in place. However, not all staff had an understanding of the MCA and how a DoLS would be determined. This meant that there was a risk that people could be provided with care that was not always in their best interests.

People had sufficient quantities of their preferred food and drink choices including fresh fruit and snacks during the day. This included a choice of appropriate diets for those people at an increased risk of malnutrition, dehydration or weight loss. However, there were missed opportunities for people to be as independent as they could have been with their eating, drinking and independence. People were supported to access a range of health care services and their individual health needs were met.

People were cared for and supported with their needs by kind and attentive staff. They and their relatives were involved in the review of people's individual care plans. People's privacy and dignity was respected by staff.

People were provided with information on accessing independent advocacy if any person required this support.

People were given various opportunities to help identify and make key changes or suggestions about any aspects of their care. Several occasions were not identified to support people with their care needs in an individualised manner.

A range of audit and quality assurance procedures were in place. These were used as a means of identifying areas for improvement and also where good practice had been established. Information regarding the running of the service and people's care was shared through a range of forums including residents', managers' and staff meetings.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were aware of their roles and responsibilities in reducing people's risks of harm.

Recruitment procedures and the number of suitable staff in post helped ensure that people's needs were met promptly.

People were administered their medicines as prescribed. There were systems in place to ensure that medicines were stored, disposed of and managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were asked to consent to the care they were provided with. Staff respected people's decisions. However, not all staff had a complete understanding of the Mental Capacity Act 2005.

People were not always supported with their independence as much as they could have been.

Staff sought and followed the advice from health care professionals who visited the service. People's health, nutritional and hydration needs were met.

Is the service caring?

Good

The service was caring.

People were looked after in a caring way and their rights to independence privacy and dignity were valued.

Staff understood people's preferences and people were supported with their right to a family life and stay in touch with those people who were important to them.

People were encouraged and included to be involved in making decisions about their care.

Is the service responsive?

Good

The service was responsive.

People were empowered to make meaningful decisions about how they lived their lives. People's sense of wellbeing was enhanced by staff who knew people's preferences. However, opportunities were missed to support people with their care in an individualised way.

People's comments, compliments, suggestions and concerns were used as a way to identify what worked well.

Is the service well-led?

Good

The service was well-led.

Quality assurance and audit processes and procedures were in place and these were used as a way to drive improvement.

People and staff were involved in the development of the service. There were arrangements in place to listen to what people, relatives and staff had to say.

There was a programme in place for the support management and development of all staff.

Brookfield Residential Home

Detailed findings

Background to this inspection

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People were provided with information on accessing independent advocacy if any person required this support.

People were given various opportunities to help identify and make key changes or suggestions about any aspects of their care. Several occasions were missed to support people with their care needs in an individualised manner.

A range of audit and quality assurance procedures were in place. These were used as a means of identifying areas for improvement and also where good practice had been established. Information regarding the running of the service and people's care was shared through a range of forums including residents', managers' and staff meetings.

Good

Our findings

People we spoke with told us that they felt safe. One person said, "I feel safe here. I'm used to using my walking [aid]. I couldn't ask the staff to be any nicer to me." Another person said, "Yes I do feel safe. Two staff help me to stand and then [put me] into my wheelchair." A relative spoke highly of the service, saying, "My [family member] is definitely in safe hands."

Staff told us, and we saw from records viewed, that they were trained and knowledgeable in recognising and reporting any incidents of harm to people. This included what types of harm people may experience and the action they would take in reporting any such events to the appropriate authorities including the local safeguarding authority.

Information about how to report such incidents of harm was publicly available throughout the service for people, staff and visitors. One person said, "They [staff] speak with us nicely and never shout or have a need to." We saw that staff were patient to those people who required more time with their support. This showed us that that there were systems in place to help ensure that people were as safe as practicable.

Risks to people, including those at an increased risk such as eating, drinking, moving and handling and health conditions, were managed effectively. This included the provision and use of mobility equipment, staff's skills at safe moving and handling and appropriate diets to reduce people's risk of choking.

