Deafway

Brockholes Brow - Preston

Inspection report

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06 September 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 17 August 2016 and 06 September 2016, and was unannounced.

The last inspection of this service took place on 11 June 2014, when we found the provider was not meeting the requirements of the regulations with regard to Records, but was meeting the requirements of all other regulations we inspected against. We inspected again on 19 November 2014 and found sufficient improvements had been made with regard to Records.

Brockholes Brow provides accommodation for up to 34 people who are D/deaf and have a range of learning disabilities, physical disabilities, and/or mental health problems. All rooms are of single occupancy and there is a communal lounge, kitchen and dining room in each of the four houses. The service is located on the outskirts of Preston city centre, with easy access to the motorway network, public transport links and a range of amenities. Ample car parking spaces are also available within the grounds of the home.

The home had a registered manager, however they had been on extended leave at the time of our inspection. 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.

Plans of care were based around the individual preferences of people as well as their medical needs. However, people and their representatives were not always involved in reviews of their care, to ensure it was of a good standard and meeting the person's needs. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems to assess, monitor and improve the quality of service provision. However, in the absence of the registered manager, these had not been operated effectively. The provider had employed a dedicated member of staff to oversee quality assurance. On the second day of our inspection, they had implemented systems around auditing and notifications which gave us assurances the quality of the service would be assessed and monitored effectively. The lack of statutory notifications regarding significant events at the service was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staffing levels at the home appeared adequate to meet people's needs at the time of our inspection. However, staff commented that they felt stretched to deliver meaningful activities for people, because of sickness absence among staff. We have made a recommendation about this.

People were safe living at the home because they were supported by a sufficient number of staff who had the right skills and knowledge to meet their needs. Staff understood their responsibilities with regard to reporting suspected abuse, in order to safeguard people.

The service followed safe recruitment practices to ensure only suitable candidates were employed to work with people who lived at the home.

The service had ensured risks to individuals had been assessed and measures put in place to minimise such risks. A comprehensive plan was in place in case of emergencies which included detail about how each person should be supported in the event of an evacuation.

Staff received induction and on-going training to enable them to meet the needs of people they supported effectively. Staff were supported by way of regular supervision, appraisal and access to management. However, senior staff had not been receiving regular supervision since the registered manager began their period of sick leave.

Effective systems were in place to ensure people's medicines were managed safely. Only trained staff were allowed to administer medicines.

Where people did not have the capacity to understand or consent to a decision the provider had followed the requirements of the Mental Capacity Act (2005) and the associated Deprivation of Liberty Safeguards.

People were supported to eat and drink enough to maintain their health. People could access external healthcare services as they required and were supported to do so.

People had access to a wide range of activities which were provided seven days a week and were supported to access the community and activities further afield. However, recent problems with staff sickness had impacted the level of support people received.

Staff were kind and caring and treated people with respect. We witnessed many positive and caring interactions throughout or inspection. Staff knew people's likes and dislikes which helped them provide individualised care for people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was safe.

Risks to individuals were assessed and managed appropriately in order to keep people safe. Risks relating to the premises and equipment were well managed.

People were protected against the risks of abuse because staff were trained to know what abuse is and what action they should take if they witnessed or suspected abuse.

The service deployed a sufficient number of staff at all times to ensure people's needs could be met safely, however staffing levels had impacted the time staff had to spend delivering meaningful activities for people. Staff were recruited following robust safe recruitment practices.

Is the service effective?

Good

The service was effective.

People received care and support from staff who had the skills and knowledge to deliver care effectively.

The provider was working in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Where people were unable to make decisions about their own care and treatment, best interests processes were followed.

People were supported to eat and drink enough to keep them healthy. People had individual health action plans which guided them and staff about how to improve their health or maintain good health.

The premises were well equipped and were undergoing refurbishment in several areas to make improvements for people who used the service.

Is the service caring?

Good

The service was caring.

People were comfortable with staff and we witnessed kind and caring interactions during our inspection.

People received care and support from staff who knew their preferences, likes and dislikes.

People were treated with respect and their dignity was maintained by staff who were compassionate.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People or, where appropriate, their representatives, were not always involved in regular reviews of care planning. This meant people's views and preferences might not have been taken into account.

The service sought guidance from external professionals when required, to ensure they had the right information to deliver care that was responsive to people's needs.

A range of activities were provided at the home and people were supported to access a wide range of activities. However, recent staffing levels had meant people may not always be supported to do what they wanted in the community.

