Northbrook Homes Limited

Brook Domiciliary Care

Inspection report

Gable House
1 Balfour Road
Ilford
Essex
IG1 4HP

Tel: 02086112705

Date of inspection visit:
24 January 2018

Date of publication:
23 April 2018

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection of Brook Domiciliary Care Ltd was carried out on 24 January 2018 and was announced. This was the first inspection of this service under its current registration.

Brook Domiciliary Care is a domiciliary care agency. It provides personal care to people living in their own homes and flats. It provides a service to older adults, younger adults, people living with dementia and people with a sensory impairment. Not everyone using Brook Domiciliary Care received a regulated activity. The Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care', such as help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

Brook Domiciliary care provided the regulated activity of personal care from an office based in Ilford, Essex. At the time of this inspection, 50 people were using the service. All the people who used the service received direct payments from the local authority and had chosen to use the service.

A registered manager was 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.

Staff supported people at home with their care needs and the service had assessed some risks. However, not all risks associated with people's health care tasks had been assessed to ensure they were safe at all times, when staff carried out personal care. Although people received their medicines, records maintained by the service were not always clear, regularly reviewed and appropriately maintained by the service.

Quality assurance systems were in place but were not always effective. The audits, which the service carried out, had not identified the shortfalls we found during the inspection to ensure people received a consistently safe service.

Care plans were inconsistent. Some care plans did not include the support people would require in relation to their current circumstances. Care plans contained information on how to communicate with people. Pre-assessment forms had been completed in full to assess people's needs and their background. Reviews were being carried out regularly. We have made a recommendation for the registered manager to review and update all the care plans with regard to supporting people based on their condition and current circumstances

People received safe care. Staff recruitment processes were followed and ensured that people were protected from being cared for by unsuitable staff. There were enough staff to provide care and support to people to meet their needs safely. Staff were trained in procedures to support and protect people from abuse.

People were supported to maintain good health and nutrition. Staff were equipped with sufficient personal protection equipment to reduce the risk of infection and cross contamination when supporting people with their personal care.

People received effective care and support. Staff received induction and on-going training for their role and understood their responsibilities to perform their roles effectively.

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 received good care from staff. They had developed positive relationships with the staff who understood their needs. Staff were kind, caring and treated people with dignity and respect.

Staff worked in a flexible way which promoted continuity of care so that they could meet people's needs in a person centred way. The registered manager ensured the management team provided staff with the support they needed.

People knew how to raise a concern or to make a complaint. The provider had a complaint policy and complaints received were investigated in accordance with this policy.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 not always safe.

Most risk assessments set out how to manage and reduce the risks people faced. However, some risk assessments did not cover all the risks relating to people's specific condition.

Medicines management was not clearly recorded in care plans leaving people at risk of not getting their medicines in a safe way.

Staff were able to explain to us what constituted abuse and the action they would take to raise concerns.

Relevant pre-employment checks were carried out when recruiting staff. Adequate number of staff were deployed to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff received sufficient training, supervision appraisals to support them in their role.

Staff were aware of the principals of the Mental Capacity Act (2005) and understood how it was applied. They asked for people's consent before providing care and support.

Assessments of people's needs were carried out to ensure effective outcomes for their care. Staff were informed of changes in people's care needs.

People's nutritional needs were met.

Staff supported people to access health care professionals when needed.

Is the service caring?

Good

The service was caring.

People and their relatives told us that they were treated well and staff were caring. People could make choices about how they wanted to be supported and staff listened to what they had to say.

People were treated with respect and staff understood how to provide care in a dignified manner and respected people's right to privacy.

Is the service responsive?

Good

The service was responsive.

Care plans were in place and included details about how people wanted their care to be delivered. However, the plans did not include the support people would require in full as they did not always include people's specific conditions and how these needs were to be met by staff.

People knew how to make a complaint if they were unhappy about the service and felt confident their concerns would be dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Although quality assurance and audit processes were in place to monitor the service, the systems were not sufficiently robust because shortfalls were not always identified and acted upon to make improvements.

People were encouraged to provide feedback on the quality of the service they received.

Staff felt supported by the provider and involved in developing the service.

The provider worked in partnership with other services to ensure they supported people in a safe and consistent way.

