Brownbill Associates Limited

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Inspection report

Kille House
Chinnor
Thame
Oxfordshire
OX9 3NU
Tel: 01844 212153
Website: office@brownbill.com

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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

Overall summary

We undertook an announced inspection of Brownbill Associates Ltd on 29 October 2015. We told the provider two days before our visit that we would be coming. Brownbill Associates provides a brokerage service for people with an acquired disability to enable people to employ their own carers. The agency acts as an intermediary between the person needing the service and specialist agencies who supply people to provide the care (care workers). Brownbill Associates supply case managers who provide training and support to the care workers who are employed by people receiving the care. At the time of our inspection 50 people were receiving a personal care service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

Where risks to people had been identified, risk assessments were in place and action had been taken to reduce the risks. Staff were aware of, and followed guidance. People received their medicine as prescribed.

People told us they benefitted from caring relationships with the staff. There were sufficient staff to meet people's needs and people received their care when they expected. The service had robust recruitment procedures.

People received personalised care. Care packages were tailored to people's individual needs and were provided by dedicated teams selected by people and their relatives. Many care teams contained healthcare professionals with specific skills to meet people's specific needs.

Staff understood their responsibilities in relation to safeguarding. Staff had received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in place to notify the appropriate authorities where concerns were identified.

Staff had a good understanding of the Mental Capacity Act (MCA) and applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves. The registered manager was knowledgeable about the MCA and how to ensure the rights of people who lacked capacity were protected.

People told us they were confident they would be listened to and action would be taken. The service dealt with complaints appropriately, sought people's views and acted upon them. The service had systems to assess the quality of the service provided. Learning was identified and action taken to make improvements which improved people's safety and quality of life.

Staff spoke positively about the support they received from the registered manager. Staff received support through supervision and training. Staff told us the registered manager was approachable and there was a good level of communication within the service.

People told us the service was friendly, responsive and well managed. The service sought people's views and opinions and acted upon them.

The registered manager had systems in place to monitor the quality of the service. Information from audits and quality monitoring was used to improve the 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 safe?
The service was safe.

Risks to people were managed and assessments in place to reduce the risk and keep people safe.

There were sufficient staff deployed to meet people's needs.

People told us they felt safe. Staff knew how to identify and raise safeguarding concerns.

Good

Is the service effective?
The service was effective.

People were supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further training and development.

Staff had been trained in the Mental Capacity Act (MCA) and understood and applied its principles.

Good

Is the service caring?
The service was caring.

Staff were kind, compassionate and respectful and treated people and their relatives with dignity and respect.

People benefitted from caring relationships with the staff. People's dignity and respect was promoted and people were involved in their care.

People's independence was promoted and staff were proactive in supporting them.

Good

Is the service responsive?
The service was responsive.

Care plans were personalised and gave clear guidance for staff on how to support people.

People knew how to raise concerns and were confident action would be taken.

People's needs were assessed prior to receiving any care to make sure their needs could be met.

Good

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

The registered manager had systems in place to monitor the quality of service.

There was a whistle blowing policy in place that was available to staff around the service. Staff knew how to raise concerns.

Staff spoke positively about the registered manager and the support they provided.

Good

Brownbill Associates Limited

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 the 29 October 2015. It was an announced inspection. We told the provider two days before our visit that we would be coming. We did this because the manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that they would be in. This inspection was carried out by an 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.

We spoke with 23 people, five relatives, two case managers and the registered manager. We looked at five people's care records and medicine administration records. We also looked at a range of records relating to the management of the service. The methods we used to gather information included pathway tracking, which is capturing the experiences of a sample of people by following a person's route through the service and obtaining their views.

Before the visit we looked at previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about in law. In addition we reviewed the information we held about the service.

Good

Is the service safe?

Our findings

People told us they felt safe with the care they received. One person said “Oh I am completely safe with them”. People were supported by staff who could explain how they would recognise and report abuse. Staff told us they would report concerns immediately to their manager or senior person on duty. One case manager said “My team come to me with concerns. I’ve encouraged them to report to me with any issues and they do”. Records confirmed the service notified the appropriate authorities with any concerns.

