Brownlow Enterprises Limited

Brownlow House Residential Care Home

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?	Requires Improvement

Overall summary

This inspection took place on 14 May 2015 and was unannounced which meant that nobody at the home knew about the visit in advance.

Brownlow House Residential Care Home is registered to provide accommodation and personal care for up to 24 older people. The home is spread over three floors with 17 bedrooms including seven double rooms. The home has 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 2008 and associated Regulations about how the service is run.

There was insufficiently clear communication about whether people living in the home had their own bedrooms, or were sharing with another person which placed them at risk of sharing a bedroom with a stranger, without their consent or a best interest decision being made.

Summary of findings

Risks to people's safety were identified and managed effectively, and there were systems in place to protect them from abuse. People's privacy and dignity was protected. People were involved in decisions about their care and how their needs would be met. Sufficient staff were available to meet people's health and social care needs. People's medicines were managed safely, and staff knew what to do if people could not make decisions about their care needs. Support was obtained swiftly from relevant health care professionals when people's needs changed.

People received appropriate support with their meals, and were encouraged to engage in activities both within and outside of the home. Staff were very aware of people's likes and dislikes regarding their care and support needs.

The home was kept clean and any maintenance issues were addressed promptly. Appropriate systems were in place to ensure the safety of the premises.

People using the service, relatives and staff found the management approachable and supportive. Staff received effective training and supervision in their role. Systems were in place to monitor the quality of the service, and address areas for improvement. People felt able to express any concerns, so these could be addressed.

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?

Good

The service was safe. Risks to people who use the service were identified and managed appropriately.

Staff knew how to identify abuse and the correct procedures to follow if they suspected that abuse had occurred. Recruitment procedures were in place to determine the fitness of staff to work in the home, and there were sufficient staff available to meet people's needs.

Systems were in place to manage people's medicines safely.

Is the service effective?

Good

The service was effective. Staff received training to provide them with the skills and knowledge to care for people effectively.

Staff supported people's nutritional needs. People's health care needs were monitored, and they were referred to their GP and other health care professionals as needed.

Staff understood people's rights to make choices about their care and the requirements of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring. Staff showed empathy and were knowledgeable about the people they supported. People's privacy and dignity was protected.

People and their representatives were supported to make informed decisions about their care and support.

Is the service responsive?

Good

The service was responsive. Care plans were in place outlining people's care and support needs, and people were able to participate in activities and stimulation within the home.

Staff were knowledgeable about people's support needs, their interests and preferences and provided a personalised service.

People using the service and their relatives had opportunities to give feedback on the service and there was a complaints system in place.

Is the service well-led?

Requires Improvement

The service was not always well-led. There was not sufficiently clear communication with health care professionals and relatives about people sharing bedrooms.

There were systems in place to monitor the quality of the service people received.

Summary of findings

The management promoted an open and transparent culture in which people were encouraged to provide feedback.	

Brownlow House Residential Care Home

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.

The last inspection of the home took place in March 2014, and the home was found to be meeting with the regulations inspected.

This inspection took place on 14 May 2015 and was unannounced. The inspection was carried out by an inspector, a professional advisor who was a nurse with knowledge of older people's needs, 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.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service.

There were 20 people living at the home on the day of our visit. During the visit, we spoke with 10 people who lived at the home, and two relatives visiting the home, five care staff, the cook, the deputy manager, and the registered manager. We spent time observing care and support in communal areas.

Some people could not let us know what they thought about the home because they could not always communicate with us verbally. Because of this we spent time observing interactions between people and the staff who were supporting them. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their well-being.

We also looked at a sample of 10 care records of people who lived at the home, six staff records, and records related to the management of the service.

Following the inspection we spoke with four relatives of people living at the home and three health and social care professionals by telephone.

Good

Is the service safe?

Our findings

All the people we spoke with told us that they felt safe in the home. When asked, one person said, “Oh yes, really I do.” Two people mentioned that they were sometimes disturbed by other people living in the home, but staff were aware of the problem and neither of them felt unsafe as a result. One of them told us, “I take no notice.” People living at the home and their relatives told us that they could talk to staff if they were worried about anything. Relatives and health care professionals also thought that the service was run safely. One relative told us that their family member’s bedroom was “spotless.”