The provider had implemented a suitable complaints policy and procedure. People were confident they could raise concerns with any staff member and their concerns would be resolved.

Is the service well-led?

Requires Improvement

The home was not always well-led.

Due to the extended absence of the registered manager, the staff team felt there was some instability at the home.

Notifications about significant events had not been submitted as required during the registered manager's absence. A process was put in place to remedy this, following our inspection.

We found a positive, caring culture at the home and staff knew the requirements of their roles and responsibilities.

The management team were receptive to our inspection findings and took action to address the points we raised immediately. This showed they were keen to improve people's experiences of the care and support delivered at the home.

Brockholes Brow - Preston

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 17 August and 06 September and was unannounced.

The inspection was carried out by the lead inspector for the service and a specialist advisor who had expertise in working with people who are D/deaf. The specialist advisor was able to converse with people using British Sign Language.

Before the inspection, we reviewed all the information available to us. This included notifications from the provider about significant events, information we had received from members of the public and from other professionals, such as the local authority and clinical commissioning groups. The provider also submitted a Provider Information Return (PIR). A PIR is a document in which the provider can tell us what they think the service does well and how they plan to improve the service further.

During the inspection we spoke with four people who lived at the home and eight staff, including the care manager. We also looked at eight people's care records, three of which we looked at in detail. We carried out observations in each area of the home. We also looked at a range of records relating to staffing and the management of the service.

Requires Improvement

Is the service safe?

Our findings

We spoke with people about whether they received safe care and treatment. People told us they felt safe and could raise any safety issues with staff. One person told us; "My room is my own. I can have people in it or not, nobody bothers me and I sleep well"; another commented "Yes safe, people can't get in. I would tell staff if somebody hurt me".

We looked at how the provider ensured sufficient numbers of staff were deployed at all times. The care manager explained they staffed the service based on people's levels of dependency. They gave us examples of times when staffing levels had been increased at short notice, due to a change in a person's needs and/or an increase in behaviour which challenged the service. This helped to show how the provider ensured staffing levels were sufficient to meet people's needs safely. However, staff we spoke with told us they felt under pressure, due to staffing levels. The registered manager had been off work due to sickness for an extended period. During this period, staff had stepped up into more senior roles to backfill positions, which had put them under more pressure. The care manager also explained sickness absence among support staff had recently been affecting staffing levels and they had to use agency staff regularly to cover shifts.

We would recommend the provider review staffing levels alongside people's holistic needs as well as the needs of the staff team, to ensure people's needs can be met safely and ensure everyone's well-being is maintained.

We looked at how the service protected people against bullying, discrimination, avoidable harm and abuse. People we spoke with told us that they had never experienced anything that gave rise to concerns. They told us staff treated everyone well and made sure everyone at the home was safe. Staff we spoke with told us they treated everyone as individuals. They had received training which helped them to understand their responsibilities with regard to promoting equality and respecting people's diversity. Staff had also received training which helped them to recognise what forms abuse may take and what action they should take if they witnessed or suspected abuse. A staff member told us; "There is a safeguarding policy there [pointing at the office filing cabinet] and we do get training. The most important thing is, we know our residents and how to manage things that would make them not safe".

We looked at care records which showed risks to people had been assessed on an individual basis, before the person first moved into the home, and then regularly each month. Risk assessments included areas such as mobility, eating and drinking, skin integrity and medicines. Where risks to people had been identified, we saw staff had put in place measures to reduce or remove the risks.

Risks relating to the premises, grounds and general operation of the home had been assessed. Where risks had been identified, such as fire, flood and utility loss, measures had been put in place to reduce the risks to people who lived at the home. There were visual alarms in each room, in each area of the home. These warned D/deaf people in the event of an emergency, in the same way as audible alarms would alert hearing people. We saw the provider had implemented a comprehensive business continuity plan. This provided staff with guidance on action they must take in the event of an emergency. Each person who lived at the

home had a personal emergency evacuation plan. They also had a one page profile of their needs, which could be shared with emergency services staff. These helped to ensure people's needs could continue to be met safely in the event of an emergency evacuation.

Routine checks which helped to keep people safe were carried out. Regular checks were carried out in regards to the general environment, fire detection equipment, moving and handling equipment and emergency lighting, among others. This helped to ensure the premises were safe and emergency equipment would operate properly when required.