Brook Domiciliary Care

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 24 January 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that the manager would be available to assist with the inspection.

The inspection team consisted of one adult social care 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. They supported our inspection by making telephone calls to people who used the service and their relatives to help us understand their experiences and views about the service provided.

Before our inspection, we reviewed all the information we held about the service. We examined notifications received by the Care Quality Commission. Notifications contain information about changes, events or incidents that the provider is legally required to send us.

During the inspection, we reviewed four people's care files and four staff files. We looked at a range of records relating to the management of the service. We spoke with 10 people who used the service and their relatives. We also spoke with three support staff, the registered manager and a care coordinator working at the service.

Requires Improvement

Is the service safe?

Our findings

During our inspection, we found concerns around the risk assessment process. We saw that some of the risks involved in delivering people's care had been assessed. This provided information to staff about the risks of injury or harm to people and how to mitigate these, for example, environmental risks and falls prevention. However, we found that the risk assessments did not contain clear and visible information on specific risks to people and actions that were required to be taken. For example, how staff should handle a person who had behaviour that may challenge the service or had diabetes. Another person was at risk of choking however, there was no specific risk assessment for this although staff were aware of what to do and that their food was to be cut up in small pieces prior to eating. We discussed our findings with the registered manager who told us that all the files will be reviewed and updated.

We found that medicines were not being managed safely. We saw one person's care plan which stated "[Person] needs assistance with medicines." The manager described this to us as the carer took the medicine out from a blister pack and gave it to the person. This meant the staff actually administered medicine to the person. However this instruction was not clarified in the person's care plan meaning that people may be at risk of unsafe medicine administration. We also found that a medicine administration chart (MAR) chart was not available for this person. Another person's MAR chart contained a handwritten list of medicines but did not state the dose to be given. This meant that the person could be at risk of unsafe medicine administration by staff who did not have clear instructions. Staff competency was not always assessed to check their knowledge about medicine management. We discussed our findings with the manager and the provider who agreed that further clarification was required in relation to this concern. After the inspection, the registered manager confirmed that care plans were updated with clear instructions regarding medicine administration with MAR charts.

The registered manager told us that relatives of people who used the service were mostly responsible for administering medicine and that the support staff only carried out this task occasionally. We discussed that in this instance it is even more important that clear instructions are available for staff to follow. After the inspection, the registered manager confirmed that care plans were updated with clear instructions regarding safe medicine administration.

The above concerns meant that the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe with staff in their homes and how staff supported them. One person said, "Yes, I've known [staff member] for a long time with no problems." A relative told us "Yes, we [relative and person] feel safe."

People were protected from the risk of harm and abuse. They were encouraged to report any concerns they had about their care. We saw examples of where action had been taken by the manager as a result of concerns raised, such as removing a carer from a call. Staff were aware of the different types of abuse and harm and the potential warning signs to be vigilant of. Staff we spoke with and records we looked at,

showed they had completed safeguarding training on how to protect people from the risk of abuse. A staff member told us "If I was concerned about abuse, I would tell the manager." The service had processes in place to support staff to report concerns.

A whistle blowing policy was in place. Staff were aware of the policy and knew the steps to follow if they had any concerns. Whistleblowing is a means of staff raising concerns about the service they work at, if they felt they were not being listened to by the management team. They were aware that in the first instance all concerns would be reported to the registered manager of the service. Staff were confident that the registered manager would take the appropriate action. They were also aware that they could report their concerns to external organisations such as the local authority or the Care Quality Commission if they felt their concerns were not listened to.

The staff rotas we looked at showed that sufficient numbers of staff were available to ensure people received the care they needed. Staffing levels were determined by the number of people using the service and their needs. The registered manager told us that they continuously recruited staff to make sure they had enough staff with the right skills to meet any shortfalls, when needed. Rotas confirmed that staff were allocated travel time between shifts so that they had enough time to arrive to their next allocated shift at the agreed time. People and their relatives confirmed that they normally received care from a regular team of staff members. They also confirmed that staff completed timesheets,, that they were usually on time and stayed for the allocated time.

Staff said they had sufficient time allocated to people's care calls and did not have to rush. Staff visits were usually arranged in certain geographical areas so they did not have far to travel between visits.

