Brownbill Associates Limited

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## 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 |

# Summary of findings

## Overall summary

We undertook an announced inspection of Brownbill Associates Limited on 26 March 2018.

Brownbill Associates provides a brokerage service for people with an acquired disability to enable people to employ their own carers. The agency acts as an intermediary between the person needing the service and specialist agencies who supply people to provide the care (care workers). Brownbill Associates supply case managers that provide training and support to carers directly employed by people receiving support. At the time of the inspection 88 people were using the service.

At our last inspection we rated the service Good. At this inspection we found the evidence continued to support the 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.

Further information is in the detailed findings below.

Why the service is rated Good:

People remained safe. Risk assessments were carried out and promoted positive risk taking which enabled people to live their lives as they chose. People received their medicines safely. The service had robust recruitment procedures which ensured there were sufficient, skilled and qualified staff to meet people's needs.

People continued to receive effective care from staff who had the skills and knowledge to support them and meet their needs. People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the procedures in the service supported this practice. People were supported to access health professionals when needed and staff worked closely with people's GPs to ensure their health and well-being was monitored.

The service continued to provide support in a caring way. Staff supported people with kindness and compassion. Staff respected people as individuals and treated them with dignity. People were involved in decisions about their care needs and the support they required to meet those needs.

People had access to information about their care and staff supported people in their preferred method of communication. Staff also provided people with emotional support.

The service continued to be responsive to people's needs and ensured people were supported in a personalised way. People's changing needs were responded to promptly and their views were sought and acted upon.

The service was well led by a manager who promoted a service that put people at the forefront of all the service did. There was a positive culture that valued people, relatives and staff and promoted a caring ethos. The manager was in a process of registering with the Care Quality Commission.

The manager monitored the quality of the service and strived for continuous improvement. There was a very clear vision to deliver high quality care and support and promote a positive culture that was person-centred, open and inclusive. This achieved positive outcomes for people and contributed to their quality of life.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

| | |
|---|---|
| **Is the service safe?**<br>The service remains Good | **Good** |
| **Is the service effective?**<br>The service remains Good | **Good** |
| **Is the service caring?**<br>The service remains Good | **Good** |
| **Is the service responsive?**<br>The service remains Good | **Good** |
| **Is the service well-led?**<br>The service remains Good | **Good** |

# Brownbill Associates 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.

This inspection took place on the 26 March 2018. It was an announced inspection. We told the provider two days before our visit that we would be coming. We did this because the manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that someone would be in. This inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses 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 us key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR and notifications we had received. A notification is information about important events which the provider is required to tell us about in law.

We contacted 28 people. However, the majority of people were unable to speak with us on the phone due to their condition. We spoke in depth to five relatives, three case managers, the head of operations, the clinical director and the manager. We looked at four people's care records, four staff files and medicine administration records. We also looked at a range of records relating to the management of the service. The methods we used to gather information included pathway tracking, which is capturing the experiences of a sample of people by following a person's route through the service and getting their views on their care.

Good

# Is the service safe?

## Our findings

People continued to feel safe. People's relatives comments included; "We have no concerns about the staff that support our relative [person] as they are all vetted by us" and "No one would cross the threshold if they were not suitable as our relative is very vulnerable. Brownbill would not put forward an unsuitable candidate".

Staff had received training in safeguarding adults and understood their responsibilities to identify and report any concerns. Staff were confident that action would be taken if they raised any concerns relating to potential abuse. Staff comments included; "We are all up to date with our training. With concerns, I'd go to [manager] and I'd contact safeguarding". There were safeguarding procedures in place and records showed that all concerns had been taken seriously, fully investigated and appropriate action taken.

There were sufficient staff to meet people's needs. Records confirmed the service had robust recruitment procedures in place. One staff member told us, "We only take on new clients when we have case manager capacity".

Risks to people were identified and recorded in their care plans. For example, where people were at risk of choking, measures were in place to manage the risk. Guidance had been sought from healthcare professionals and staff were aware of, and followed this guidance. Other risks assessments included; mobility, infection control and skin care.