All the staff on duty had had safeguarding training and were able to give examples of types of abuse. They said that they would feel able to raise any concerns with the management if needed. The home’s building presented some challenges, with narrow corridors and staircases to navigate, however there had been no falls at the home for approximately six months before the inspection, despite a number of people having mobility support needs, being encouraged to move around as independently as possible.

Risk assessments in people’s care records enabled identified risks to be managed effectively, and these were reviewed approximately monthly. There were no people with pressure areas at the time of our visit, however people at risk had prevention plans in place, which were followed appropriately. We discussed with staff how they supported people with behaviours that challenged the service, and found that this was appropriate and corresponded with their risk assessments for managing behaviours that challenged.

People who needed support with managing their monies had systems in place to protect them. We looked at records of three people’s personal monies kept for safekeeping in the home, and found that these were recorded appropriately to protect people from financial abuse in line with the provider’s policy. Staff had undertaken first aid training and knew what to do in the event of a medical emergency or in the event of a fire at the home.

Safe recruitment procedures were in place to ensure that staff were suitable to work with people. Staff files including those for recently recruited staff members contained evidence of appropriate checks of people’s fitness to work. They included copies of criminal records and barring checks, written references, identity checks, copies of employment histories and qualifications. The registered manager advised that new records were being put into place to record interview notes in more detail, for any new staff commencing work at the home.

Staff were visible at all times in the main area of the home and were seen visiting people who had chosen to stay in their own rooms. Staff were very busy on the morning of the inspection, but all but two people living at the home said that there were enough staff available. These two people told us, “There’s mostly enough [staff] but we’re a bit short sometimes,” and “They’re very short staffed. Sometimes you ask someone to do something and they don’t. It’s not because they don’t want to or they forget, they have to go and do something else.”

Whilst staff appeared to be very busy, there was also evidence of good interaction and when people asked for assistance they were assisted very promptly. All the staff told us that there were enough staff to safely care for people in the home, although one member of staff did say, "We could always do with extra staff as we are always rushing around.” We looked at the previous month of staffing rotas, and noted that since the last inspection an additional member of staff was now available in the morning to assist people with morning care.

No agency staff were used in the home, so that people were supported by staff they knew well. Most staff had been at the home for more than two years and said that they enjoyed working there. Staff said that sickness and absences were covered effectively.

We looked at the medicines administration records (MAR) and stocks of medicines for seven people living at the home. People had their allergy status recorded to prevent inappropriate prescribing. No controlled drugs were prescribed in the home, and medicines were stored securely and at an appropriate temperature. We did not find any gaps in the administration records or inconsistencies between the stocks and records. Records included pictures of people and their tablets, and body charts to illustrate the site for topical lotions to be administered. Medicines were signed in and out of the home to ensure stock control, and checks on the medicines records were recorded on a weekly basis.

Good

Is the service safe?

Staff told us that medicines were only administered by senior staff, who had undertaken the appropriate training. We observed medicines being administered appropriately during our visit.

The senior care workers on duty were clear about how to understand the administration instructions for people on warfarin, which changed regularly. They confirmed that they received clear information when there was a change in the dose, and felt that the system was safe.

The home was clean, although the décor showed some signs of age with the carpets on the stairways particularly worn. We observed staff washing their hands in between tasks, and a domestic worker was cleaning the home on the day of our visit. Care staff ensured that tables were clean and tidy throughout the day. Bathrooms, though clean, had worn and ill-fitting lino flooring, and one of the bath hoists had rusted, which was difficult to keep clean. Decoration work was being undertaken during our visit, and the registered manager provided a schedule of works to be completed within the home. It was noted in a previous inspection that the floorboards in the corridor leading to room 18 were noisy, and may have disturbed people's sleep as staff carried out checks at night. This remained the case, and the provider advised that they were looking into solutions for this issue.

