DSRE Services Limited

Brownhill Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 21 June 2016 and was unannounced.

Brownhill Lodge is a residential care home for up to 21 people. At the time of the inspection the service was providing support to 20 people.

The service did not have a registered manager at the time of the 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.

People in the service were safe because staff had the training and knowledge to identify abuse and take steps to protect people if they suspected they were at risk. Staff assessed people's risks to ensure they were safe from preventable harm. People were assessed for their risk of pressure ulcers and action was taken when people's skin integrity was threatened. There were enough staff available at all times to support people and they were recruited using robust procedures to ensure they were safe to work with potentially vulnerable people. Staff ensured that medicines were administered safely and that mobility equipment was safe to use.

People who lived in the service were safe because staff had received training to safeguard people from abuse. People's risks of avoidable harm were managed by detailed and regularly reviewed risk assessments. People received medicines safely and their risks of infection were managed by good hygiene practices within the service.

People were supported by staff who were supervised, supported, appraised and trained. People gave consent to the treatment they received in relation to mental capacity legislation. People received nutritious food and were supported to access health and social care professionals whenever they were required.

Caring and kind staff delivered care and support to people. Staff respected people's privacy and dignity and promoted their independence. People at the end of their lives were treated with compassion to ensure they had a dignified death.

People received personalised care based upon individual needs assessments. People participated in the development of their care plans which stated their preferences. The service offered a range of activities for people to choose from and participate in. The provider obtained and acted upon feedback from people and their relatives and dealt with complaints appropriately.

The service did not have a registered manager but the acting manager had commenced the process of registering with the regulator. The acting manager led the service well. The views of staff were sought and

the service collaborated with local health, social care, cultural and religious organisations to meet people's needs. There were robust quality assurance processes in place to drive improvements in the care and support people received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

People were safe. Staff understood safeguarding and their role in identifying and reporting abuse.

The risks people faced were identified, assessed and managed.

There were staff in enough numbers to keep people safe and meet their needs.

Staff were recruited using a robust series of checks that ensured they were suitable to work with people.

People received medicines safely.

Is the service effective?

Good

The service was effective. Staff received training to keep their skills and knowledge up to date.

Staff were supported, supervised and evaluated through an appraisal system.

People's rights under mental capacity legislation were upheld.

People had healthy diets and enough to eat. Action was taken to support those at risk of under eating.

People had timely access to healthcare professionals.

Is the service caring?

Good

The service was caring. People told us the staff were caring.

People were supported to maintain their independence.

Staff respected people's privacy and treated them with dignity.

People were supported with compassion and dignity at the end of their lives.

Is the service responsive?

Good

The service was responsive. People's needs were assessed and care plans detailed how identified needs should be met.

People made choices and participated in a range of activities in the service.

The provider sought the views of people and their relatives.

People knew how to make complaints and their complaints were addressed.

Is the service well-led?

Good

The service was well led. The service did not have a registered manager but was well led by an acting manager supported by a deputy.

The quality of the service was audited and shortfalls were acted upon.

The staff felt supported and able to share their views as to how the service could improve.

The service worked in partnership with local resources.

Brownhill Lodge

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 unannounced inspection took place on 21 June 2016 and was undertaken by one inspector and one 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.

Prior to the inspection we reviewed the information we held about Brownhill Lodge including notifications we had received. Notifications are information about important events the provider is required to tell us about by law. We used this information in the planning of the inspection.

During the inspection we spoke with nine people, three relatives, the acting manager and deputy manager. We also spoke with seven staff. We reviewed 10 people's care records, risk assessments and medicines administration records. We looked at documents relating to staff and management. We reviewed eight staff files which included pre-employment checks, training records and supervision notes. We read the provider's quality assurance information and audits. We looked at complaints and compliments from people and their relatives.

Following the inspection we contacted six health and social care professionals to gather their views about the service people were receiving.

Good

Is the service safe?

Our findings

People told us they felt safe. One person told us, "I'm fine. I'm safe. There's nothing to worry about." Another person said, "I am not left on my own, if I was I would be scared. I never feel afraid. There is always somebody there." A healthcare professional told us, "The acting manager has [put in] place robust measures to prioritise [people's] safety and care."

People were protected from the risk of abuse. Staff received training to identify the signs of neglect and abuse and knew what actions to take to support and protect a person they suspected may be at risk of abuse. Records showed staff had discussed different types of abuse in team meetings and one to one supervision meetings with the acting manager. Each staff member we spoke with were knowledgeable about the provider's safeguarding procedures and were confident they could spot and report abuse.

