Brooker Care Limited

Brooker Care Limited

Inspection report

Unit 2D, First Floor, Phoenix House
57-59 Lingfield Road
East Grinstead
West Sussex
RH19 2EU

Tel: 01342311999
Website: www.brookercareltd.com

Date of inspection visit:
22 May 2018

Date of publication:
20 June 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on the 22 May 2018 and was announced. The provider was given 48 hours' notice because the location provides a care at home service. We wanted to be sure that someone would be in to speak with us.

Brooker Care Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community and provides a service to adults. On the day of the inspection the service was supporting thirty eight people with a range of health and social care needs, such as people with a physical disability, sensory impairment or people living with dementia. Support was tailored according to people's assessed needs within the context of people's individual preferences and lifestyles to help people to live and maintain independent lives.

At the last inspection on 23 May 2016, the service was rated as good in the areas of Safe, Effective, Caring, Responsive and Well-led. At this inspection we found the evidence continued to support the overall rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

People told us that they felt safe. Staff remained to have a good understanding of their roles and responsibilities for identifying and reporting allegations of abuse and knew how to access policies and procedures regarding protecting people from abuse. Risks to people were assessed and monitored during their stay and communicated with other healthcare professionals involved in their care.

People remained were able to make choices about their support provided to them and were able to maintain their independence. People and were provided with information and guidance to access other services which were relevant to them for any on-going support they may need.

The service had experienced staff to ensure people were safe and cared for on visits. Sufficient numbers of staff were employed to ensure visits were covered and to keep people safe. Staffing levels were determined by the number of people using the service and their needs.

Staff considered peoples capacity using the Mental Capacity Act 2005 (MCA) as guidance. People's capacity to make decisions had been assessed. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People's individual needs continued to be assessed and detailed care plans were developed to identify what care and support they required. People were consulted about their care to ensure wishes and preferences were met. The provider had arrangements in place for the safe administration of medicines. People were supported to receive their medicine when they needed it.

People's individuality was respected and people's preferences were taken into account when planning their care such as religion. There was an accessible complaints process in place which people knew how to use if they needed to.

Staff continued to receive regular training and updates to be able to have the right skills and knowledge to be able to meet people's assessed needs. Staff had regular spot checks, supervisions and appraisals to help them to understand their roles and responsibilities.

Staff received infection control training and used Personal Protective Equipment (PPE) when supporting people with personal care tasks.

Quality assurance and information governance systems remained in place to monitor the quality and safety of the service. People and relatives all told us that they were happy with the service provided and the way it was managed.

Further information is in the detailed findings below

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Brooker Care Limited

Detailed findings

Background to this inspection

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

The inspection took place on the 22 May 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. We wanted to be sure that someone would be in to speak with us.

The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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 they do well and improvements they plan to make. We looked at this and other information we held about the service. This included notifications. Notifications are changes, events or incidents that the service must inform us about.

During our inspection we spoke with five people and eleven relatives over the telephone. Four care staff, an administrator, registered manager and the provider. We observed the staff working in the office dealing with issues and speaking with people over the telephone.

We reviewed a range of records about people's care and how the service was managed. These included the care records for five people, medicine administration record (MAR) sheets, four staff training, support and employment records, quality assurance audits, incident reports and records relating to the management of the service.

The service was last inspected on the 23 May 2016 and was awarded the rating of Good. At this inspection the service remains Good.

Good

Is the service safe?

Our findings

People and relatives told us that they felt safe using the service. A person told us "They are careful to make me feel safe". One relative described a situation where their relative was found on the floor when the carer arrived and the carer immediately called the ambulance and stayed with the person. They told us "I would say that they seem to know exactly what they are doing". Another relative told us "Yes the service is safe, the office phone me if there is a worry or concern about my relative".

Staff were consistently recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks had been completed which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or adults. The provider had obtained proof of identity, employment references and employment histories. We saw evidence that staff had been interviewed following the submission of a completed application form. This meant the provider could be sure that staff employed were suitable to work with people and of good character and not put people at risk of harm.