Records were available of regular cleaning tasks carried out at the home including cleaning of people's commodes, wheelchairs, wardrobes, bed changing, and all toilets and bathrooms. There were also records of regular deep cleaning of people's carpets.

Good

Is the service effective?

Our findings

People living at the home spoke positively about the staff and felt that they met their needs well. One person said, "I've no complaints." When asked if they could see a doctor one person said**,** "Oh yes when I need to." Relatives said that staff kept them up to date with any concerns about their family member's health as agreed. One relative told us, "There is hardly any turnover of staff," which meant continuity of care for people living at the home.

Staff working at the home had relevant training to meet people's needs. Staff undertook induction training after recruitment, and their training records showed that most staff had completed all areas of mandatory training in line with the provider's policy, and those who had not had been identified and were due to complete this training. Staff also had training on mouth care, nutrition, dementia, mental health, and managing behaviour that challenged. Most of the care staff had attained a national vocational qualification in care. A training matrix chart was used to identify when staff needed training updated.

Staff told us that they had a lot of training, and reported attending recent training in end of life care, which they had found helpful and very interesting. One of the staff said "Oh yes we have lots of training, it's good here." Another staff member said they had undertaken a pressure area care course at a hospital which was very good. All staff said that if they had training needs identified, they were addressed.

Staff said that they received regular supervision and felt well supported by management. Staff records we looked at showed that staff received supervision sessions approximately two-monthly and annual appraisals in line with the provider's policy. Some supervision sessions involved observation of care provided, and staff being asked to complete a question and answer sheet which was reviewed with the deputy manager.

People said they were able to make choices about their care. There were assessments available regarding their capacity to make decisions and consent to their care and treatment. Care records made it clear as to whether people had capacity to make specific decisions about their care and treatment, and ensured that care was delivered in people's best interests when they lacked capacity to consent. Staff were aware of the principles of seeking consent and had sufficient knowledge of the legislation relevant to their role. All staff were able to give examples of gaining consent before providing care to people. One care assistant said, "If we went to give a wash to one of the residents in the morning and she refused this, we would get a cup of tea for her and explain and come back to her a little later and offer a wash again, we would keep offering, but would not distress her. Sometimes it is better to get another member of staff to offer as it maybe that she doesn't want me to help her today, some of our residents have dementia and we must offer things in different ways." One person who refused to have a particular prescribed lotion administered, was found to have capacity to make this decision, and the issue had been discussed with their GP as appropriate. The deputy manager advised that she was the mental capacity act champion for the home, and that this topic was covered in mental health and dementia awareness training courses.

One person had a Deprivation of Liberty Safeguard (DoLS) in place, and was escorted on trips out of the home as stipulated in the conditions of this safeguard. The registered manager was aware of the duty to ensure that further applications were made for DoLS in the light of the most recent Supreme Court judgement.

People had mixed although mostly positive feelings about the food served at the home. One person praised the kitchen staff, noting that the cook knew their religious dietary needs and, "goes to a lot of time and trouble for me." Others said, "The food's good most of the time," and "It's OK, it's not too bad." One person told us they didn't like some of the food served, but staff supported them to heat up soups and other items of their choice instead. We observed this being carried out during the visit. A relative told us that their family member "loves the food."

Throughout the day, people were offered tea and coffee at regular intervals. There was a tray with juice available in the main lounge area and we observed one person helping themself to a drink. Others were offered juice or asked for it and care staff responded immediately. Breakfast was served at 9am, but people were provided with refreshments before this time.

There lunchtime atmosphere was relaxed and unhurried, but with people served promptly. One person living at the home set the tables, a task they undertook regularly. We observed that people had a choice of a fish or a meat dish and a vegetarian option at lunch. They had been asked to choose earlier in the day. Staff told us that it was possible

Good

Is the service effective?

to get an alternative meal choice and the cook would always find an alternative if somebody didn't like the food. However there were no menus on the tables or the walls and not all staff told people what they were getting when they served them. There was also some inconsistency in approach by the staff to those who were reluctant to eat, with some people offered more assistance and prompting than others. These issues were reported to the registered manager.