People were safe because staff understood the provider's whistleblowing procedures. Whistle-blowing is the practice of reporting concerns about people's safety to an external organisation if the provider does not address them appropriately. One member of staff told us, "I would report any abuse to my deputy or manager straight way. Absolutely immediately. But if they sat on my concerns I would take them over to the CQC." This meant staff knew how to keep people safe in the event that the provider was not doing so.

People's safety was enhanced because staff made plans to reduce known risks. People's risks of avoidable harm were assessed and managed. For example, people who were at risk of falls had their mobility assessed by occupational therapists. The findings from the assessments were reflected in care records which provided details to staff as to how a person's falls could be prevented. This included supporting people to use walking frames. A member of staff said, "For those people who use Zimmer frames, we make sure their frames are within easy reach." Another member of staff said, "We have people who might get surprised by their urgency to use the toilet and might rush there. They could fall so we just give them a discreet reminder and then support them to go at a safe pace."

Risks arising from people's health needs were assessed. People at risk of developing pneumonia as a result of unsafely swallowing normal consistency fluids were identified. Staff made referrals to speech and language therapists who made recommendations. For example, one person at risk of fluids getting into their lungs because of their unsafe swallow had guidance for staff in care records directing them to add thickening agents to drinks. This meant the risk of aspiration was reduced. In another example, we found people presenting with risks associated with their blood sugar levels had guidance in care records to assist staff. This included identifying signs that people's blood sugar levels may be too high or too low and the actions staff should take.

There were enough staff available to meet people's needs safely. At the time of our unannounced inspection there were three care staff, a chef, cleaner, deputy manager and acting manager in the service. People and their relatives told us there were enough staff available to support them. One person said, "Whether we're in here [the lounge] or we're in there [the dining room] there's always enough staff milling around and helping out." Another person said, "I have a call bell but if I need staff I just call them and they come straight away".

People were safe because the way in which staff were recruited was safe. All staff working in the service had their details checked against criminal records and lists of people barred from working with vulnerable groups. The provider had interviewed prospective staff to ascertain their level of skills and knowledge and obtained references which detailed their employment histories. The provider verified people's identification and confirmed proof of address and the right to work in the United Kingdom. This meant people received care and support from suitable staff.

People received their medicines safely. People's medicines were stored, recorded and administered appropriately. One person told us they received their medicines in liquid form as they found tablets hard to swallow. Another person told us, "The staff make sure you take it." Medicines were kept in a locked area. Staff retained the key. The temperature of the medicines storage area was monitored. The acting manager audited medicine administration record (MAR) charts and undertook a physical check of blister packed, bottled and 'when required' medicines each week. We found that when an incorrect code, had been entered on a MAR chart, the acting manager had identified the error and addressed the issue with the member of staff during supervision.

People were safe because the service undertook fire prevention measures and were prepared to respond in the event of fire emergencies. The service had fire alarms, smoke detectors, fire extinguishers and emergency lighting throughout the premises. These were checked weekly. The service tested fire alarms and practiced building evacuation. We found that each person had a Personalised Emergency Evacuation Plan (PEEP) which detailed the specific support they required to staff safe in an emergency.

People were protected from the risk of avoidable infection by the hygienic practices of staff. Staff wore personal protective equipment when providing personal care. For example, staff wore single use gloves when supporting people to bathe and shower. The home was clean and free of clutter and malodours. One person told us, "The cleaner works very hard in here, she keeps the place spotless, and she is very good."

Good

Is the service effective?

Our findings

People's care and support was delivered by staff who received regular training to meet their needs. The service sent staff to attend local authority delivered training sessions. Records showed staff attended sessions which included moving and handling, dementia awareness, safeguarding and managing medicines. Posters were displayed in the office informing staff of the availability of places on upcoming training courses. We found three staff were currently completing their care certificate whilst three others were studying the NVQ in care. This meant people were supported by staff who received training to keep their skills and knowledge up to date and aligned with best practice.

People were supported by staff who had completed induction programmes. New staff had a planned introduction into the service which included orientation to the provider's policies and procedures and familiarisation with people and their needs. During their induction new staff shadowed their experienced colleagues who role modelled good practice. This meant people were supported by staff who knew their preferences.

People received care and support from staff who were supervised by managers. The acting manager and their deputy held one to one supervision meetings with staff every two months to discuss people's changing needs. Supervision meetings were used to gauge staff knowledge. For example, in one staff member's supervision we read they were asked to identify signs that a person maybe dehydrated. The member of staff responded, "They maybe thirsty or have dark urine". Staff were aware of when their supervision sessions were planned as the acting manager displayed a supervision matrix in the office. This meant staff had regular opportunities to discuss people's changing needs with their line manager.