A planned programme of maintenance was in place to help maintain a safe environment in the service. This included checks for lifting equipment, infection prevention and food hygiene. This helped ensure that the service was a safe place to live and work in.

Accidents and incidents, such as people experiencing unplanned weight loss or an increased number of falls, were investigated and action was taken to prevent recurrence. For example, referrals were made to the most appropriate health care professional. This included the person's GP or speech and language therapist.

Staff and people living in the service confirmed that there were sufficient numbers of staff on duty to ensure that people remained safe. We noted that people's request for assistance were responded to promptly. One person said, "Staff do have the time to help me and spend time talking." Another person told us, "I am much better off here rather than being at home as I feel safer." One member of staff said, "We cover for each other if this is required and the [registered] manager pitches in as well if needed." The registered manager advised us that if there was a shortage of staff due to unplanned absences, the regular bank staff would be used.

They also explained that in response to a change in people's care needs they had recruited an additional member of staff for busy periods such as in the morning and lunch times.

The registered manager used a recognised dependency assessment tool to help determine the number of staff to safely meet people's needs. This was reviewed regularly and always after a person had been to hospital where their care needs may have changed. We saw that this and the number of staff on duty meant that people's care needs were met.

Staff told us, and we found, that there was a robust recruitment and induction process in place. We found that checks included requests for two written employment references, evidence of any unacceptable criminal convictions and recent photographic identity. Care staff confirmed to us the records that they had been required to provide, as well as their job interview before they were offered employment. This demonstrated that staff who were employed had undergone rigorous checks that deemed them suitable to work with the people who used the service.

People told us that they received their medicines on time and they were aware of the medicines that they were prescribed. We observed staff administering medicines. Staff explained what the medicines were for and then made sure the person took all their medicines correctly. One relative told us that their [family member] took regular pain relief and that staff always made sure that this was available and provided. One person told us, "I have [health condition] in my hands and I take [medicines] to help with that. Another person said, "I have lots of tablets so I have my water for them." Staff who administered medication confirmed that they had received training and that their competency to administer medication was regularly assessed by the registered manager. We noted that the arrangements for the storage, handling, management and disposal of medication were satisfactory. A member of staff told us that the registered manager regularly undertook spot checks and audits of medicines administration and the appropriate records to help ensure that they were accurate. This meant that people were given their medicines safely and as they were prescribed.

Requires Improvement

Our findings

People's choices, preferences and assessed needs were met by staff who were skilled in meeting these. However, we saw that staff did not always respect people's abilities to be as independent as possible when eating and drinking. People were offered a choice of ravioli or spaghetti bolognaise with white or brown bread. One person promptly asked what these meals were. The staff tried to describe the meals to this person who then made a choice. Staff asked what people wanted rather than offering a physical choice. Another example was that the types of bread available were not placed on the dining table where people could access this independently. One person said to another person, "You had better eat this quick as it's cold." Staff reheated their meal but did not then ask other people if theirs was hot enough. Whilst is was good to see that people were asked for their preference, people could have been supported to be more independent with their eating and drinking, especially at meal times so that people could then help themselves.

We found, and staff confirmed, that people, including those with food allergies, reduced sugar, or soft food diets, were offered a choice of appropriate food and drinks. This included a variety of drinks, meals, fruit and snacks that were accessible throughout the day. We saw that people were supported with their eating and drinking by staff to ensure they ate and drank sufficient quantities. One person told us, "The food is always very good. We have the option of a glass of wine before the evening meal if we want." Another person said, "There is always plenty to eat. We have a roast on Sunday and we can always ask for more." A relative told us that their family member liked their food and felt that they had enough to eat.

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

Staff had received training on the MCA and DoLS. We found that some staff lacked an understanding of these subjects. This put people at risk of receiving care that was not always in their best interests. Some people using the service had been assessed as lacking mental capacity to make decisions with or without support from staff. Appropriate applications had been made to the local authority to lawfully deprive people

of their liberty and these had been acknowledged. Lawful advanced decisions were in place for people's health, finances and welfare. This was for people if they ever lacked mental capacity to make their own decisions. Records viewed showed us when and whether people could or couldn't make specific decisions. For example, the time they liked to get up, the clothes they preferred and if they wanted to go out into the garden or accessing the community with staff.