The cook had a good knowledge of people's dietary requirements and had a clear chart available for quick reference with regards to people's dietary needs. Special diets provided included diabetic, soft, low fat, low sugar, vegetarian and fortified meals. She was able to describe how each of these meals was prepared and had a detailed knowledge of the likes and dislikes of each person as she had got to know them over time. The kitchen appeared clean and well organised.

People's weights were monitored monthly, and there were no people living at the home assessed as requiring food and fluid monitoring.

People told us that they had the support they needed to access health care professionals such as their GP. Within the care plans there was a health professional communication log, and we were able to track how recent health issues had been managed, such as a person who had needed recent dental care. These demonstrated that health professionals were contacted promptly, and documented clearly the outcomes of each appointment and care instructions. Health professionals consulted included community nurses, community psychiatric nurses, dietitians, dentists, opticians and chiropodists. Risk assessments were in place describing preventative measures to protect people from identified health risks such as developing pressure sores.

Staff said that there were no difficulties accessing health care professionals and a GP visited every week. A senior care assistant said that they "would call the GP in hours, and out of hours they would call 111. If it was an emergency they would phone an ambulance."

Health and social care professionals told us that communication with the home was good, the manager always found time to spend with them, and staff would call if there were any problems. One professional said it felt like they were "working together."

Good

Is the service caring?

Our findings

People living at the home spoke positively about the way in which staff supported them. They told us, “The staff are all very nice,” “It’s a good place to be, the staff are very good,” “The staff are so nice,” and “[a staff member] is marvellous. She listens to all my problems.”

Relatives of people living at the home were also very positive about the staff approach. They said “The staff are very kind,” “My [relative] is very happy here,” “My [relative] is well looked after,” and “They’re all very polite.” One relative was very impressed that on an occasion when a piece of clothing turned up in their relative’s wardrobe which was not theirs, the staff immediately knew to whom it belonged, they told us, “They said, of course that’s so-and-so’s. They know. It’s very impressive.” Health and social care professionals told us that staff were always very friendly, pleasant and caring, and supported people in their preferences.

Staff were observed being kind and gentle with people. They clearly knew their characters well and interactions were respectful and friendly. The morning shift was busy and we observed mostly task-centred interactions, but in the afternoon some staff were observed sitting and chatting with people, who clearly enjoyed their company.

Relatives visited people at the home during the day, and in one case took their relative out for lunch, however there were suggested restrictions on visiting times posted in the entrance hall, to avoid mealtimes. The registered manager advised that this was to avoid distractions to people during mealtimes.

Staff demonstrated a good knowledge of people’s likes and dislikes, and spoke with them compassionately. We observed one person being supported to speak to their relative on the phone, when they expressed anxiety about when they would they would next visit. All staff we spoke with could explain well how they provided care to people ensuring dignity and respect. One staff member said “You can’t have one without the other, you should respect everyone, and care for people as you would want to be cared for.” Another staff member said “When we are washing the residents we protect their dignity, we close the door and keep them covered.”

Most bedrooms had en suite toilets but bathrooms were shared. Given the lack of en suite bathrooms, we asked people if they were able to have a bath or shower when they wished. They told us that this was not a problem.

We observed staff knocking on people’s bedroom doors prior to entering to ensure people had privacy. Staff told us they had enough time to talk to people and recognise their needs. People were encouraged to feedback about their experience of care in the home at resident meetings held on a regular basis.

Staff understood people's needs with regards to their disabilities, race, sexual orientation and gender, although they had not yet undertaken equality and diversity training. Care records showed that staff supported people to practice their religion, by supporting attendance at places of worship and having a weekly Catholic service in the home.

Care plans included detailed information about people’s past lives, their likes and dislikes, family and employment and this information was used in planning care. For example one person liked to watch films and was not always happy in the surroundings of others; the staff facilitated them to be in the conservatory with access to a TV and DVD player.