We looked at how the provider recruited staff to make sure only suitable candidates, of good character, were employed to work at the home. The provider operated robust processes, in line with their recruitment policy. We saw checks had been undertaken to verify candidates' identification, skills and qualifications, performance in previous jobs and also with the Disclosure and Barring Service (DBS) - formerly the Criminal Records Bureau (CRB). These checks helped to make sure candidates were suitable to work with people who lived at the home. A record of checks, along with interview questions and application forms was kept on staff personnel files.

We looked at how the service managed people's medicines, to make sure they received them when they needed them and in a safe manner. We found the provider operated safe systems with regard to ordering, receipt, storage, administration and disposal of medicines. People we spoke with told us they had never had cause for concerns regarding their medicines and they received them when they should. Staff followed the home's policy and procedure when administering medicines.

Good

Is the service effective?

Our findings

People were supported by staff who had sufficient skills and knowledge to provide effective care and support for people who lived at the home. Staff told us they had good access to training. They explained most training was sourced from external providers and delivered on site at the home. Training records confirmed staff had received training in a variety of topics. These included safeguarding, health and safety, equality and diversity, dignity in care, fire safety, infection control and emergency first aid. Staff also received training to enable them to deliver care to meet people's specific needs, such as diabetes, epilepsy, autism and mental health conditions. This showed the service provided a good level of training to staff, which helped to ensure people's needs were met.

The staff team was made up of people who were D/deaf and people who were hearing. All staff received training to enable them to communicate with people who used the service who were D/deaf. Staff told us and records confirmed they had all completed an accredited level 2 British Sign Language (BSL) course. People who used the service had come from all over the UK and brought with them regional signs or 'accents'. Staff had to spend some time acquiring these signs from people when they first moved to the home. We observed communication between staff and people who use the service and asked people whether they found it easy to communicate with staff. We saw, and were told by people, that communication was good. Staff clearly understood people and vice versa. Staff knew people well and were skilled in communicating effectively with people who were vulnerable because of their circumstances.

With regard to the BSL training, staff told us it was a 'crash course'. They had two days' training before the level 1 exam, then another three days' training before taking the level 2 exam. Staff told us they found this "scary and a lot of pressure". Staff explained they found it difficult to take this training into the service, but it did provide them with the skills they required to communicate with people who used the service, and enabled them to learn as they went. This 'learning as you go' is often the way when acquiring any new language and this is particularly so when working with people with minimal language skills which was evident during our inspection.

We looked at how the provider ensured staff received sufficient levels of support, supervision and appraisals in order to carry out their roles effectively. Staff we spoke with told us they felt well supported by management and found them approachable. Support workers told us and records we looked at confirmed they received regular supervision sessions and annual appraisals. This gave staff the opportunity to discuss their performance, any issues, training needs and to discuss aspirations with their manager. However, we found supervision sessions for senior staff were not carried out as regularly. They explained this was because they did not want to put any more pressure on their colleagues who had 'stepped up' to more senior roles to cover whilst the registered manager was absent. They did, however, confirm they could request supervision sessions whenever they felt they needed them.

We would recommend the provider review their systems and processes around staff supervision to ensure all staff receive regular, worthwhile supervision sessions. Supervision sessions are important for all staff and particularly so for senior staff who are providing leadership to the staff team.

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 whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had made several applications under DoLS for people who had been assessed as lacking capacity to make the decision about where to receive care and treatment. We reviewed cases where applications had been authorised by the local authority. In each case we found conditions stipulated in the authorisations had been incorporated into people's plans of care.

Staff had received training with regard to the MCA and DoLS which equipped them with the skills and knowledge to effectively carry out their responsibilities. Where there were concerns about people's capacity to make decisions, the service sought input from external professionals to assist in assessing the person's capacity. We saw evidence of best interest meetings which had been attended by a range of professionals, the person themselves and their representatives. This process helped to ensure any decisions made about the care a person received were in their best interests.

People were supported to eat and drink enough to keep them healthy. Each person had a health action plan in place. This helped to identify their individual needs with regard to eating and drinking healthily. It also guided people and staff with regard to making healthy choices about food and drink. Each house was had a large and well equipped kitchen area, which people could use to prepare meals, drinks and snacks. Staff supported people to be as independent as they wished with preparing meals and drinks. There was also a canteen which was separate from the three houses. A wide range of nutritious meals were freshly prepared each day for people who wished to make use of this service. We saw the majority of people used the canteen at lunchtime on the day of our inspection and told us they liked going to the canteen because it was a social event.

People were protected against the risks of poor nutrition and hydration. Staff continually monitored how much people ate and drank. This helped staff to assess whether people were eating and drinking enough to stay healthy. Where concerns were identified, increased monitoring was put in place including people being weighed more frequently. We saw the service made timely referrals to the dietician and speech and language therapists, where appropriate. This helped to ensure staff had access to specialist professional advice and guidance about people's nutrition.