The provider had a robust recruitment and selection procedure in place. They carried out relevant checks before they employed staff in order to make sure they were suitable to work with people who used the service. This included Disclosure and Barring Service (DBS) checks. These checks identified if prospective staff had a criminal record or were barred from working with children or vulnerable people. At least two references were obtained, including one from the staff member's previous employer. Proof of identity was obtained from each member of staff, including copies of their passport and driving licence. Staff confirmed that they had undergone the required checks before starting to work at the service.

Staff had received equality and diversity training and knew how to identify and protect people from discrimination. Staff had been made aware of their responsibilities for working inclusively with people they cared for and others, such as their colleagues. The provider had a process in place to deal appropriately with any allegations or complaints about discriminatory behaviour.

Staff were provided with gloves, aprons and hand gel to help prevent the spread of infection. Staff were aware they had to use protective clothing when providing personal care such as gloves and aprons and to use antibacterial hand wash. They told us they collected the protective clothing from the office and always had a sufficient supply.

Records showed accidents and incidents were reported to the relevant authorities, investigated and where required action was taken to prevent further risks. The registered manager analysed the incidents to help identify any trends, so that action could be taken to drive improvements by making staff aware of these.

Good

Is the service effective?

Our findings

People's care and support needs had been assessed by the registered manager before the package of care commenced. This included a detailed care needs assessment to ensure people's individual needs could be met to ensure the care being delivered was effective. Following this a care plan was developed. A relative confirmed that they had been involved in the assessment process and found that the registered manager had listened to them and provided a team of care staff that met their family member's needs.

People with diverse cultural and lifestyle needs, their preferences about the staff gender and language skills was documented. This helped to assure people that they had the right staff with the skills required to support them effectively.

People told us they felt the staff team were appropriately trained to meet their care and support needs. A person who used the service said, "Yes. They've all been very efficient." A relative told us, "Yes, [staff member] is. I've seen [staff member's] work. [Staff member] feeds [the person] and takes time. [Staff member] is patient and understanding and calls me if there are any questions."

Training records showed that staff received training in a range of topics. These related to health and safety, using moving and handling equipment and reporting procedures in the event of an accident or emergency. New staff members had completed induction training, which included working alongside an experienced member of staff that helped them to get to know the person and learn how they wanted to be assisted. Staff confirmed they were satisfied with the amount and quality of training they received. A staff member told us, "We get enough training and if we need any more they arrange it." Staff also told us that the training equipped them with the skills needed to support people. For example, staff members told us they were trained in moving and handling people and their competency was assessed to support people who used a hoist or other special equipment.

Staff received additional support through regular supervision as well as observations of their care practice. This helped to ensure that staff skills remained current and relevant to people they cared for. One staff member told us, "I have regular supervision. We talk about our work and also ask for any training or guidance. I can ask at any time I don't have to wait."

The staff team supported people to have sufficient food and drink when they carried out a mealtime call. One person told us, "Yes. She puts the food on the table for me." A relative told us, "[The person] can feed themselves with a spoon, they just cut the food up for [the person]." Staff knew the importance of making sure people were provided with the food and drink they needed to keep them well. Care plans included people's food preferences, health and cultural dietary needs and the level of support needed. For example, one person's care plan stated, "Ensure [person] is in a sitting position when eating. Give them small pieces of food. Drinks to be given in a plastic beaker."

Staff monitored people's health and wellbeing and when concerns about people's welfare had been identified, these had been reported to the office and acted on. Care plans included instructions provided by

healthcare professionals to meet specific health needs. For example, how to carry out basic stretching exercises shown to carers by a physiotherapist to support a young person with cerebral palsy. A staff member told us "I checked [person's] hoist which was unsuitable for them so we called the OT (occupational therapist) who carried out an assessment and they got the right equipment." This meant that the service worked in co-operation with other organisations to deliver on-going care and support, when required. Staff completed daily log sheets for each person, to communicate with each other at the end of each shift so that people received continuity of care.

People's care and support were provided in line with relevant legislation and guidance. The Mental Capacity Act (MCA) 2005 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 make 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.

Management and staff had completed MCA training and understood its principles. People were encouraged to make decisions about their care and their day to day routines and preferences.