Staff could give examples about engaging people to make decisions around their care. For example finding out where they wished to go out to, giving meal choices, and in delivering personal care. This was reflected in their care plans, for example one person chose not to wear socks and shoes and their care plan included an assessment that they did have the mental capacity to make this decision, and clear documentation that the person had capacity to make these decisions. Where people preferred to stay in their rooms this too was facilitated and care staff were seen going regularly upstairs to check on them.

Staff in the home promoted independence, and people were free to walk around and go back and forth to their rooms as they required. On the day we visited there was a problem with the lift and care staff supervised the use of the lift to enable people to move around the home as they wished.

Good

Is the service caring?

The staff we spoke with all said that they would feel empowered to challenge any practice, if they witnessed it, where privacy and dignity was not maintained. One staff member said, " I would tell them straight away and then go straight to manager to report it."

Many staff had been at the home for some time and knew the people living there well, and showed a strong concern for them. They gave us examples of taking them to the pub, cafes and the shops and the staff said they were lucky to be in a location with so many local amenities nearby. On the wall in the lounge/dining room there were pictures of activities and trips out that people had taken part in. This was also used as a talking point for people living at the home.

Good

Is the service responsive?

Our findings

People told us that they had regular music sessions with visiting entertainers and none complained of a lack of activity. On the morning of our visit there was a short activity session using a music and movement tape led by a senior member of staff. Several people joined in and appeared to enjoy the activity. In the afternoon, some people played with a ball with support from staff, and this activity seemed to be popular. Later, a large group gathered at a table for a memory session in which each person took it in turns to tell a story. They were chosen at random by spinning a bottle, and when they told their story they wore a colourful hat. Once they'd completed the story they were given a large paper star with their name on as a badge. The activities coordinator leading the session made it fun and lively and was clearly attuned to the different capabilities of people in the group. For instance, those with limited memory or communication skills were simply asked to tell their name and where they came from, which sometimes prompted more discussion. Several people were very engaged and there was a lot of laughter and banter.

People were able to pursue their own interests as much as possible. For example one person chose to stay in their room with their TV and books. Staff knew that this was their preference, and that they liked to come downstairs later in the afternoon. People who chose to stay in their bedrooms, had a call bell within easy reach.

People said that they went out occasionally, with staff support, and there were photographs on the walls of local outings. Relatives told us their family members were "very well taken care of," and " looked after pretty well." Most relatives told us that there were enough activities, but one relative was concerned about a lack of stimulation for their relative, and access to the conservatory, which was mostly used by one person. This information was passed on to the registered manager, who undertook to look into it.

People's care plans were person centred. They included detailed information about people's personal history, individual preferences and information about activities they liked to take part in. For example one person had been a hairdresser, and their care plan highlighted how important it was for them to have their hair done regularly by a hairdresser of their choice. The home operated a 'service user of the day' system so that on each day one person was given a particular focus, and had all of their care records reviewed. This meant that approximately monthly all care plans were reviewed for each person. We found that this system was effective, with care plans amended appropriately when people's care needs changed. All care plans had a summary of information about the person at the front of the record, for easy access. However we did find some gaps in people's monitoring records, for example one persons pressure sore (Waterlow) assessment had not been completed for three months. This was passed on to the registered manager to be addressed.

The care staff told us that they would escalate any concerns to a senior care worker or manager, for example if someone lost weight or if they were unwell. They were able to describe good, responsive care and explain how they would care for people who exhibited behaviour that challenged. Referrals were made to health care professionals when people's needs changed, such as physiotherapy referrals if people became unsteady on their feet.

People living at the home and their relatives confirmed that they were consulted about their care when they moved into the home and their needs changed. This was recorded in people's care records. Monitoring records were in place for people who had particular needs such as mental health issues, or a risk of developing pressure ulcers. Health and social care professionals told us that they found the home's care plans to be clear and up to date.

Activities recorded for people included reminiscence, arts and crafts, bingo and quizzes, and musical entertainers attended the home regularly. A mobile library visited the home regularly. Some people went out in small groups with staff support, to the local shops, cafes, parks, and pubs. The main lounge/dining room was decorated with large, bright pictures and some drawings produced by people living at the home. There were some stimulating displays including photographs of people at various events, a skyline drawing of the city and a collage depicting the local area. Health and social care professionals told us that there were quite a lot of organised activities going on.