The acting manager evaluated staff performances to ensure people received good quality care. Staff participated in appraisal meetings once a year. These identified areas for professional development and staff goals. A member of staff told us, "Appraisals are helpful because they help you focus. You get to look at where you might be a bit weak and see where you want to be in a year. If it helps me be a better worker then it's helpful for the people who live here too."

We found people had signed the care records we reviewed. People told us they were consulted about their support and preferences. One person told us, "They [staff] always ask me if this is ok and if that is ok and what would I like." This meant people gave their consent to the care they received.

The managers and staff understood the provider's policies relating to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA and DoLS exist to protect people who may lack capacity and ensure their best interests are considered when decisions that affect them are made. DoLS ensure that people receive the care and treatment they need in the least restrictive manner. None of the people in the service were subject to DoLS.

People told us they had enough to eat and enjoyed the meals they were served. One person told us, "the food is good, you get a choice". Another person told us, "You can eat what you like." We observed people

eating in the lounge and found it was a social occasion with interaction amongst people and with staff. People chose where they ate. One person told us, "I like to eat in the lounge it is more private and I can enjoy my food better". Another person told us, they chose to eat their main meal in the dining room after everyone else had left. Several people told us they often preferred to have their breakfasts in bed. This meant people chose what they ate and where.

Where people were at risk of malnutrition they were weighed monthly. When rapid weight loss was noted staff took action. For example, one person's records showed that when they experienced weight loss, referrals were made to their GP and dietician. Staff implemented their recommendations by supporting people to take high calorie drink supplements. This meant people received timely support to maintain their weight and health.

People told us they had access to healthcare professionals as and when they needed. One person told us, "The doctor, dentist, optician and chiropodist visit me here." People received the support they needed to attend appointments. Staff implemented the recommendations from healthcare professionals' assessments. For example, staff supported people with mobility needs to use equipment to maintain their independence.

Good

Is the service caring?

Our findings

People told us the staff were caring, attentive and kind. One person told us, "It's lovely here, the staff are like friends." Another person told us, "The staff are very kind. They notice when you're not feeling good in yourself and have a little talk with you." Other comments people made to us included, "I am happy here", "[the staff] are very good and friendly" and "They look after me well."

People were supported to maintain relationships that were important to them. People told us their families were always made to feel welcome when they visited the service. Staff made phone calls to relatives to inform them of people's changing needs and when people wanted information shared. Staff supported people to maintain connections with local cultural organisations and church congregations. For example, one person was supported to receive visits from parishioners from their church and hold private prayer meetings at home.

People made decisions about how they spent their days and how their support should be delivered. We observed staff involving people in decision making throughout our inspection. People were asked what they wanted to do, where they wanted to sit, what they wanted to eat and drink and if they "fancied a chat". People's care records informed staff about the level of support people required to make a decision.

People's independence was promoted. For example, people were supported to eat independently. Where people required staff to verbally prompt them to eat, this was recorded in care records. Similarly, people were encouraged to meet their personal care and mobility needs where they were able to with the provision of mobility aids and staff supervision. People chose the times at which they went to bed at night and arose in the morning.

People told us staff respected their privacy and promoted their dignity. People told us staff always addressed them by the preferred names and these were recorded in care records. A member of staff told us, "I always introduce myself by name. It's reassuring to people, particularly if they're getting forgetful." Another member of staff told us, "A lot of the ladies want us to ensure that their dresses don't ride up too high when they are sitting. We do this with a discreet word and they like that." A third member of staff said, "When we [staff] support someone to use the toilet we make sure the doors shut and we don't stay in the room with [people] unless their care plan says we need to."
People were supported with compassion and dignity through their end of life care. A healthcare professional told us, "The staff are trying very hard to complete advance care plans with me for every resident which states their wishes and preferences should their health deteriorate." People who were dying were supported with a reassessment of their needs including an assessment of their mental capacity and the management of their pain. People's advanced wishes were recorded in care records. Macmillan nurses had attended the service to support people and staff during end of life care. A certificate awarded by the beacon palliative care service, St Christopher's Hospice, was on display in the reception area in recognition of staff skills in palliative care.

Good

Is the service responsive?

Our findings

People received care and support that was personalised. People's needs were assessed before they received a service. Care records were written by the acting manager and staff to ensure people's needs were met. People's needs were reassessed and new care plans written when needs changed. One healthcare professional told us, "[The service] was open and receptive to comments and suggestions as to how their level of care improves."