Staff continued to receive training in safeguarding adults with regular updates. People remained protected from abuse and harm and staff knew how to recognise the signs of potential abuse. Staff knew what action to take if they suspected people were being abused. Staff had received training in safeguarding and knew they could contact the local safeguarding team or CQC if they had any concerns. Staff were able to name different types of abuse that might occur such as physical or mental abuse. A member of staff told us "Signs of abuse can be bruises, people being quieter than usual. I would immediately report it to my manager and the details of what I saw. I can report to the local authority if I don't think it is being responded to but I have no worries as the manager always responds to concerns".

Enough skilled and experienced staff remained to ensure people were safe and cared for on visits. We looked at the electronic staff rotas and saw there were sufficient numbers of staff employed to ensure visits were covered and to keep people safe. Staffing levels were determined by the number of people using the service and their needs.

Staff continued to take appropriate action following accidents and incidents to ensure people's safety and this was recorded in the accident and incident book. We saw specific details and any follow up action to prevent a reoccurrence. Any subsequent action was updated on the person's care plan and then shared at staff handover meetings. The registered manager analysed this information for any trends.

People were protected by the prevention of infection control. Staff had good knowledge in this area and attended regular training in this area. One member of staff told us "I am an infection control supervisor. I like to see things get better and I care about the health of others. I am there to help other people improve their infection control practice which can only be good for our clients. I am happy to train the new staff and I really like to train people to get better and improve the quality of infection control". PPE (personal protective equipment) was used when required including aprons and gloves. The provider had detailed policies and procedures in infection control and staff received copies of these in their staff handbooks on induction.

People remained supported to receive their medicines safely. We saw policies and procedures had been drawn up by the provider to ensure medicines were managed and administered safely. Audits of medicine administration (MAR) were undertaken to ensure they had been completed correctly. Any errors were investigated, for example, if a missing signature had been highlighted for the administration of a medicine. The manager would investigate and the member of staff would be spoken with to discuss the error and invited to attend further training if required. People told us they received appropriate support with their medicines.

Detailed risk assessments had identified hazards and how to reduce or eliminate the risk. For example an environmental risk assessment included an analysis of a person's home inside and out. The condition of pathways and access to a person's home considered whether a risk of trip, slip or fall for either the person or the staff member and if there was adequate lighting. Other potential risks included the equipment people used and how personal assistants could ensure they were used correctly and what to be aware of. For example one care plan detailed that a person used a walking aid and how staff needed to make sure the person was encouraged and supported the person to use the aid. This meant that risks to individuals were identified and managed so staff could provide care in a safe environment.

Good

Is the service effective?

Our findings

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. Staff had good knowledge and an understanding of the (MCA) because they had received training in this area. People were given choices in the way they wanted to be cared for where possible. People's capacity was considered in care assessments so staff knew the level of support they required while making decisions for themselves. Staff told us how people had choices on how they would like to be cared for. One member of staff told us "Mental capacity act allows people to be safe if they do not have capacity to make decisions. One person I support had a little accident and did not want to change her pad and did not have capacity to understand why it was a good idea. I explained to her why it was a good idea in a clear way and worked in her best interests and we changed the pad with her consent through being patient and reassuring".

Staff gave us examples of how they had provided support to meet the diverse needs of people using the service including those related to disability, gender, ethnicity and faith. People's needs were recorded in care plans and staff we spoke to knew the needs of each person well. Staff also attended equality and diversity training. People using the service also commented on how well their individual needs were met.

People and relatives felt confident in the skills of the staff and felt they were trained well and also felt staff had been well matched. One person said "Well they definitely know what they are doing" One relative who thought the staff were skilled told us "I am just so thrilled the company have hit the right balance. They retain their carers and this means that the staff know my relative really well".