In addition to the care plans each person had a 'daily log' book. This was used to communicate between shifts and to summarise the care needs required on each shift. There was also a handover between each shift. We sat in on this, and found that information was shared appropriately.

Good

Is the service responsive?

People did not have any complaints about their needs being met, but said they felt able to speak up if they had any concerns. One relative told us, “I have no complaints whatsoever.” We asked staff how they would deal with complaints and concerns raised by people living at the home or their relatives or other representatives. They all said that they would deal with the complaint/concern at the time if they could, and also inform the registered manager. As one staff member noted, “if someone didn’t like the food I would offer them something else, but I would let the manager know.”

No complaints had been recorded since the previous inspection. However, although the complaints procedure was included in the home’s brochure, there was no visible notice about the complaints procedure nor a feedback book available in the home’s reception. It was suggested that the home maintain a record of informal concerns raised by people, and the action taken to demonstrate the home’s responsiveness in this area. This was discussed with the registered manager who advised that this would be considered.

Requires Improvement

Is the service well-led?

Our findings

People spoke positively about the management of the home, and particularly the assistant manager (the most senior person with whom they had most contact). Throughout our visit we found that the management were visible and accessible to people who used the service. People told us that meetings were held at which they talked about the care and services at the home. Relatives were very positive about the way the home was run, one relative told us "It's a small home, which suits [my relative] perfectly."

Health and social care professionals we spoke with did not have concerns about this home. Most bedrooms were single occupancy, but three were shared by two people in each. We were concerned to find that the relative of one person, and the placing authorities of four people sharing bedrooms were not aware that they did not have a room to themselves. At best this indicated poor communication about the living arrangements for these people. This placed people at risk of sharing a bedroom with a stranger, without their consent or a best interest decision being made. We notified the placing authorities, so that they could ensure that contractual arrangements were being met.

Staff described an 'open door policy' from management, and were very positive about the working environment. During the inspection we observed the assistant manager engaging with people, and leading the exercise session, demonstrating leadership by example.

Meetings were held quarterly for people living at the home and their representatives, at which they were able to participate in decision-making. Most recent topics discussed included activities, menus, the home environment, personal care, privacy and the home's management. We observed that issues raised by people at this meeting regarding the home environment, were addressed by the next meeting.

Staff explained the procedure for reporting items which needed to be repaired. Management were informed and items were documented in a maintenance book. Management then arranged for head office to undertake the work. Records indicated that maintenance issues were addressed swiftly. On the day of the inspection there was a minor fault with the lift, and this was reported and repaired on the same day.

Staff told us and records confirmed that there were regular fire drills and fire alarm checks and servicing of alarms and fire fighting equipment. A recently reviewed fire risk assessment and evacuation plan were in place. Certificates were available to demonstrate current and appropriate gas and electrical installation safety checks, and portable appliances testing. At the most recent food hygiene inspection by the local authority in January 2014 the home was awarded five stars (the maximum).

We asked the management how they reviewed the quality of the service. They showed us records of audits undertaken including those relating to medicines records, and the time taken for call bells to be answered. Quality assurance checks were also carried out by head office staff including some placement reviews, and reviews of staffing , financial audits, cleaning, fire safety and accidents and incidents.

Incident and accidents were recorded with details about any action taken and learning for the service. Staff said that learning from incidents was discussed at staff meetings and in their training.

The provider had a system to monitor and ascertain people's views of the quality of the care and support they received. The most recent feedback forms from 2014, returned by stakeholders in the home, were very positive about he service including comments such as, "They are excellent," "I found the staff very professional and friendly," and, "Record keeping is excellent and client centred."

Staff attended team meetings approximately quarterly. Minutes of recent meetings included discussion of rotas, personal care, cleaning, nutrition, key working, record keeping, maintenance, mental capacity and deprivation of liberty safeguards.

A programme of redecoration was underway in the home at the time of our inspection visit. We were provided with a schedule of the works to be undertaken, which included the areas that we found in need of improvement in the home environment.