# Home from Home Care Limited

# Brambles

## Inspection report

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## 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 |

## Overall summary

The inspection took place on 12 October 2015 and was unannounced.

Brambles is registered to provide accommodation and personal care for up to six people who have a learning disability. There were five people living at the service on the day of our inspection.

There was not a registered manager in post at the time of our inspection. However, the acting manager had submitted their application to CQC to become 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 the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect

# Summary of findings

them. The management and staff understood their responsibility and made appropriate referrals for assessment. Four people living at the service had their freedom lawfully restricted under a DoLS authorisation.

People were kept safe because staff undertook appropriate risk assessments for all aspects of their care and care plans were developed to support people's individual needs. The acting manager ensured that there were sufficient numbers of staff to support people safely and this varied depending on the activities and outings that people were involved in.

People were cared for by staff that had knowledge and skills to perform their roles and responsibilities and meet the unique needs of the people in their care. Staff received feedback on their performance through supervision and appraisal

People had their healthcare needs identified and were enabled to access healthcare professionals such as their GP, dentist and specialist services.

People where able were supported to make decisions about their care and treatment and staff supported people to enhance their skills and improve their independence. People were treated with dignity and respect by kind, caring and compassionate staff and staff acknowledged that the service was like the person's own home.

People were treated as individuals and were supported to follow their hobbies and pastimes. People were involved in planning the menus and staff supported them to have a nutritious and balanced diet.

The registered provider had robust systems in place to monitor the quality of the service, including regular audits and feedback from people, their relatives and staff.

# Summary of findings

## 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 was safe.

There were enough staff on duty to meet people's needs.

Staff followed correct procedures when administering medicine.

Staff had access to safeguarding policies and procedures and knew how to keep people safe.

Good

**Is the service effective?**
The service was effective.

People were involved in planning a nutritious diet and were supported to have enough to eat and drink.

Staff had received appropriate training, and understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were cared for by staff who had the knowledge and skills to carry out their roles and responsibilities.

Good

**Is the service caring?**
The service was caring.

Staff had built a positive and caring relationship with people and treated them with kindness and compassion.

People were treated with dignity and staff respected their choices, needs and preferences

Good

**Is the service responsive?**
The service was responsive.

People were at the heart of the service. They were enabled to take part in a range of innovative activities of their choosing that met their social needs and enhanced their wellbeing.

People's care was regularly assessed, recorded and reviewed to meet their individual and changing care needs

Good

**Is the service well-led?**
The service was well-led.

The provider had completed regular quality checks to help ensure that people received appropriate and safe care.

There was an open and positive culture which focussed on people and staff and people were enabled to be involved in developing the service.

Good

# Brambles

**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 12 October 2015 and was unannounced.

The inspection team was made up of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of 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 the service does well and what improvements they plan to make. We used this information to help plan our inspection.

We looked at information we held about the provider. This included notifications which are events which happened in the service that the registered provider is required to tell us about. We used this information to help plan our inspection.

During our inspection we spoke with the acting manager, the assistant manager, two members of care staff and five people who lived at the service. We also observed staff interacting with people in communal areas, providing care and support. Following our visit we spoke by telephone with two relatives.

We looked at a range of records related to the running of and the quality of the service. This included two staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the provider completed which monitored and assessed the quality of the service provided. We also looked at care plans for four people and medicine administration records for five people.

Good

# Is the service safe?

## Our findings

People who used the service were unable to tell us if they felt safe living there. However, we watched people interact with staff and saw that they were comfortable with staff and trusted them. We spoke with relatives who told us that staff made people as safe as they could. One person's relative said, "By the nature of their condition they will always be in danger, but staff are aware of the dangers and all they can do is their best to keep them safe."

Staff were aware of safeguarding policies and procedures and knew what to do if they suspected that a person was at risk of abuse. One member of staff said, "I would report it. The phone number is on the board in the office. Keeping a person safe is our first priority. I tell new staff never be scared to report concerns."