We toured the premises and found them to be generally well equipped. There were three separate houses on the site, where people had their bedrooms and could make use of communal kitchens, lounges and dining rooms. A new arts and crafts room had been added to one of the houses which provided a good space for people who wished to make use of it. Other areas of the home were in the process of being refurbished, such as bathrooms in each of the houses. The provider had begun work to create decking and garden areas within the grounds for people to make use of in good weather. People were able to grow plants, flowers and vegetables in the gardens and greenhouses if they so wished. The site also included a sports hall and social club which we were told people made good use of.

People told us, and care records confirmed, people had access to a range of external healthcare

professionals including, GPs, district nurses, opticians and chiropodists.

Good

Is the service caring?

Our findings

We received positive feedback from everyone we spoke with about how caring the service was and about the approach of staff. When we asked one person whether they thought staff were caring, they replied; "Yes, I always speak to staff about feelings. We laugh. I laugh at them sometimes but they don't mind."

Staff we spoke with had a good level of knowledge about people and their life histories. This included people's past employment, where they had lived, hobbies and interests, and people who were important to them. We saw this type of information had been gathered in people's care plans when they first moved into the home. The information helped staff to get to know the person and to build relationships with them. We observed staff were caring and responsive toward people without being patronising. They knew people well and were able to joke, banter and spoke in an adult manner with them.

We observed kind and caring interactions throughout the inspection. People were comfortable and relaxed with staff and the atmosphere in the home was pleasant and cheerful. People told us staff took time to sit and chat with them. We witnessed this during the inspection. Staff told us they got to spend time with people to get to know them well. This helped staff foster positive and caring relationships with people they cared for. Staff knew people's likes, dislikes and preferences. This helped to ensure people received care and support in the way they wanted it to be delivered.

We looked at how the service ensured people were treated with dignity and respect during their stay at the home. People we spoke with told us staff were always respectful and caring towards them. They gave us examples, such as, staff knocking on bedroom doors before they entered and ensuring doors and curtains were shut before personal care was delivered. We saw staff were caring and attentive to people during our inspection. Staff approached people and asked for their permission before they delivered any care or support.

The service had supported a number of people to access advocacy services and staff were aware of services to refer people to. An advocate is an independent person who acts on behalf of another person to put forward their views.

The provider actively encouraged people to maintain contact with family and friends. This was through arranged visits, text messaging and video calling.

Requires Improvement

Is the service responsive?

Our findings

We looked at how the service provided personalised care that was responsive to people's needs. Before people moved into the home, a comprehensive assessment of their care needs was undertaken. The areas covered by assessments included, people's mobility, communication, eating and drinking, as well as any health care needs. This helped to ensure people's needs could be met before they moved in to the home.

People told us they had been involved in the initial assessments and care planning process. This helped to ensure people's needs were accurately assessed and their preferences explored, in order to provide personalised care to them. People's likes and dislikes were documented in well organised care files. This helped to give staff easy access to important information about how people wanted their care to be delivered. We witnessed staff anticipated people's needs well and responded promptly to any requests for assistance.

However, we found there was a lack of evidence people were involved in monthly reviews of care plans which took place. Records we looked at did not show people were involved in monthly reviews of their care plans. Staff told us care plans were reviewed between support workers and team leaders, often without the person or a representative being present. When we spoke with the care manager, they confirmed monthly reviews often did not involve the person themselves. This meant people may not be fully involved in reviewing their care to ensure it still met their needs and reflected their preferences. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service sought guidance and advice from external professionals and followed up any referrals in a timely manner. Guidance and advice from professionals was used to inform care planning with the aim of providing the best possible outcome for people. People's assessments and care plans were reviewed on a monthly basis, or more often, in line with changes in people's needs. This helped to ensure they reflected the person's current circumstances.

Staff at the home provided people with a range of activities to help prevent social isolation. The home had good links with the local community and organised people's participation in activities further afield, such as adventure weekends. We saw lots of pictures of people taking part in a range of activities including work placements. Staff spent time finding out what was important to people in terms of meaningful activities. They then used this information to try and provide such activities for people, so they could maintain their interests. We observed three activity sessions which were well coordinated and supported to enable as many people to participate as wished to.