Staff had a good understanding of people's rights and confirmed consent was always sought before they provided any support. One person said, "[Staff member] asks 'shall I do this or that and listens." Another person told us, "[Staff member] always asks and talks to [the person]." A staff member explained, "We always give them choices and ask what it is they want you to do today (if they have capacity). If not you still ask them and discuss and gently work through the care plan." Records showed that staff respected people's choices and decisions.

Good

Is the service caring?

Our findings

People told us the staff team were kind and caring and treated them with respect. People commented, "Yes, Of course" when asked if staff were caring. Another person told us, "Yes, we've usually had kind ones. We've had problems with one or two, their attitude needed to be addressed with management and they've been taken off the job." Relatives felt the staff were caring and considerate. A relative said "Yeah, definitely."

Information about the service was given to people when their package of care was assessed. It informed people that they would not be discriminated under the Equality Act, on the basis of their gender, race, religion and lifestyle choices, amongst others. The service had recruited some staff from the same cultural background as people who used the service. For some people it meant that they were able to communicate with staff in their first language, which was not English and that their diverse culture and lifestyle was understood and respected. One person told us, "Yes. [Staff member] from (name of the same country as the one the service user comes from) as well and we speak in English and our first language. We share the same culture and religion." A relative told us "[Staff member] has the same background. We waited 2 to 3 weeks to have them."

Care plans showed that people and their relatives, where appropriate were involved in the development and review of their care plans. A staff member described the gestures or body language a person used to communicate their responses and wishes. For people with communication difficulties, care plan described non-verbal prompts and what they meant, which helped staff to respond and support people appropriately. For example, a staff member described how they gauged people's facial expressions, hand gestures and took time to indicate things as well learning a few words in a person's own language in order to provide the level of support a person needed.

Staff told us they generally provided support to the same people so they had continuity of care. They told us that they were aware of people's preferences and how their support should be delivered. Staff ensured that people were called by their preferred name and respected people's decisions if they preferred gender specific staff to carry out their personal care.

People confirmed their privacy and dignity were promoted when being assisted with personal care. One person said, "Yes, [staff member] stands outside the door." A relative told us, "Yes, [staff member] covers [person] and is doing everything nicely." Staff were trained in the promotion of people's dignity and privacy. They gave examples of how they preserved people's dignity when supporting them. A staff member said, "I don't undress all of them and cover them with a towel to preserve their dignity and close the curtains and the door." The language and descriptions used in the care records were referred to in a dignified and respectful manner.

. People told us the service they received helped them to be independent so they could remain living at home. Staff gave examples of how they involved people with domestic tasks and doing certain aspects of their personal care to help them become more independent. A staff member told us "You don't want to step in and do it [task]. I assist if they are struggling to put on a top or eat by themselves but always prompt first

to encourage independence."

A confidentiality policy was in place. Staff told us they understood the importance of maintaining people's confidentiality and would always have discussions in private. People's files were kept secure in filing cabinets and computers were password protected. Information about people was shared on a need to know basis.

Good

Is the service responsive?

Our findings

The care and support that people needed was determined after an assessment of their needs had been completed. This allowed people or those acting on their behalf, to have a say in how and when their care was provided.

The assessment and care planning process considered people's communication needs, beliefs, hobbies and interests. The care plans covered needs associated with personal care, medicines, communication, continence management, eating and drinking and activities. Some of the care plans included personalised information based around the needs of the individual. For example, a care plan stated, "I like someone to sing to me (a specific song was listed). I don't like loud noise and loud people." Another care plan stated, "Staff to assist with transfers using the rota stand." These meant staff were aware of how to meet people's individual needs. However, although staff were aware of how to support people with dementia and diabetes, there were no care plans outlining people's support needs in relation to these conditions.The registered manager informed us that the service was in the process of reviewing and updating all the care plans. We recommend that the service carry out a review of all the care plans in order to ensure that they are up to date and covered all aspects of people's individual needs and wishes and how these were to be met.