There were systems in place to support staff when the acting manager was not on duty, such as access to on-call senior staff out of hours for support and guidance. Staff also had access to a business continuity plan to support them in an emergency situation such as a power failure. If the service needed to be evacuated in an emergency, procedures were in place to relocate people to neighbouring services or for their families to take them home. In addition, if staff needed urgent assistance they had a radio alert system and could summon immediate assistance from neighbouring services.

People had their risk of harm assessed for a range of activities inside and outside the service. We found that people had care plans in place to support their assessed needs. For example, we saw that one person who was prone to epileptic seizures had their risk of harm assessed and a care plan to support the actions staff would take to protect them. Another person had a support plan in place to keep them calm when travelling by car or minibus as there was risk that they would become overexcited and distract the driver.

Some people were unable to call staff for assistance or make their way safely to the toilet when they were on their own in their bedrooms at night. To help keep them safe systems were in place to assist staff to respond to their needs in a timely manner. For example we saw bed, floor and door sensors that alerted staff when a person had got out of bed or had gone to the bathroom.

We found that the environment was adapted to support people's individual needs. For example, a hand rail was in place to enable a person who was registered blind to make their way safely about the service and maintain their independence. People had their freedom supported and were encouraged to use the grounds. We observed that each person had a door from their bedroom to a private garden.

There was a robust recruitment processes in place that identified all the necessary safety checks to be completed to ensure that a prospective staff member was suitable before they were appointed to post. In addition new staff had undertaken a three month probationary period before they were signed off as competent to meet people's needs.

We found that the provider employed sufficient numbers of staff to keep people safe and each person had a support worker allocated to them for all their care needs. The acting manager explained that the service used a layering system of staffing to ensure people had the right support to undertake hobbies and interests and keep them safe inside and outside of the service. Having a layering system meant that staffing levels were increased to cover periods of high activity. Staff told us that there was enough staff to meet people's care needs. Relatives told us that their loved one had the right level of support to meet their needs.

There were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner and out of date and unwanted medicines were returned to the pharmacist. In addition medicines were administered in line with the provider's policies and procedures. Staff had access to medicine guidance sheets in people's care files.

We were unable to observe medicines being administered as people were only prescribed medicine at breakfast time and bed time. However, we looked at the medicine administration charts (MAR) as saw that they were no gaps or omissions. As a safeguard people had their photograph on their MAR chart for identification purposes. We saw that when some medicines had been administered that there were two staff signatures on the MAR chart. We were told this was because a staff member was having their competency to administer medicines checked. People had a medicine support plan with instructions on how a person took their medicine. For example, two tablets on a spoon at a time or from a medicine pot.

Good

# Is the service safe?

We saw that one person had a special plan for emergency medicine to be given when they had a seizure to ensure that it was administered safely.

Good

# Is the service effective?

## Our findings

The provider had appointed a training manager to coordinate training throughout the organisation and staff told us that they were supported to gain the necessary knowledge and skills to undertake their roles. Newly appointed staff spent their first four weeks in post completing mandatory training and shadowing more experienced staff. Furthermore, additional training was tailored to meet the unique needs of people in their care. For example, sensory training, intensive interaction training and training in the use of non-verbal communication methods.

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.

We saw where people lacked capacity to consent to their care that their next of kin was a court appointed deputy. A court appointed deputy is someone appointed by the Court of Protection to make decisions on behalf of a person who is unable to do so themselves.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirements in the DoLS and four applications had been submitted to the local authority and were approved and another one was pending. Furthermore, we saw that the provider had complied with the conditions of the DoLS.

The provider had properly trained and prepared their staff in understanding the requirements of the MCA and staff knew how to support people subject to a DoLS authorisation.

People were involved in planning a four week menu. The menu was pictorial and this helped people to make their choice. The weekly food order arrived and we saw that the ingredients were there to make homemade meals and salads and there was a good selection of fresh vegetables. A member of staff told us that people were provided with a nutritious well-balanced diet. They said, “The meals are all homemade, we make our own puddings, they enjoy baking and love cake.”

