Brookvale Homes Limited

Brookvale Lawn

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

The home provides accommodation and care for up to 30 people and there were 25 people in residence when we visited, some of whom were living with dementia. The home is over three floors with bedrooms on each floor. The main communal areas are on the ground floor.

This inspection took place on 22, 23 and 30 April and was unannounced.

There was a registered manager in place. 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 and associated Regulations about how the home is run.

People said they felt safe living at the home and that staff met their needs. The registered manager worked in partnership with the local authority safeguarding team when necessary. Safeguarding procedures were in place to protect people from abuse. Risks to people's wellbeing had been identified and risk assessments were in place to minimise risks. Examples of this were where people

Summary of findings

needed bed rails or sensor mats to alert staff to people moving out of bed, unsupported. People received their medicines as prescribed and managed them independently where they were able to. Medicines were stored safely and securely.

The provider had a recruitment procedure which included seeking references and completing checks through the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. These checks had been undertaken before new staff started work. New staff completed an induction and were supported in their work through training, supervision and annual appraisal.

People's dietary and healthcare needs were met. People felt cared for and staff respected their privacy and dignity when supporting them with personal care. However, some people's dignity was compromised when using a downstairs toilet and staff did not always wait for permission before entering people's bedrooms. People received personalised care that was responsive to their needs. The provider employed an activities co-ordinator who provided a range of group and one to one activities.

There was a quality assurance programme in place and people could make complaints, which would be investigated and responded to in a timely way. People could attend 'resident's meetings' and complete questionnaires to give their views on the service provided.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 10 (2)(a).

You can see what action we told the provider to take at the back of the full version of this report.

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 not always safe.

There were enough staff to meet people's needs in the day. However, it was not clear if the staffing levels at night always met people's needs.

New staff had undergone recruitment checks before they started work. People were protected from abuse because staff understood what abuse was and how to identify it.

People received their medicines safely and as prescribed.

Requires improvement

Is the service effective?
The service was not always effective.

The registered manager understood the Deprivation of Liberty Safeguards and how they should be used to protect people. However, some staff were unclear about whether the safeguards currently applied to anyone.

Staff were supported in their work through induction, training and supervision.

People were supported to have sufficient to eat and drink and access healthcare.

Requires improvement

Is the service caring?
The service was not always caring.

People's dignity was not respected when using a particular area of the home and staff did not always wait for an answer before entering bedrooms.

People could make choices about their care and support.

People felt cared for.

Requires improvement

Is the service responsive?
The service was responsive.

People received personalised care that was responsive to their needs.

People were encouraged to give their views and procedures were in place to enable them to complain.

Good

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

The management team were open to listening to people and staff.

There was an internal quality assurance audit system in place to monitor the quality of the service. Action was taken to make improvements when needed.

Good

Brookvale Lawn

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.

We last inspected the home on 9 December 2013. At that inspection we found the service was meeting all the essential standards that we assessed.

This inspection took place on 22, 23 and 30 April 2015 and was unannounced. The inspection was brought forward due to concerns we had been made aware of through our notifications and enquiry system. These concerns were regarding staffing levels and care at night. One inspector undertook the inspection.

Before the inspection, we reviewed the information we held about the service. This included notifications about important events which the home is required to send us by law and our previous inspection report.

During the inspection we looked around the premises, observed people eating their lunch and socialising. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with seven people living in the home, three visitors, eight staff, the registered manager, the nursing manager and a district nurse. We looked at three care plans daily notes, medication records, and a range of records regarding the management of the service, such as audits and staff recruitment records.

Requires improvement

Is the service safe?

Our findings

The provider employed a range of staff in different roles. Care staff were supported by an activities co-ordinator, cleaners, seniors and management as well as staff in the kitchen and laundry. The provider filled gaps in the rota by using agency staff. During the night shifts it was usual for an agency worker to work alongside a permanent worker. If two agency workers were working together, a senior staff member would sleep in overnight, so they could be 'on call'. There was also a 'second and third tier on call' which meant support was available on the telephone. The registered manager completed a staffing dependency tool every three months or when new people moved in.

This process formulated how many staff were needed to meet people's needs, which had resulted in two staff on duty at night to cover three floors. We spoke with two people about how staff supported them during the night. They told us they used their call bells and said staff came within minutes. Our first visit was in the evening and we saw staff responding to call bells soon after they rang. However, there was not a system in place to monitor the effectiveness of the call bell system at night. This meant the registered manager and provider were not able to assure themselves that people got the assistance they needed as soon as possible. Staff had mixed views about the staffing levels at night and whether they could meet people's needs in a timely way. One staff member said people's needs were variable which meant that night duty was "sometimes hectic, sometimes quiet".

We observed a night staff member being patient with a person who was confused about where they were and whether they had slept there before. However, two people who were sat in the lounge needed support drinking a cup of tea. One staff member was supporting one person, whilst the other person struggled to hold their cup, their hand shaking and resulting in the tea starting to spill over the top. The staff member came to assist, but could not stay and the drink was not finished when we left, thirty five minutes later. The registered manager said they had been in the process of reviewing the number of night staff and was planning to work some nights themselves. They had also added a senior staff member to work as a third care worker.