There were sufficient staff deployed to meet people’s needs. The registered manager told us staffing levels were set by the dependency needs of people. People’s needs were assessed and dedicated teams allocated to support the person. Some people required 24 hour care and we saw where this was the case, sufficient, appropriately trained and qualified staff were deployed to support them.

Staff told us there were sufficient staff to meet people’s needs. Comments included; “Yes there are enough staff. Within my client group we have more than enough staff and I have empowered my team to meet our client’s needs” and “We do have enough staff. People’s care packages are tailored to their individual needs and this includes staff”.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the service. These included employment references and Disclosure and Barring Service checks. These checks identify if prospective staff were of good character and were suitable for their role.

Risks to people were managed and reviewed. Where people were identified as being at risk, assessments were in place and action had been taken to reduce the risks. For example, one person could mobilise independently but could not walk for long distances without the support of a wheel chair. Guidance relating to this risk was provided for staff and stated ‘for day outings or walks further than 500 metres’ a wheel chair should be used. Staff were aware of and followed this guidance.

Another person could become frustrated and angry. Risks associated with this behaviour were identified and triggers prompting this behaviour were highlighted. For example, lack of eye contact and a thumbs down gesture. Guidance provided for staff to reduce this risk included the presence of two care staff ‘at all times’. Records confirmed this guidance was being followed.

People had their medicines as prescribed and when they needed them. Records confirmed medicine records were accurately maintained and checked regularly. Staff were trained to support people with their medicine and their competency was checked regularly by case managers. One case manager said “Medicines are well managed here. Competency checks are made and my team are up to date. I also audit medicines for my team and information is shared which allows me to pick up and trends that occur. We never get any errors”.

Good

Is the service effective?

Our findings

People told us staff knew their needs and supported them appropriately. Comments included; "I know the carers are good because I was involved in selecting them and made sure that they understood what we needed" and "I am more than happy with the support I get. It's really important that [my relative] is enabled to be as independent as possible and when we were looking for a carer I made it very clear that we needed somebody who was active and would support [my relative] to lead as independent a life as possible. I think very highly of Brownbills. Our case manager understands our needs and is very on the ball".

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Many of the staff supporting people were healthcare professionals such as nurses and occupational therapists. Staff underwent induction training linked to 'Common Induction standards' and some staff had completed further training. For example, City and Guilds and National Vocational Qualifications (NVQ) in health and social care. One member of staff said "We get good training, particularly around the mental capacity act (MCA). We also get client specific training to ensure we can meet their needs".

Staff received regular supervision (a one to one meeting with the line manager), competency spot checks and appraisals. Records showed staff also had access to development opportunities. Staff told us they found the supervision meetings useful and supportive. One member of staff said "I have formal supervision approximately every six weeks, plus informal chats. I also conduct supervisions for my staff. They are extremely useful as they help to identify issues within my staff group. For example, if there is a training need. I can arrange for the training to meet that need".

We discussed the Mental Capacity Act (MCA) 2005 with the registered manager. The MCA protects the rights of people who may not be able to make particular decisions themselves. The registered manager was knowledgeable about how to ensure the rights of people who lacked capacity were protected. One person had a relative appointed as having 'Lasting Power of Attorney'. This gave legal authorisation for the relative to make decisions relating to property and affairs on the person's behalf.

People's capacity was assessed to support people to make their own decisions. For example, one person had capacity but had a poor memory and decreased concentration. As a result they found it difficult to retain information. Staff were guided to 'remain neutral' when offering choices and to 'maintain a quiet and relaxed environment' to allow the person to concentrate on their decisions. All the care plans were signed and agreed by people along with legal documents relating to the conditions of their care.

Staff were able to demonstrate a good understanding of the principles of the Mental Capacity Act (MCA). One case manager said "All my team come from a brain injury background so MCA knowledge and practice is good. Training is on going so we all keep up to date". Another case manager said "One of my staff has supported a client to manage their own money. They keep their own records which they enjoy doing and this has really empowered them".