The food cupboards were locked as a safety precaution; however people could have a drink or snack at any time. We saw that pictures of different snacks and drinks were posted on the cupboard doors so as people could point to them when they wanted a snack.

One person liked to be responsible for their own cooking. They told us that they ate well and said, “I make lots of stuff. I cook my meals, I make homemade burgers and I make my own bread.” Staff told us that they oversaw this to ensure food was stored and cooked properly and that they person ate a balance diet, without taking away their independence.

We observed lunchtime and saw that there was no set menu and people could choose what they wanted to eat. For example one person was supported to choose a selection of finger foods. One person who was assessed at risk of choking had their food specially prepared to reduce the risk of this happening. Staff and people ate together and there was a friendly atmosphere with lots of chatter.

People were supported to maintain good health and enabled to take part in activities and exercises suitable to their physical ability. One person told us, “I like a routine. I exercise on my bike for 40 minutes every day and I like to swim and horse ride.”

People had access to their GP, dentist and optician at any time. We saw when a person needed special healthcare needs that the appropriate professional was sought. For example, one person who was at risk of choking was referred to the speech and language therapist and measures were put in place to reduce this risk. Another person received support to control their seizures was seen regularly by their neurologist and a protective helmet had been prescribed. We saw that professionals worked together to maintain continuity of care for this person. They had an up to date hospital grab sheet with information about their health and wellbeing and family contacts. It

Good

# Is the service effective?

was clearly recorded that if the person was admitted to hospital that their neurologist must be informed. We saw evidence in their care files that people were supported by staff to attend hospital appointments and ensured that any pre- procedure instructions were carried out. Relatives told us that staff always informed them if there are any changes to their health or if they have been seen their GP.

We found that when a person recently had an accident staff took appropriate action and called the paramedics for assistance. The paramedics and support staff agreed to act in the person's best interest and take the least traumatic approach as the person was very distressed. A nurse practitioner attended and rather than take the person to hospital.

Good

# Is the service caring?

## Our findings

We found that people were treated with kindness and compassion by caring and attentive staff. One person said, “It’s a nice place. The staff are very nice. They make my bed with me every day.” We saw that there was good rapport between people and their support worker and they worked in partnership together. For example, we saw one person was assisted to put away the weekly shopping and check the ingredients were there to make particular dishes.

Relative’s told us that people were treated with kindness and were well cared for. One relative said, “They are very caring. All genuinely care about [person’s name].” Another relative told us, “Absolutely excellent. We never have any problems. They are safe and well cared for. Staff work really hard for my relative and has an amazing bond with staff.”

Staff told us that they enjoyed their role and felt that they made a difference to people’s lives. One staff member said, "It’s a rewarding experience.”

We found that people were at the centre of the caring process and were actively involved in making decisions about all aspects of their care and environment. Staff enabled people to maintain their independence. The service did not employ ancillary staff and people were supported to undertake housekeeping activities, such as putting the shopping away, doing their personal laundry and preparing meals. We observed one person in partnership with their support worker clean their bedroom and en-suite bathroom.

Several people had complex needs and had difficulty in effectively communicating their views and opinions verbally. We observed that all the support workers showed consideration and patience when people tried to express their needs, make a decision about an aspect of their care or responded to a question. We observed the interactions between one person and their support worker at breakfast time. The person successfully prepared their breakfast and the support worker continually praised the person throughout the procedure. We saw by the person’s facial expression and actions that they were proud of their achievements. Another person had specially designed picture cards, called pictorial exchange picture cards (PECs) that they could put together to form a story of their needs and preferences. A relative told us that although their loved one could not communicate verbally they had no concerns about staff being able to understand their needs.

People had a communication passport. We found this was person centred and focussed on non-verbal communication methods and the person’s understanding of key words and simple requests.

People took their communication passport with them to different health and social care settings that they visited so that the staff in those settings would know how to communicate with them effectively.

