Prestwick Care Limited

Brooke House

Inspection report

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Ratings

Is the service responsive?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 27 January 2015. A breach of legal requirements was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach of regulation relating to record keeping.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met the legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Brooke House on our website at www.cqc.org.uk.

We found the provider had met the assurances they had given in their action plan and were no longer in breach of the regulations.

Records were up to date and reflected the care and support provided by staff. Risk assessments were in place to reduce risks to people's safety. They were regularly reviewed and evaluated to ensure people received safe care and treatment that met their current needs. Care plans were put in place where risks had been identified. They were regularly reviewed to record people's current individual care and support needs. Care plans detailed how people wished to be supported. Detailed individual information was in place to help staff provide care to people in the way they wanted. Staff knew the people they were supporting and provided a personalised service.

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 responsive?

We found that action had been taken to improve the responsiveness of the service.

Staff were knowledgeable about people's needs and wishes. People received support in the way they needed because records were up to date and detailed. They provided guidance for staff about how to deliver people's care, in the way the person wanted.

We could not improve the rating for: is the service responsive; from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Requires improvement

Brooke House

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Brooke House on 23 June 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider had been made after our comprehensive inspection on 27 January 2015. We inspected the service against one of the five questions we ask about services: Is the service responsive? This is because the service was not meeting some legal requirements at the time of our initial inspection.

The inspection was undertaken by an adult social care inspector. During our inspection we spoke with the senior nurse and looked at the care records for five people who used the service. After our visit we spoke with the registered manager.

Requires improvement

Is the service responsive?

Our findings

We reviewed the action plan the provider sent to us following our comprehensive inspection in January 2015. This gave assurances that records would accurately reflect people's current care and support needs. The provider told us they would be compliant with the regulations by 31 May 2015.

At our visit we saw improvements had been made to ensure people's records reflected the individual care and support provided by staff. We were told record keeping would be further enhanced as the provider was in the process of introducing new care documentation that would be completed by 31July 2015.

In the meantime the records we looked at showed a detailed life history. A 'This Is Me' document had been completed for people. This gave information about a person's preferences, previous lifestyle, significant events and people of importance in the person's life. This information was important so each person was recognised as a unique individual with a history and a future and to help staff provide more individual care. We were told some families had supplied the information as not everyone was able to communicate this information themselves.

Assessments such as for people's pressure area care, nutrition, mobility and moving and assisting requirements were up to date and were reviewed monthly. They identified areas of need which were transferred to care plans. For example, with regard to nutrition and falls. Where necessary referrals were made for further assessment with specialists, such as to the falls clinic when a person had a number of falls.

Risk assessments were up to date and reviewed monthly. We saw specialist advice had been obtained for a person who had been assessed as being at risk of choking. The speech and language therapy team and dietician had become involved to provide assessments and a detailed nutritional care plan. This was to help ensure the risk was reduced to the person and to provide advice and guidance to staff.

People's care plans were personalised and provided more specific information for staff about how care was to be provided to the individual and in the way they wanted. For example, a person's mobility care plan stated, "I use a Zimmer frame to support me when I'm walking and I need one carer to walk by my side to ensure my safety." For the same person another care plan detailed, "I will on occasion look as if I'm leaning to one side so staff need to prompt me gently to sit up." Another person's personal hygiene care plan stated, "I can use a face cloth and wash my face" and "I can dress myself in jumpers and trousers but I cannot pull zips or fasten buttons." A care plan was in place for a person who required support with decision making. It gave information to staff about how to help and retain the involvement of the person in their daily decision making. It detailed, "I can answer staff if you speak to me slowly and clearly so I can understand" and "I will choose if given choices what I prefer."

Care plans for people who experienced distressed behaviour provided more detail. They contained information about the person and how they should be supported so consistent care was provided that reduced a person's anxiety. Advice and guidance was provided by the behavioural team to help staff understand the triggers for the behaviours and why the person may show the distress.

Records for people who required covert medicines were in place. Covert medicine refers to medicine which is hidden in food or drink. Care plans detailed why the medicines needed to be given covertly and documented the relevant people who had been involved in the best interest decision making on behalf of the person.

We found the assurances the provider had given in the action plan with regard to record keeping had been met.