Staff confirmed that they were supported with training, a formal induction and shadowing opportunities with experienced staff. We found that staff completed their induction prior to working on their own. Training included subjects such as moving and handling, infection control and health and safety. One staff member said, "I get all the support I need from [name of registered manager]. I am not just saying this because [our inspection]. They are the best manager I have ever had. If I need or ask for help I get it."

The provider and registered manager were keen to develop all staff's knowledge. This was with any additional training needs such as gaining health care related diplomas. All staff confirmed that they felt that the support mechanisms available in the service helped them to provide people's care needs safely and effectively. We sat in on a staff meeting that was being held. We found that staff were supported by a registered manager who kept themselves up-to-date with information about staff qualifications including the Care Certificate for new staff. This is a nationally recognised qualification in care and includes additional requirements for staff competency in basic life support. One member of staff told us that there were many subjects to be covered during training. They told us, "We have also had end of life care, first aid and the Deprivation of Liberty Safeguards training."

People could be assured that the staff would take action to reduce and prevent any risks that were associated with their health. One person said, "I am sure they [staff] would call a GP if I needed one. There is a GP who visits weekly." Where people were at an increased risk due to their skin integrity, appropriate monitoring arrangements were in place. This included regular health care professional visits to monitor people's blood sugar levels. This was to help ensure that people's diet met their health needs. Another person told us that prior to living at the service they had been supported with their health condition and that this had continued. They said, "I have my [name of medicines] every day."

Good

Our findings

People and their relatives were complimentary about the compassionate care provided by the staff and the registered manager. We observed how staff supported people with their care needs such as placing a footstool in front of the person's chair following an operation where this support had been required. Other ways included all of the staff team being able to assist with the preparation of people's meals. One relative said, "They're [staff] lovely I can't fault them." One person told us, "I do like this place [name of care service] it's not too big and it's like a family." A third relative told us that one thing they really liked about the service was, "The homeliness of it. I have no qualms about leaving [family member] here."

The registered manager told us and staff confirmed that people who lived at the service also sat on the interview panel when new staff were recruited. This was to help ensure that new staff were able to care for people in a way the person preferred as well as having the right skills, such as how people preferred their support at night time. Staff told us, "It was nice to be able to ask people about their lives and what was important to them." This showed us that the registered manager considered and put people's needs first. Other ways people were supported was with their faiths. One person told us that the registered manager had arranged someone from the local church to visit to provide the support them with their faith and that this had made a difference to their lives.

People valued their relationships with staff and felt that staff always met their expectations about privacy and dignity. We observed the interactions between people and staff and these showed us how well staff knew the people they cared for. A relative explained to us, "I am really happy with the carers [staff] – I know they'll phone me if there is a problem or if they need to ask me anything about [family member]." They went on to say, "They've [care staff] been brilliant, very reassuring." They told us that this was because all the staff and care services provided were undertaken with consideration for each person's needs.

Ways staff used to respect people's dignity was by closing curtains and doors and by engaging in general conversation or having a laugh where this was appropriate. One person said, "They [staff] always respect my dignity. I know I need help but they do it so sensitively." We saw that staff spoke with people by their preferred name and in a calm manner. During the morning staff meeting, several off duty staff came and sat and chatted with people in both lounges. We saw they made a point of saying good-bye to people as they left. We also observed how care staff spoke with people in a discreet manner when asking if they needed any personal care such as going to the toilet. When speaking with relatives the service's house keeper came in to the lounge to say that they would close the door as they were hoovering the hallway and did not want to disturb people and our conversation. This demonstrated to us that all staff considered people's wellbeing.