However, we found due to staffing levels recently, activities had been more limited. One Support Worker said; "People don't always want to do things as a group and getting out in the community would be best but we're short of staff" People told us activities sometimes only lasted a short while. We fed this back to the care manager at the end of our inspection. They assured us they would look into this, along with staffing levels to ensure people were not adversely affected by staffing issues.

Staff listened to and responded to people's complaints and comments. People told us they could approach any member of staff with any concerns and they were confident any issues would be resolved. People told us staff often asked them whether everything was ok.

The provider had implemented a complaints policy and procedure. This was made available to everyone who lived at the home and their relatives. The policy provided a framework for how management should deal with any complaints. This included contact details of other organisations which people could escalate their complaint to, if they did not receive a satisfactory resolution. The service had not received any complaints in the 12 months prior to our inspection. We looked at two complaints and saw they had been managed appropriately, in line with the provider's policy. The service had received a number of compliments from people's relatives which praised the standard of care provided to their loved ones.

Requires Improvement

Is the service well-led?

Our findings

Whilst the registered manager had been absent, we had not received notifications from the service about significant events. During the first day of our inspection, the care manager told us about incidents for which we require notifications. They explained they had involved the police with regard to one service user. Providers are required to notify CQC about any incidents reported to or investigated by the police. We checked our records and found we had not received such notifications. We discussed this with the care manager and found, whilst the registered manager was absent, there was no contingency for submitting notifications. When we fed-back our inspection findings, they explained they had worked with the person in charge of quality assurance to put in place a process to ensure notifications were submitted, regardless of the absence of management.

The lack of statutory notifications about significant events at the service was in breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was a clear feeling of instability at the time of our inspection. Staff told us they felt this was due to the extended absence of the registered manager. During this period, a team leader had stepped up to cover the registered manager's role, with other staff stepping up to back fill more senior positions. Staff told us this had impacted on the support available to senior staff, by way of supervision, because they did not want to put ore pressure on colleagues who had stepped up.

Staff told us they felt the trustees did not take an active role in monitoring and developing the service. We discussed this with the care manager who agreed the trustees did not take a very hands-on approach. They told us they would take our feedback to the board of trustees, along with suggestions about how the trustees could become more involved in the running of the service. They told us they already had ideas to suggest about how the trustees could seek people's views and experiences and how they could become more involved with assessing, monitoring and improving the quality of the service.

There were a variety of systems to assess and monitor the quality of the service provided. These included surveys, regular meetings, safety checks and audits on a variety of matters, such as medication, care planning and incidents. However, we found whilst the registered manager had been absent, audits and checks had not been carried out robustly and where issues had been identified, they were not always addressed. For example, it was identified in an audit that someone's care plan had not been reviewed. Subsequent audits also identified the same issue. This showed that although the issue had been identified, action had not been taken in response.

The provider had employed a member of staff to take the lead on quality assurance two weeks prior to our inspection. This person was in the process of implementing systems and schedules for auditing and other quality monitoring measures. On the second day of our inspection, they were able to show us they had made good progress and had begun to carry out audits, the first of which was a site-wide health and safety audit. They showed us how the audits provided a trail of accountability for any issues identified, including responsible persons and timescales for action. This gave us assurances systems to assess, monitor and

improve the service would be more effective.

We found the atmosphere at the home was open and pleasant. There appeared to be a positive, caring culture between people who lived at the home, their relatives and staff. Staff we spoke with told us they enjoyed their job and tried to help people make their stay at the home as good an experience as they could. Throughout our inspection, we saw many positive interactions between staff and people they cared for. We observed staff were well organised, with clear lines of accountability and responsibility at each level.

Whilst planning for this inspection, it became clear the provider had not submitted a statement of purpose for some time. A statement of purpose is a document which we require from providers. It tells us about the services they want to provide and about service user groups they want to provide care for. This enables us to make sure their registration with us is correct and gives us the opportunity to ensure the service will be able to meet the needs of people they want to provide care and support to. The provider was registered only to provide care to people with sensory impairment. However, we found they also provided care to people with a combination of sensory impairment, learning disabilities, physical disabilities and mental health problems. We discussed this with the care manager and made them aware of the need to ensure the statement of purpose was up to date and accurate. They assured us they would address this following our inspection.

The management team were receptive to our inspection findings and took action to address the points we raised immediately. This showed they were keen to improve people's experiences of the care and support delivered at the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not submitted statutory notifications about events reported to or investigated by the police. Regulation 18 (1)(2)(f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People and their representatives were not always involved in reviews of their care, to ensure they met their needs and reflected their preferences. Regulation 9(3).