People were supported to maintain good health. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included people's GPs, district nurses and specialist professionals. For example, one person was supported by an appropriate healthcare professional. Guidance from specialists was highlighted in care plans and regularly reviewed.

Where people required support with eating and drinking, clear guidance was provided to staff to enable them to support people effectively and safely. For example, one person was at risk of choking and needed support with 'coughing and clearing their airway'. The person had been assessed by a speech and language therapist (SALT) who had provided guidance for staff. Staff had also received training from the SALT to support this person. One case manager said "We get good advice and guidance from specialists regarding people's nutrition, however I have no one at risk of malnutrition or dehydration".

Good

Is the service caring?

Our findings

People told us they benefitted from caring relationships with the staff. Comments included; “We get on well. Not only do they listen to me, they also listen to [my relative]. He was involved in the selection of carers and we wouldn’t have taken anybody who he didn’t think he could get on with”, “The carers do lots of activities with [my relative]. She goes out and about with them a lot and they really encourage her to be as independent as possible” and “We’re more than happy with both our carer's, who are wonderful, and with the support from our case manager who really listens to what we need”.

Staff told us they enjoyed working at the service. One member of staff said “I really like this work, very rewarding”. A case manager said “We have some really caring relationships with clients. My staff are very good and professional, especially at maintaining appropriate boundaries. This is really important for people with brain injuries”.

People selected staff or staff teams to support them with case managers providing oversight of the support package. This meant people were supported by the same staff who were familiar to them. One case manager said “Each person’s care is tuned to their needs involving them and specialist professionals”. One person said “The case manager is very good and the other carers are just fine”. New staff were selected by people and introduced by the case manager.

People were involved in their care. People selected support staff and outlined the type of care package they wanted. For example, one person had stated they wanted ‘a healthy diet to prevent malnutrition or dehydration’. The person wanted to be involved with their support and guidance to staff stated in the care plan ‘encourage them to contribute with this process as much as they are able’. Records confirmed this guidance was being followed.

Staff told us how they involved people in their care. A case manager said, “We’ve talked as a team on how to empower clients. We offer choices, what to eat, where to shop or what to wear. We always try to give appropriate options. In some instances this has led to physical improvements. One client I can think of is now calmer and their habit of nervous scratching has really reduced. This has been achieved because they have been involved in their daily activities and care which has given them more confidence”.

People’s dignity and respect was promoted. People told us staff were polite and respectful. One relative had commented, “Very pleased with our care worker. Polite and respectful”. When staff spoke to us about people they were respectful and spoke with genuine affection. The language used in care plans and support documents was respectful and appropriate.

Good

Is the service responsive?

Our findings

People told us the service responded to their needs and wishes. One person said "The case manager is very good but I don't have a lot of contact with her. That is my choice because I prefer to deal with things for myself and I don't need a lot of involvement. The way things are working suits me. I do think I would get more support if I needed it, but at the moment, I don't". Another said "There are sometimes small problems. Brownbills do sort them out though as quickly as they can".

People's needs were assessed prior to receiving any care to ensure their needs could be met. People had been involved in their assessment as were specialist healthcare professionals. Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. For example, one person had stated they wished to visit a relative's grave regularly to 'preserve memories'. Care notes evidenced this person was supported to do this.

Another person had stated they required support with their memory and wanted to 'promote concentration and understanding'. Staff were guided to 'fully involve the person in their daily life' and to use board games to stimulate the person's memory. Daily notes show this guidance was being followed and the person was also involved in weekly menu planning, shopping lists and 'other activities involving forward thinking'.

People's care plans were personalised. Each care plan contained a 'pen portrait' giving details about the person. People had listed personal events important to them and activities they liked to engage in. For example, one person had stated 'I have a very active life and enjoy bowling, cinema and the theatre. A case manager spoke with us about personalised care. They said "We allow people to be independent and we prompt them to help themselves. I noticed one person had difficulty putting on a particular shirt and they appeared to have restricted shoulder movement. We arranged for an occupational therapist to review them. They now choose a different style of shirt which has helped with their range of movement".