We saw that staff regularly sought or asked about people's general well-being and responded appropriately where this was required. For example, staff asked a person if they were alright as the person had not slept well and then offered the person some pain relief at their request. A relative said, "The staff are always happy to have a chat about [family member] and to tell me what [family member] has been up to." Throughout the day we saw that the registered manager and staff spent meaningful time with people. We observed that people responded positively. Whilst sat in the dining room after breakfast one person engaged in conversation with staff about their family member who shared the same school as that of the staff member. They went on to have a conversation about this which the person enjoyed.

People, relatives and the registered manager confirmed that there was never any restriction on visiting or being visited. One person said, "I have grand and great grandchildren visit me. It's nice to see them." Care records were held securely and were only reviewed or read in private. We saw that pet dogs visited and there was a resident cat. These visits were the subject of much jovial discussion and people showed their happiness, excitement and pleasure at these.

We found that people had relatives, friends and representatives who acted as an advocate for them if required. Advocacy is for people who cannot always speak up for themselves and provides a voice for them. The registered manager and staff were aware of organisations which offered this service if required. This showed us that people's wishes, needs and preferences were respected if people were not able to speak up for themselves.

Good

Our findings

The registered manager and staff got to know people's initial care needs by visiting people in their place of residence. This was to assess people's care needs, life history and to find out information about them. This information then formed the basis of people's care plans and was used by staff to help them understand what really made a difference to people's lives. As well as information about people's preferences, clear signage around the home helped people, and those living with dementia, orientate themselves better. This was to help ensure that the service and its staff were able to respond to people's needs in a way the person wanted. Records we viewed confirmed this.

People were given the opportunities to contribute to the assessment and planning of their care needs. This included both formal and informal reviews of care such as conversations about people's day to day lives. One relative told us, "My [family member] has accepted personal care here better from [staff] than they did when [they were] living with me." One person said, "I do as much as I can but they [staff] help me with my back and my feet."

People's individualised care was focused on what they wanted. For example, one person asked for their daily newspaper and staff responded by finding and giving it to them. Other hobbies and interests people were supported with included hand manicures, having a one to one chat, reading the newspapers, visits by birds of prey from a sanctuary and talking about people's current and past lives. Although there were regular planned activities, such as hoop-la art, cards, puzzles and reminiscence, these were limited to a single occasion each day. There were, however, missed opportunities for people to be more involved in their care. For example, people living with dementia could have had access to items of memorabilia that they could engage with during the day. Also they could have assisted in folding serviettes, which staff asked people to help them with when we prompted them. Other missed opportunities included people being able to water the plants rather than staff doing this.

Other people were engaged in their own hobbies such as reading the sports pages of a newspaper, doing a crossword or completing puzzles. One person also told us they had a typewriter in their room so that they could write and send letters to friends and families. One care staff said, "I love making a difference to the people who live here and learning about them. They were young once as well." We found that one person was involved in the RSPB survey of birds that visited the service's gardens. This had a positive impact on the person and how they lived their life.

Each person had a key worker. This is a member of staff with specific responsibilities for the individual

aspects of people's care. This included the responsibility to keep families and relatives informed about people's care, reviewing care plans and being the person's first point of contact. A member of staff told us that it was people's preferences and not staff's that were most important. They told us that this is what made people feel they mattered. People had requested that the evening meal was the main meal as this had helped keep people more alert in the afternoon. This request had been implemented. Care staff also used information from relatives and friends to be included in care plans they had read and knew well. This was for the aspects of people's lives that were important to them.

People and staff told us about the social activities, hobbies and interests they had taken part in as well as others that were available. The registered manager supported people to take part and access the local community such as visits to a local park, garden centres and visits by local school choirs. Other hobbies and interests that people were supported to take part in included helping with baking or cooking and celebrations of festive occasions.

People were actively encouraged to give their views and raise concerns or make suggestions before they had the potential to become a complaint. We saw that staff checked people's general wellbeing and if the person was unhappy about anything. The staff then took prompt action if this was required. People and their relatives knew how to make a complaint and staff knew how to respond. Information in the form of a service user booklet was provided on how to raise a concern or complaint. One relative told us, "From how [family member] is I can see they are settled here. I don't have any concerns. If I did I would speak with [name of registered manager]."