People, their relatives and health and social care professionals participated in needs assessments and the development of care plans. The needs assessed included people's health, mobility, personal care, cognition, communication and independent living skills. Care records guided staff as to how people's needs should be met in line with their preferences and professionally recognised good practice. For example, people at risk of pressure ulcers were supported by staff using a range of monitoring tools including of their movement, nutrition, hydration and skin colouration. This meant staff met people's needs in a planned, methodical and person centred way.

People made choices about their care and support and how they spent their time. For example, one person told us they preferred to relax in the garden because they used to be a gardener. Their care plan included a risk assessment on supporting this. A member of staff told us, "We make choices as practical as possible, like I might show two plated options for dinner or two nice dresses for the day." People decided when to go to bed and care plans reflected their choices. For example, one person's care records stated they preferred to have their bedroom light off but their bedside lamp on when they were in bed.

The service ensured a range of activities were available for people to participate in. One person told us, "There is always movement. I like the singing and activities." We observed an activities coordinator leading games and singing sessions in the lounge during the inspection. These were well received by people and many participated. We saw that about six people joined in the sing-a-long and two people were dancing. A similar number engaged in seated exercises whilst five people were involved in a spelling quiz. Other activities we observed included colouring and puzzles. We noted in the care records of one person that they enjoyed making puzzles but needed encouragement and appreciated "subtle assistance". This meant people received the support they required to participate in the activities they choose.

People shared their views about the quality of care they received from staff with the acting manager. The service facilitated residents meetings every three months. These meetings provided an opportunity for people to shape the service. For example, records from the March 2016 residents meeting showed that more than half of the people living in the service were present. People proposed a number of days out for the summer, included seaside trips, and we found these were in the advanced stages of planning at the time of their inspection.

The provider sought the views of people and their relatives. People and their relatives were given surveys to complete each year about the service being delivered. Responses were reviewed by the provider acted upon and the outcomes were evaluated.

People and their relatives told us they knew how to make a complaint and felt any concerns raised would be dealt with appropriately. One person told us, "Yes I know how to complain but I have never had too. I am very happy here, the staff talk to us, I am not left on my own." The service had a large print complaints procedure on display on the reception area. We read the provider's complaints records and found that complaints were investigated and responded to in writing in line with the timeframe laid out in the provider's policy.

Good

Is the service well-led?

Our findings

The service did not have a registered manager at the time of the inspection. However the acting manager had applied to the Care Quality Commission a month before the inspection to become a registered manager.

Staff, people and relatives spoke positively about the leadership of the service. One member of staff told us, "The acting manager is great. She's really motivated and understands what's going on." Another member of staff told us, "[acting manager's name] understands people's needs and the things that we need to do to be sure all of the needs are met. She encourages all of the staff to work hard."

There was a positive atmosphere in the service. Good management was evident in the way the service operated. Staff were skilled and knowledgeable. Steps to keep people safe had been taken. People shared their views, made decisions and engaged in activities of their choice. Care records, including needs assessments, care plans, risk assessments and medicines records were up to date and accurate.

Staff felt supported by the acting manager. Staff providing end of life care were given support by the managers. A healthcare professional told us, "Reflective debriefings are carried out after a resident's death which gives staff an opportunity to talk about how they are feeling. They can also discuss what they have learnt from the experience and what they would do next time."

The provider sought the views of staff. At the time of the inspection the provider had sent out a survey to employees and was preparing to analyse the results and produce an action plan based upon them. Staff, along with people and their relatives were able to share ideas through a suggestion box. Minutes of monthly team meetings showed staff had the opportunity to share ideas around improving the service as well as meeting people's changing needs.

The acting manager undertook a number of regular checks of service quality. We read audits of health and safety, room standards, medicines, kitchen hygiene and care records. We found were shortfalls were identified action plans were drawn up and implemented. For example, an audit of care records revealed one person's care plan did not contain their photograph whilst another person's care records did not state the name of their keyworker. In both instances the actions to be taken, by whom, and when were stated and the completion of both tasks were confirmed.

The acting manager understood their legal responsibilities to keep CQC informed of important events through notifications and had forwarded them when required.

The service worked in partnership with health and social care providers. Records showed staff worked in collaboration with social workers, palliative care specialists, occupational therapists and district nurses to support people's changing needs. The service were present at the local authority's nursing and residential home providers forum where best practice was discussed including falls prevention and preventing pressure ulcers. This meant the provider worked in partnership with other organisations to achieve the best

outcomes for people.