People remained supported by staff who had the knowledge and skills required to meet their needs. The staff induction incorporated the new Skills for Care care certificate for the staff. The certificate sets the standard for new health care support workers. It develops and demonstrates key skills, knowledge, values and behaviours to enable staff to provide high quality care. Care staff received essential training which provided them with the skills and confidence in providing effective care. The online training plan documented when training had been completed and when it would expire. On speaking with staff we found them to be knowledgeable and skilled in their role. One member of staff told us "My induction was very good, I came from a different profession and it really helped me to learn. Brooker Care have made it possible to have a new career, they have supported me to learn more and supported me to do a Level 2 and 3 diploma and I have now finished my qualification in infection control. We always complete our refresher training annually and they stop giving our calls if you are not up to date with your training".

Staff received support to understand their roles and responsibilities through supervision these consisted of individual face to face where they could discuss any concerns, training and development. One member of staff told us "We have regular supervisions, appraisals and spot checks and the spot checks are unannounced. This is good as they keep you on your toes and you can learn from it at the supervision

meeting afterwards".

Staff supported people to eat and drink by helping them with shopping and preparing food. Staff were knowledgeable about people's preferences and dietary requirements and gave examples of how they needed to remind and encourage some people to eat and drink sufficiently. One member of staff told us "I follow the care plan and always ensure I ask if people want something to eat or drink. I also look at the notes to see that other people are offering food and drink."

People remained supported to access and attend routine health care appointments such as visits to the GP, dentist and chiropodist. Staff monitored people's health and wellbeing and supported them to access or request referrals to services as and when required. Guidance for staff remained in place and staff clearly understood people's conditions and were able to confidently describe the actions they would take should they become unwell and how they worked closely with health professionals when needed.

Good

Is the service caring?

Our findings

People continued to benefit from staff who were kind and caring in their approach. Comments from people included "They are so obliging", "They are such a good bunch, they are my friends. They are really good, I can't fault them". A relative told us "They are excellent, polite, very pleasant and very caring, they know my relative very well. They have meaningful chats with her".

Staff spoke with great affection and warmth in their approach towards people. They gave examples of how over time, rapport had built up with people and their relatives One member of staff told us "We deliver great quality of care, we are always encouraged to sit and talk to people if we finish early which is unusual for a care provider, I love that about Brooker Care".

Peoples' differences remained to be respected and staff adapted their approach to meet peoples' needs and preferences. Diversity was respected with regard to peoples' religion, care plans detailed this. The registered manager gave us an example of how they respected a person no how they wanted to be addressed due to their religion and told us "All staff respected the wishes of the service user". People were supported to live their life in the way they wanted.

Staff remained aware of the need to preserve people's dignity when providing care to people in their own home. Staff we spoke with told us they took care to cover people when providing personal care. They also said they closed doors, and drew curtains to ensure people's privacy was respected. People we spoke with confirmed dignity and privacy was always upheld and respected.

Staff also told us how they promoted people's independence. Staff told us that wherever possible people were encouraged to maintain their independence and undertake their own personal care. Where appropriate staff prompted people to undertake certain tasks rather than doing it for them. One member of staff told us "I supported a person with a trainee member of staff, the person was struggling with her buttons. I supported her to try the buttons herself as she has had a broken hand and wants to regain her independence. We take people out to get fresh air and support independence and walking with one person round the block to get fresh air".

People's confidentiality was respected. Staff understood not to talk about people outside of their own home or to discuss other people whilst providing care to others. Information on confidentiality was covered during staff induction, and the provider had a confidentiality policy.

People and relatives told us they could express their views and were involved in making decisions about their care and treatment for their relative receiving care and support from the service. They confirmed they had been involved in designing their care plans and felt involved in decisions about their care and support.

People had been supported to maintain links with their family and friends. For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available. The registered manager was aware of who they could contact if people needed this

Good

Is the service responsive?

Our findings

People continued to be involved in making decisions about their care wherever possible. Staff understood people's individual needs and there was the opportunity to build positive and supportive relationships. People and relatives told us they received a service that was responsive to their needs. One person told us "I asked them to add in a call, and got a good response". One relative told us "They are good at adapting things to make improvements all the time, for example when care needs change. There was an occasion where meals were being thrown away by my relative and so they decided, along with us to order smaller meals and to present them on a larger plate as they were used to having very small meals. This was very successful and they are eating much better now".