Medicines were managed safely. Records relating to the administration of medicines were accurate and complete. Staff responsible for the administration of medicines had completed training and their competency was assessed regularly to ensure they had the skills and knowledge to administer medicines safely. Protocols for 'as required' medicines were in place along with detailed guidance for staff on when and how to administer these medicines. One relative said, "Medicines will be given if we are not there but we prefer to do it ourselves if possible. Any medication given is rigorously documented so we can see what has been given".

Accidents and incidents were recorded and investigated. They were also analysed to see if people's care needed to be reviewed. Reviews of people's care included referrals to appropriate healthcare professionals. The manager looked for patterns and trends within accidents and incidents to prevent reoccurrence. For example, one person was prone to choking, staff were provided with updated information and guidance and records confirmed choking episodes for this person had reduced. This demonstrated the service learnt from incidents.

People were protected from the risk of infection. Infection control policies and procedures were in place. Care plans provided staff with guidance relating to infection control and detailed procedures for them to follow which included the use of protective equipment and hand washing protocols.

Good

# Is the service effective?

## Our findings

The service continued to provide effective care and support to people. People were supported by staff who had the skills and knowledge to meet their needs. We noted all case managers employed by Brownbill associates held a professional qualification.

Staff told us and records confirmed that staff received support through regular one to one meetings with their line manager, spot checks and training. Staff training records were maintained and we saw planned training was up to date. Where training was required we saw training events had been booked. One staff member said, "I am supported through supervision and there is always someone to talk to or ask".

People's needs were assessed prior to commencement of the service their admission to ensure their care needs could be met in line with current guidance and best practice. This included people's preferences relating to their care and communication needs. For example, one person communicated using a computer. However, staff were guided to encourage the person to verbalise as this was slowing improving their ability to communicate.

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. Staff had received training and understood how to support people in line with the principles of the Act. One staff member said, "I used to be a best interests assessor. We don't make blanket judgements and we protect client's rights to make decisions".

People's nutritional needs were met. Care plans detailed people's nutritional needs including; special diets, allergies and preferred meals. Care plans guided staff on how to support people in a way that enhanced their well-being. For example, one person needed support to eat and drink but staff were guided to 'allow time for [person] to practice' eating independently. A relative commented, "My relative has 24/7 care and during that time will need support with food and drink. Wherever possible the choice will be made by my relative so that they are involved in that aspect of their daily routine".

People were supported to maintain good health. Various health professionals were involved in assessing, planning and evaluating people's care and treatment. Visits by healthcare professionals, assessments and referrals were all recorded in people's care plans. One relative said, "The team, which has been put in place, have full knowledge of the issues and needs of my relative. If at any time, we are not available and medical support is needed I am confident that the right calls would be made".

Good

# Is the service caring?

## Our findings

The service continued to provide a caring service to people who benefitted from meaningful relationships with the staff. People's relatives comments included; "It was important that the staff we employed got on with not just our relative but the whole family and we are delighted with our team" and "To see the genuine affection that our relative's [person's] team have for them is just amazing and so reassuring".

People were supported by a dedicated staff team who had genuine warmth and affection for people. Staff comments included: "We are caring, we are deeply involved in client's lives and we try to go above and beyond".

People were involved in their care and were kept informed about their care and support visits. Daily visit schedules and details of support provided were held in people's care plans and included what staff would be visiting and the type of support to be provided. Details of other specialist support relating to a specific condition were also recorded. Schedules of support were updated in line with care reviews informing both people and staff of the support needs. One relative said, "We are so pleased with the care plan and the amount of personalisation it contains along with all the actions for it to be delivered, so yes, we are involved".

People's independence was promoted. One care plan highlighted the person could 'undress with very little help'. Staff were guided to give the person 'time and encouragement' to complete this task. One staff member spoke about the approach taken towards independence. They said, "We keep people at the centre of what we do. We try to see what they used to be like and we aim to get them as close to that as we can. It's all individual, who they were (used to be)".