The provider had a recruitment procedure which included seeking references and completing checks through the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. These checks had been undertaken before new staff started work. Recruitment files contained other information such as an application form which showed a full employment history as well as a medical questionnaire to ensure staff were fit to work.

People received their medicines as prescribed and managed them independently where they were able to. Medicines were stored safely and securely. Records were completed which showed when people had taken their medicines and the stock matched the records. Trained and competent staff gave people their medicines and there was always someone trained on duty during the day and night. Where people needed their medicines to be given covertly, a thorough process had been completed to ensure this was done safely and in the person's best interests.

We observed a senior staff member giving out medicines. Staff were patient with people who were unsure why they were taking tablets and gave them explanations. Staff also offered a person pain relief because they recognised through their body language that they were agitated and therefore could be in pain.

People said they felt safe living at the home. One said, "I have never had staff be rude or nasty to me." The registered manager worked in partnership with the local authority safeguarding team when necessary. The registered manager had recently held staff meetings to remind staff about how to report any safeguarding concerns and checked they felt comfortable with the process. Staff had received training in safeguarding and gave us examples regarding what abuse was and said they knew who to report concerns to. Safeguarding policies and procedures were in place to guide staff if necessary.

Risks to people's wellbeing had been identified and risk assessments were in place to minimise risks whilst maintaining independence where possible. Examples of this were where people needed bed rails or sensor mats to alert staff to people moving out of bed, unsupported. Each person had a personal emergency evacuation plan in place which was regularly updated.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager had made DoLS applications for some people living in the home and was waiting for a response from the local authority. One staff member was clear that applications had been made but none had been agreed yet. However, some staff were less clear about whether anybody living at the home was deprived of their liberty under the safeguards. One said "the majority here would be, I don't know if anyone has DoLS in place". Another staff member thought there was a DoLS in place for one person as they could not go out alone. This lack of clarity could put people at risk of being deprived of their liberty illegally.

People were supported to have sufficient to eat and drink. Two people told us the "food is very good" and confirmed there was a choice of meals. One said staff went "out of their way to find an alternative if you don't like something". Special diets were catered for and we saw people who needed gluten free food had lots of choice on the afternoon tea trolley. A relative said the staff were good at providing a range of gluten free foods to choose from and understood the person's dietary needs. We heard people asking for drinks at times other than mealtimes and saw they were provided with what they asked for.

Some people had specific needs with regard to eating and drinking and advice was sought from healthcare professionals such as speech and language therapists when necessary. Where people needed their drinks thickened or fortified, these were provided. On the first day of our inspection we saw one staff member standing up to support somebody with eating their meal, which was not good practice. Later, a staff member sat down, but were supporting two people to eat and helping a third. We spoke with the registered manager who confirmed this should not have happened. On our second visit, we saw staff supporting people individually.

People had access to health care services when needed. One person told us "staff make sure we are well in ourselves". During our first visit we saw a GP visiting the home in the evening as someone was unwell. Whilst people usually saw healthcare professionals, such as GPs in their bedroom, sometimes it was in their best interests to be seen in communal areas. A district nurse visited to attend to a dressing on someone's arm and staff put a screen in place to protect their dignity.

Staff were supported in their roles, starting with a period of induction for new staff. The 'in house' induction had increased from three to five days shadowing both other care staff and senior staff. New staff without a health and social care qualification completed a more in depth induction for care staff run by the local authority. Subsequently, staff were encouraged to register for a national qualification in care.

There was a programme of supervision which included observational (task orientated) and written supervisions which were tailored to subjects the registered manager needed to address, such as safeguarding and medication. Staff received supervision every two months. A staff member who worked nights said their supervisor "stayed behind" to make sure they received their supervision. Staff who had worked at the home over a year qualified for annual appraisal but the registered manager said these were not up to date. An action plan had been put in place so that all those eligible would receive an appraisal.

Staff said they had undertaken training which included subjects such as dementia awareness, medication, fire safety and continence. However, the provider had identified through auditing the training matrix that there were gaps in staff training. The reasons for this were investigated and addressed. All staff had been trained in what the provider considered mandatory, such as moving and handling. The training plan for the year, showing who was attending training and when, was displayed on the office door where it was clearly visible to staff.

The Mental Capacity Act 2005 provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. Staff understood the complexities around whether people had capacity or not. One said, "One day they could have capacity, another they might not. We always assume they do, give them the information to make choices; any decision made by us will be in their best interests and the least restrictive". Another staff member said, "People can lack capacity in one area but not everything".

Requires improvement

Is the service caring?

Our findings

People's privacy and dignity was not always respected. The downstairs toilet did not have an adequate door or space which therefore compromised people's dignity. We observed that a person could be seen by anyone in the hallway when staff left the toilet to give person privacy. Staff knocked on bedroom doors before entering but did not always wait for an answer confirming they could enter.

These issues were a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff explained how they respected people's dignity when assisting them with personal care. This included closing doors and curtains and covering them up with a towel. Staff explained what they were going to do before they supported people with personal care. Where people could undertake some of their own personal care, staff encouraged them to do so. This respected the person's privacy and helped the person remain independent.