Good

Our findings

The registered manager told us that the provider contacted them several times a week by telephone and visited them when required. This was to support the registered manager with any aspects of the home which needed improvement. The registered manager said, "If there is anything that I need approval for the owner is very good with this." People's, relatives' and health care professionals' views about developing and improving the service were sought in the most appropriate way. This included residents' meetings, staff spending time with people and their relatives as well as a quality assurance survey. We saw that the majority of views had been positive. One comment from the service's GP surgery was that "the service was always very well prepared in providing people's health care records as well as returning unused equipment." Where actions were required the registered manager confirmed that these were in progress. This was because the results of the most recent survey had not yet been collated. Comments were then used as a way to drive improvement.

All staff had praise for the way the registered manager led the service. One care staff told us, "The [registered] manager is brilliant and very supportive. She always makes sure we get the training we need." The staff also explained how well the domestic staff and care staff all worked as a team. The registered manager was very aware of the day to day staff culture and picked up if staff did not appear to be their usual selves. Staff confirmed that the support they received enabled them to do their job effectively. For example with mentoring, supervision as well as supporting staff at meetings about developments at the service such as increased funding for people's hobbies and interests.

A combination of audits and spot checks were undertaken by the registered, manager. The registered manager also worked shifts with staff at nights and weekends. This helped them identify any issues either at day or night in a proactive manner. If required they then put measures in place to support staff such as additional mentoring. One member of staff said, "We are all here to help each other, especially if staff are busy in other areas of the home."

The registered manager had, from records viewed, notified the CQC of incidents and events they are, by law, required to tell us about. Audits of medicines had identified that staff had needed a a change to their prescribed visual correction so that they could see more clearly when recording people's medicines. Staff told us that the registered manager often called in unannounced at night and at weekends. This was to ensure staff were supporting people and maintaining the right standards of care as well as offering any support if this was needed. The registered manager had also identified that the current electronic care plan system was not as effective as they wanted. They explained to staff at the meeting we sat in on that a new

system had been obtained and was to be introduced. This was to better collate all records such as those about the person, healthcare visits and the management of risks people could take.

Strong links were maintained with the local community and included various trips out to local shops, a nature reserve and going out for trips. One person told us, "I love the summer when I can get out more as I don't like the cold." Other links included a visiting singer. Social inclusion was promoted and supported.

Staff told us that as well as daily hand over meetings they also ensured comments from people were recorded in daily notes. Where issues affected people's care the registered manager was kept informed. For example, with the use of new equipment after a person had been discharged from hospital. This helped identify the detailed aspects of people's care which then prompted any action that may have been required. One person told us, "I do see [registered manager] frequently but it is always a nice thing as they ask how I am."

Staff spoke confidently about the provider's key values of putting people first and treating each person as an individual. Staff confirmed that they liked working at the service. One said, "I love coming to work here. I can't imagine doing anything else." Relatives told us that they were always invited to meetings with their family members as well as being given information in the form of a newsletter. We saw that this included important information and events that had taken place such as celebrations for people's and staff's birthdays as well as future planned events such as Valentine's themed celebration and a party that involved a pet pony.

From our observations throughout the day we saw that the registered manager and staff understood their role and the key risks and challenges in running the service. This included balancing what people wanted to do with the resource, staff and time available. We saw that people were supported to take part in the running of the service as much as practicable and that people's abilities were supported. This showed us the service sought to ensure that people lived a meaningful life.

Staff were regularly reminded of their roles and responsibilities at supervisions and staff meetings. Staff told us they felt very confident that they would be supported to escalate any issues or concerns they became aware of if this was required. One care staff said, "The morale of the staff team is very good but I would report any concerns straight away to the [registered] manager."

The service had been awarded a rating of four out of five for food hygiene [this is the second highest award]. Part of this assessment includes the management of food hygiene. We saw that action had been taken to make the required improvements.