People confirmed that care plans were regularly reviewed and when needs changed their care plans were updated. One person told us, "(Name of someone from the office) came to do the care plan. It was updated in July and we're waiting for a review." Another person said, "Yes. They're doing the care plan review next week." Records showed a person's mobility had deteriorated and the registered manager along with a health care professional carried out a further assessment. This meant that the care package was increased and the care plan was updated to ensure staff knew how to support them. People told us that the staff knew them well. Staff were able to describe people's background and knew what care and support they needed. The service ensured people had access to the information they needed in a way they could understand it, such as large print or electronic amongst other formats, to comply with the Accessible Information Standard. This is a framework and a legal requirement for all providers to ensure, people with a disability or sensory loss can access and understand information they are given. It requires services to identify, record, and meet the information and communication support needs of people with a disability or sensory loss.

From our discussion with staff and review of people's records, we saw that people had made choices in their everyday life and were involved in activities in the local community. For example a staff member supported a person to access the wider community, go shopping, have a meal in pubs and join in various social activities, this meant the person was in control of their life and were not isolated.

People and their relatives knew how to make a complaint and were confident that their concerns would be carefully considered by the management team. People and their families knew that they could contact the registered manager who would address any concerns they had. One person said, "We have no complaints." Another person said, "Yes, I do (know the complaints procedure) and I'm comfortable doing it." Records of complaints and concerns showed that they were being addressed and responded to in accordance with the service's complaint policy. Whilst looking at the log of complaints the registered manager was able to

demonstrate that they used concerns raised to drive improvement within the service. Where issues had arisen with care staff and their performance, appropriate measures were put in place to ensure the quality of care expected was maintained, for example via additional training and supervision.

Records were maintained of compliments. A person who used the service wrote, "I would like to compliment [staff member] as they are excellent, look after me, is concerned about my wellbeing and makes me laugh."

The registered manager told us the service was not providing support to people with end of life care needs at the time of our inspection. They informed us that staff will be provided with this training before they began to provide such care if requested.

Requires Improvement

Is the service well-led?

Our findings

During our inspection, we found that the provider did not ensure there was an effective system in place to assess, monitor and mitigate the risks to the health and safety of people. The lack of robust quality assurance, to check the overall level of service delivery, could have a negative impact on people's health and put them at risk. We found that risk assessments had not been comprehensively completed for people. Care plans did not always have the full information needed to support people effectively. There was a lack of clarity regarding safe medicine administration and management. The registered manager and provider of the service acknowledged that improvements were required. At the time of writing this report the registered manager had arranged for the pharmacists who supply medicines to people, to provide them with printed medicine administration charts (MAR).

There were quality assurance systems in place to monitor and improve the quality of the service. We saw that spot checks of care staff took place and regular telephone calls to people were made by office staff to ensure they were satisfied with their care worker. People were also asked for their views about the service via satisfaction questionnaires. However, the return rate was low.

Although the provider was able to identify issues and concerns within the service that required further action, the existing internal systems needed to be more robust. This would ensure that all concerns found during our inspection would be identified and actions would be taken promptly to ensure people received their required care and were safe at all times.

The above issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were complimentary about the service provided and the agency. When asked if they thought the agency was well run, one person told us "Yes, they seem to be and the carers seem to work in the office too. I'm pleased with them. They're the best we've had so far." A relative said, "Yes, definitely, 100%."

Staff members felt that the service was well-led and that the registered manager was approachable. One staff member said, "They are a good employer and very responsive. We can contact them at any time we need any assistance." Another staff member told us, "Good company to work for. We get good training and support from the management team." Staff felt involved and informed about the service. They confirmed that team meetings were held where their views were sought and information was shared between staff members and management.

A system was in place to ensure staff understood their role and were aware of the policies and procedures in place. Staff practices were observed and their knowledge assessed through unannounced spot checks. Feedback from people helped to ensure that they were satisfied with the quality of service provided and any shortfalls were addressed.

The registered manager was aware of the need to report certain incidents, such as alleged abuse or serious

injuries, to CQC and had systems in place to do so, should they arise.

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were placed at potential risk because there was a failure to manage people's medicines safely. People who use services and others were not protected because not all risks to people were assessed with actions in place to mitigate those risks.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The home service did not have robust systems in place to assess, monitor and improve the quality and safety of the service and mitigating the risks relating to the health, safety and welfare of service user's who may be at risk which arise from the carrying on of the regulated activity.