The provider ensured that people had access to an advocacy service to speak out on their behalf. Advocacy services are independent of the service and local authority and can support people to make and communicate their wishes. People met regularly as a group with an independent advocate. A member of staff attended these meetings and took minutes. Records of the meetings were presented to people in an easy read format at their monthly house meetings and the outcome of their discussions was fed back at the next advocacy meeting. A member of staff told us that they gained people’s feedback on matters raised by looking for non-verbal signs and actions. One staff member said, “If we raise a popular activity or event people may run up to us and give us a hug.” We saw the minutes of the meeting held in September 2015 and subjects discussed had a thumbs up symbol beside them to record that people had agreed.

We found that several relatives lived in other parts of the country and regular visits were not always an easy option. However, people were supported to maintain contact with their families through regular phone calls and social media. We were told that most families supported their loved ones at significant events such as barbeques and birthday parties. Staff told us that they were liaising with one person and their family to arrange a fancy dress party for their 21st birthday. One person told us, “I send letters to my family and speak with them on the phone on Sundays and Wednesdays. My family visited on Sunday, they always bring me treats and we went out for lunch.” Relatives told us that they could visit at any time and could call and skype when the wanted to. One person’s relative told us, “We normally take her out at the weekend.”

Good

# Is the service caring?

We observed mealtimes and noted that support workers treated people with dignity and respect. For example, we noted that staff placed a protective tabard over a person with poor manual dexterity and coordination to reduce the risk of them soiling their clothing with food and drink. In addition, the person was provided with adapted cutlery and a non-spill plate.

Staff empowered people and enabled them to maintain their independence. For example, a person who was registered blind wanted to have control of their shopping and cooking and reduce their dependency on staff. Their support worker assisted them to shop, put away their shopping and cook their meals. The assistant manager explained that they used a process called mental mapping to ensure that the person could access what they needed. They said, "Everything had its place and nothing was moved from that place." We saw that this included their food, kitchen utensils and all their personal belongings and clothing. We found that to reduce the risk of some people becoming distressed or upset when looking for their belongings that they had pictures on their furniture showing them what was kept inside. For example, a picture of socks on their sock drawer.

Several staff spoke about the importance of maintaining a person's dignity and respecting the service as the person's own home. One staff member said, "I don't feel like I am coming to work, I feel like I am coming to someone's home and making a difference." A senior support worker was registered as a national dignity champion and shared up to date information with their colleagues on promoting dignified care.

Good

# Is the service responsive?

## Our findings

The service was purpose built to meet the individual needs of the people who lived there. Each person had a bedroom, lounge/study room and an en-suite bathroom/wet room. People were happy to show us their rooms. We saw that their decoration, furniture and personal items were relevant to their needs. For example, one person had posters of numbers and letters in their study to support them with their writing skills and another person who required intensive interaction had their study area converted into a sensory room with special laser lights. The assistant manager told us this helped to keep the person calm. People told us that they liked their bedrooms and study area. In addition there were two open plan kitchen, lounge, dining areas where people met to take their meals and socialise. Relatives told us that the service had a homely atmosphere. One relative said, "It's not like an institution. It has a homely atmosphere. They are like a family, they all eat together. It's very much person centred."

We found that before a person moved into the service there was a period were a key member of staff got to know the person and their relatives and supported the transition from one care environment to another. The assistant manager regularly met with the person and their family in their current location and got to know their care needs, likes and dislikes We saw that their bedroom was being decorated and that their relatives had chosen the decoration including their carpet and curtains. In addition, their bathroom was being fitted in a way that would look familiar to the person. We were told that this would help the person to move into the service without too much distress.

People had care plans personal to their individual needs. Relatives told us that they were involved in regular reviews of their loved one's care. One relative told us, "Everything is positive. We trust them to give her a full and enjoyable life." Another relative said, "We initially met every three months, and now it's every six. It's absolutely the highest level of care. At home we did everything for my relative but they have enhanced their skills and helped them to become more independent."