The service adapted to people's specific needs. One person had been living in a care home receiving support. However the person wanted to live at home. The person had complex needs but the service was able to provide a 24 hour care package to meet this person's needs. The person's home was adapted and they now lived at their own home.

People knew how to raise concerns and were confident action would be taken. Details of how to complain or raise concerns were held in people's homes. This included the provider's policy on complaints. We looked at the complaints folder and saw there had been two complaints since the last inspection. Both had been dealt with compassionately, promptly and in line with the complaints policy. Staff told us they would support people in raising a concern. One said "I would support a client to complain, in fact I have in the past".

People's compliments and opinions were recorded. For example, one person had emailed the service stating 'thrilled with the new case manager'. They went on to say they thought the service was 'always brilliantly proactive'. People's opinions were also sought through postal and telephone surveys.

Good

Is the service well-led?

Our findings

People knew, and had regular contact with their case managers. People and their relatives were complimentary about case managers. Because the service covered large areas of the country the registered manager was not as well known. However, people who had dealt with the registered manager spoke positively about them. One person told us about a resolved issue. They said "I had a problem but they dealt with it very professionally. I was worried about the impact on [my relative's] care but it was sorted out very well. I would recommend them to somebody else any day".

Staff spoke positively about the registered manager and the service. Comments included; "The manager is very supportive and approachable" and "The manager is always available and very supportive. They are a good source of information and I can approach them with issues. This is an open and honest service, yes. It's an extremely transparent service because of our legal obligations to our clients".

The registered manager monitored the quality of service provided. Case managers conducted regular audits covering all aspects of care. The results were fed back to the senior management team who analysed the results to improve the service. For example, it was identified there was a trend relating to people's sexuality. Case manager 'study days' were held to review this trend and identify actions to address the issues. Actions were then taken and learning was shared with individual teams. Medicine administration records (MAR) were also audited by case managers. However, as all MAR charts were held in people's homes there was not a system in place to collectively review MAR charts to look for patterns and trends across the service. We discussed this with the registered manager who told us they would review this issue and rectify it as soon as possible. This issue had not impacted on the care and support people received.

Senior management meetings were regularly held to make improvements to the service. For example, a new 'case manager induction' process was being introduced and we saw feedback from the staff attending was reviewed and discussed. Staff had commented the new process 'flowed better' and 'was an improvement'.

Accidents and incidents were recorded and investigated. Learning from accidents and incidents was shared with care teams and staff. For example, one person had lost their balance and had to be supported by staff. This made them angry. Learning from this incident was shared and the person's care plan updated giving guidance to staff to help prevent a reoccurrence. A case manager said "We share learning and information amongst ourselves and our teams by meetings and supervisions".

Annual surveys were conducted to seek people's views on the service. Comments from the latest survey were overwhelmingly positive. Comments included; 'contact with Brownbills has been wonderful. They are a dedicated team' and 'my support team are excellent'. Results of the survey were feedback to people via a news letter.

People received quality assurance visits by the registered manager. Quality assurance checks were also conducted by telephone. The results of these checks were analysed by the registered manager and improvements made to the service. For example, on one visit it was identified one person had new issues with mobility and had developed specific needs relating to the new equipment they used. As a result of the visit staff training was updated to address this person's specific needs. The registered manager told us they were increasing the frequency of quality assurance visits for people with complex needs. They would be receiving a visit every year.

The registered manager told us about their personal vision for the service. They said "I want to get things right for our clients. We provided bespoke care tailored to their individual needs because people are not all the same". All the staff we spoke with mentioned 'individual care' and emphasised its importance. One case manager said "This is a different type of work to normal care and can get quite technical. You need an understanding of how individual care is delivered safely".

There was a whistle blowing policy in place that was available to staff. Staff were aware of the policy and were confident about raising concerns.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager of the service had informed the CQC of reportable events.

Good

Is the service well-led?

The service worked closely with other healthcare professionals including GPs, occupational therapists dieticians and district nurses. Records of referrals to healthcare professionals were maintained and any guidance was recorded in people's care plans.