People were treated with dignity and respect. When staff spoke about people with us or amongst themselves they were respectful and they displayed genuine affection. Language used in care plans was respectful.

People received emotional support. People's emotional support needs were assessed and, where required, guidance was put in place to help staff support the person. For example, one person had specific emotional support needs relating to their condition. The care plan noted 'agreed strategies to support [person]' were in place. These included regular sessions with a psychologist.

Staff spoke about emotional support. One staff member said, "We discuss emotional support in supervisions, so we are there for them (people)".

Good

# Is the service responsive?

## Our findings

The service continued to be responsive. Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. Staff were aware of, and respected people's preferences.

People were treated as individuals. Care plans were personalised and tailored to suit people's individual needs and preferences. One person had communication difficulties and could become frustrated and anxious when trying to communicate. The person's care plan highlighted they could be calmed by 'reassurance and touch'. This met this person's individual needs.

People's diverse needs were respected. Discussion with the registered manager showed that the service respected people's differences and ensured people were treated equally. The provider's equality and diversity policy supported this culture. We asked staff about diversity. One staff member said, "Everybody is an individual so we individualise care plans"

People had access to information in a way that was accessible to them. Where appropriate, care plans contained information in a picture format or used photographs to explain procedures. Care plans were also available in large print or foreign languages. One person did not speak English and their team of care staff all spoke this person's native language enabling effective communication.

Care plans and risk assessments were reviewed to reflect people's changing needs. For example, one person's condition changed and their support needs had reduced. The person's care plan highlighted the changes which included a change in the medicine support plan. One relative said, "The best thing is that the service is able to adjust to the needs of [person], which is important as things change".

The service had systems in place to record, investigate and resolve complaints. One complaint was recorded for 2017/18 and historical complaints had been dealt with compassionately in line with the policy. Relatives spoke with us about how well the service responded to concerns. Their comments included; "There would be no need to complain formally as the case manager is the buffer in all this, little things are magnified sometimes due to worries or fatigue so the case manager is there to ease away the strains and worries" and "If we need to make changes then we call the case manager and they listen to us and then act on what we have discussed, it doesn't get any better than that instant response and then action".

At the time of our inspection, no one was receiving end of life care. The manager told us, "It is rare for our clients to talk about end of life as the vast majority tend to be younger. However, any advanced wishes would definitely be recorded and respected".

Good

# Is the service well-led?

## Our findings

The service was well-led. There was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The new manager was registering with the Care Quality Commission.

Relatives spoke positively about the service. Their comments included; "For the service to be as good as it is, it has to be well managed and this service is excellent" and "I know I couldn't manage without our case manager and Brownbill, they support [person] and me and the family. They are wonderful". One relative highlighted how their opinions were sought through feedback forms distributed by the service. They said, "Our input is really sending back responses to questions and constantly telling the case manager just what a fantastic job they are doing".

Staff told us they had confidence in the service and felt it was well managed. Comments included; "[Manager] is like a breathe of fresh air, she is approachable and has a depth of knowledge" and "She [manager] is very good and supportive. I think this is a well-run service".

The service had a positive culture that was open and honest. Throughout our visit management and staff were keen to demonstrate their practices and gave unlimited access to documents and records. The manager spoke openly and honestly about the service and the challenges they faced. Staff told us they felt the service was open and honest. One staff member said, "Yes we are honest, this is an upfront service".

The manager monitored the quality of service provided. Regular audits were conducted to monitor and assess procedures and systems. Audits covered all aspects of care and were modelled on the five domains used in CQC inspections. This allowed the service to match the audit results against our inspection criteria. Audit results were analysed and resulted in identified actions to improve the service. For example, one audit identified staff training needs and records confirmed this training was provided.

The manager worked in partnership with external agencies and healthcare professionals. The manager was also a member of the British Association of Brain Injury Case Managers (BABICN). The manager said, "We strive to keep up to date with current best practice and these important links help us to do just that".

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 manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.

The manager told us their vision for this service. They said, "I want this service to be an exemplar, a benchmark for other services. This is and will continue to be a safe, responsive and regulated service".