An initial assessment had continued to be completed for any new people wanting to use the service. This identified the care and support people needed to ensure their safety. The registered manager undertook the initial assessment, and discussions then took place about the person's individual care and support needs. Work had continued in order to maintain the detail within people's individual care plans and gave detailed information on people's likes, dislikes, preferences and care and support needs, which had been regularly updated and reviewed. Staff told us communication was good in the service and when changes had occurred and they received information about any changes in people's care and support needs. On member of staff told us "The care plans are very detailed, we read the care plan before we start the call. It makes the work easier and gives you more time with the clients as you know what you need to do".

Information for people and their relatives could be created in a way to meet their needs in accessible formats, to help them understand the care available to them. The registered manager told us this could include large print and also told us "We did communicate with one service user with picture cards to meet their communication needs and some staff had used Makaton before".

Where appropriate and required people's end of life requirements and wishes where discussed with people, relatives and professionals. These were documented in people's care plans to ensure staff were aware of their needs and wishes for the future. The registered manager told us "We have recently introduced a new document to ensure we have people's future wishes recorded and also work with a local hospice when needed".

Staff told us that there was always enough time to carry out the care and support allocated for each person. The registered manager told us that the hours needed for care would be changed on review if needed to ensure people received a quality service and how the service was flexible to people's needs if required. We spoke with the member of staff who completed the staff rotas and discussed the scheduling with them. The staff member told us "We have permanent and bank staff to ensure all the calls are covered. If staff are running late for any reason they will contact the office and we would call the service user and let them know". Another member of staff told us "We have enough time in the calls to do what we need. We always know where we are going and care calls are structured and people have regular times for their calls."

People and relatives were aware of how to make a complaint and all felt they would have no problem

raising any issues. The complaints procedure and policy were provided to them at the start of using the service. Complaints made were recorded and addressed in line with the policy and included a detailed response. Most people we spoke with told us they had not needed to complain and that any minor issues were dealt with informally. One person told us that the office sorts things out quickly. They said "There was a period of short staffing which affected the timing of care calls. We fed this back to the office and it got sorted".

Good

Is the service well-led?

Our findings

Staff continued to promote an open and inclusive culture. People, relatives and care staff all told us that they were happy with the way the service was managed and stated that the registered manager remained approachable and professional. One person told us "The office staff are very approachable, always there and available and on an emergency number at weekends. They are very good and very helpful". A relative told us "I always get a fantastic response from the manager".

The service had a registered manager. 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. There was a clear management structure with identified leadership roles. The registered manager was supported by a deputy manager and senior care staff. Care staff told us they continued to be well supported.

The registered manager had maintained systems to monitor the quality of the service which included regularly speaking with people to ensure they were happy with the service they received and used to improve people's care. Feedback came from regular meetings with people and their relatives and annual surveys. Comments were positive from a recent survey and any suggestions made were taken on board by the registered manger and acted on. The information gathered from regular audits, monitoring and feedback was used to recognise any shortfalls and make plans accordingly to drive up the quality of the care delivered. The recruitment process and regular supervision ensured that the care staff understood the values and expectations of the provider. Staff meetings were held and had been used to keep care staff up-to-date with developments in the service.

Records demonstrated that the management team was open and transparent with staff within staff meetings and staff told us there was good communication between staff and management. Staff we spoke with all praised the registered manager and the provider. Comments included ""Brooker is the best place I have worked for, the manager is so supportive. I couldn't ask for more", "My manager is very supportive for example when I started there was client that wasn't very nice to me and being discriminatory and the manger spoke to the client and said it was not acceptable and supported me through it and I was not put in that situation again" and ""My manager is very supportive and caring. She has an open-door policy".

The registered manager was committed to keeping up to date with best practice and updates in health and social care and spoke of positive partnership working closely with external health care professionals such as GP's and District Nurses when required. They were also aware of our revised Key Lines of Enquiries that were introduced from the 1st November 2017. Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The care manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if

things go wrong with care and treatment.