People were supported to take part in hobbies and pastimes of their choice. We found that they had a busy schedule tailored to their likes and preferences. For example, going to the local park, shopping and maintaining contact with family and friends. We observed one person plan their morning with their support worker. When asked what they would like to do they replied, "Go to the park with [name of friend]." Another person was invited out to lunch by a friend and their support worker went with them. Relatives told us that their loved ones had lots of activities. One relative said, "So many activities, they are amazing. Always kept busy and incredibly happy."

We found that some people liked their support worker to read to them. We observed a support worker read to a person with limited verbal communication skills. We saw that the person gained a lot of pleasure from this and laughed and clapped their hands throughout the story. We were told that music played a bit part in people's lives. We saw that one person played classical music on their electronic keyboard and another person played African drums. Other people liked to socialise and attended an evening club where they met up with friends from others services.

We saw that each person had a garden that was tailored to meet their needs and preferences. For example, one person had a garden chair and parasol, because they liked to sit in the garden in warm weather and listen to their radio, another person had sensory plants such as fragrant aromatic herbs and another had a raised bed to grow their own vegetables.

The provider had a complaints procedure, with information for people and their families on how to raise their concerns. We saw that this was in an easy read pictorial format that helped people to understand actions to take if they wanted to make a complaint or needed to talk with a member of staff. Relatives told us that they had never had to make a complaint as they were always kept up to date and could talk with staff at any time.

Good

# Is the service well-led?

## Our findings

People were actively involved in the day to day running of the service. They attended weekly meetings with staff to discuss events and any changes they would like to see implemented. People's relatives were encouraged to give feedback on the quality of the service their loved one received and we saw that responses received in 2015 were positive and full of praise for the staff. For example we read comments such as, "You give our relative an excellent quality of life" and "Lovely friendly family organisation," and "Wonderful level of commitment."

Staff told us that people were well known in the local community and they accessed the local pub for tea, the park and the doctors' surgery. One staff member said, "We are accepted into the local community, people we meet say hello."

Staff told us that the provider had a philosophy of care that promoted independent living in a safe environment so as people could enjoy life. We saw evidence that the philosophy was upheld in person centred care. For example, one person had recorded in their care file that their overall goal was, "To build my independent living skills and ensure I stay safe and well."

Staff spoke positively about the support they received from the acting manager and assistant manager. One staff member said, "[acting manager's name] is brilliant. Has the knowledge, can go to them at any time. The morale has zoomed up since they came. They are visible and on-site and will answer our calls out of hours." Another staff member said, "This is one of the best teams I have ever worked with, we are the best and will stay the best."

Staff attended regular meetings and told us that they had a say in the running of the service. One staff member said, "We are given the opportunity to speak. We go round the room." The acting manager said that staff feedback was important and told us that staff had fedback that the layering rota system had facilitated more activity time for people.

Staff received supervision and appraisals and said that they were a positive experience and they welcomed feedback on their performance and were able to set professional development targets. One recently appointed staff member said, "I am very well supported. I have supervision every couple of weeks. I feel a lot more confident." In addition, the acting manager told us that they were well supported in their role by the provider.

Staff had access to electronic and hard copies of policies and procedures on a range of topics relevant to their roles. For example, we saw policies on safeguarding and reporting incidents and guidance on delivering personal care.

Staff exchanged information about people's progress and care needs through verbal and electronic shift handovers. We found that all records including care plans and the daily communication diary were stored electronically and password protected. However, staff were able to access them at any time.

We found that there were systems and processes in place to record and monitor any accidents or incidents. For example, if a medicine error was made, staff reported it through the provider's electronic reporting system and the error was investigated by senior personnel.

At the time of our inspection there was not a registered manager in post. However, the acting manager had submitted an application to CQC.

There was a robust and effective quality assurance system in place to monitor the quality of service people received and to drive continuous improvement. We saw that following an audit an action plan was developed to implement change.