People felt cared for. One person told us they liked all the staff very much and that they were, "good and kind and offer to help". Another told us staff cared about them and that, "Most of them will do extra little bits".

Staff had positive caring relationships with people living in the home. We saw staff interact with people without any task being undertaken, for example, going to sit next to a person and start talking to them. Staff became aware that one person was slightly agitated so they sat with them and stroked their hand which they responded well to. One person stood up independently, knocking into a piece of furniture. The staff member was visibly concerned about them and rubbed their back in a kindly way.

People could make choices about their care and support. One person told us, "Yes, they ask how I prefer [personal care], they give me a choice. There is a choice of food and drink…I sometimes go to bed at six, I like it". We heard two people saying they did not want any lunch. One subsequently ate their meal with staff support but the other consistently said no, to a number of different staff who all tried to persuade them to eat something.

Staff were clear that people could and should make their own choices. People could choose when to get up and when to go to bed. On the first day of our visit, which was in the evening, we saw some people were up and sitting in the lounge. Staff told us when they came on duty at 8pm, they would assist anyone who wanted to go to bed, if not they undertook other tasks until people were ready. Some people stayed up until 12 or 1 o'clock and one person often chose to sleep in an armchair.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. One person told us, "I sometimes say, 'would you mind not doing that now?' They're very good, I am very pleased with the staff". Another said, "They're not muttering about doing something for you, they do it willingly, they are very good". A visitor said, "They are good at monitoring, I am kept up to date if there is a change".

Staff discussed care plans with people and their relatives to ensure they were involved and could make choices about their care. Some people needed two staff to support them and this was detailed in care plans. If people became unwell staff responded to their changing needs in a timely way, for example, by two staff supporting what they could usually do with one. Care plans included information about people's preferences and how they liked to be supported.

The provider employed an activities co-ordinator who had attended training relevant to the role. A relative outlined the range of activities and entertainment they had seen whilst visiting, which included music workshops and quizzes, singers and theatre performances. People also enjoyed in-house activities, such as word puzzles, art and manicures. A staff member told us they sometimes got a balloon for people to "bat to and from", which resulted in people laughing and having fun. Group or one to one activities were available, depending on people's needs and wishes.

People felt able to complain if they needed to. One person said, "I have no complaints, everyone is nice, kind and approachable. If I had a complaint I would find a way to get it over. If something has gone wrong there must be a reason." Another person said "They will deal with any complaints, they do all they can to put things right".

The registered manager had investigated one formal complaint since our last inspection. Records showed how the complaint had been dealt with and what action had been taken. The registered manager also investigated and responded to "informal concerns", such as a suitable dessert not being offered.

People were invited to attend 'Residents meetings' and were asked for their agenda items. Minutes were kept and showed the meetings were used to inform people of proposed changes in the home, to discuss activities and menus and to seek people's views.

Good

Is the service well-led?

Our findings

The management team were open to listening to people and staff. A visitor told us they had raised a concern with a member of the management team last year, and their response had been, "superb, they kept me informed and showed me how they were monitoring fluids. I can walk in and ask how [their relative] is and get an open and honest answer". Staff echoed this statement. One said, "this is a lovely, warm environment. There is an open door policy" and another said, "we can express ourselves and raise concerns, or we can go and talk anytime. I think it's well run."

The registered manager was supported by a management structure organised by the provider. This included practical support and regular quality auditing by the 'nursing officer'. A staff member said the nursing officer often visited the home outside of office hours and unannounced, to undertake house checks, making sure everything was safe and working well.

One person said, "I think it [the home] runs very smoothly, it's not easy to run". A visitor said, "I think the management team has been strengthened. There is a senior on every day shift and it feels like someone is really steering". Senior staff were aware of their responsibilities and completed the tasks allocated to them. "Everyone is friendly, we all help each other. We can ask the management for help if we are busy, there is no problem". Staff were aware of their roles and the ethos of the home was that people could make their own decisions and choices, with support if necessary.

The nursing officer was also starting to involve staff in monthly auditing to enable further responsibility in their roles. The provider ran an 'employee of the month' scheme as well as 'employee of the year' to recognise staff commitment.

The registered manager ensured the home met registration requirements. This included sending notifications of any reportable incidents when necessary to the Care Quality Commission.

There was an internal quality assurance audit system in place to monitor the quality of the service. The registered manager undertook monthly audits of incidents such as falls, safeguarding and complaints. The registered manager had become aware of issues through their quality assurance system and taken action to improve staff practice. An example of this was finding gaps in care records, which was raised in senior meetings and a new process put in place for seniors to check. Further training had also been accessed. Regular team meetings were also used to communicate where improvements were needed.

The nursing manager had made changes to their monthly auditing schedule so it was up to date with the new regulations. The provider also commissioned a regular audit of the whole service by an outside company, who visited and spoke with people. If improvements were suggested, these were addressed. A quality assurance questionnaire had recently been given to people and the registered manager was in the process of analysing the results.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Dignity and respect.** **People's dignity was not always respected. Regulation 10 (2(a)**