Livability

Brookside House

Inspection report

Ash Close
Edgware
London
HA8 8YD

Tel: 02089592792
Website: www.livability.org.uk

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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 the 30 November and 5 December 2016 and was unannounced.

The previous inspection was on the 15 January 2014 where all standards inspected were met.

Brookside House is a residential care home providing accommodation and personal care for up to 24 people living with physical disabilities, sensory impairment and learning disabilities. The service is part of Livability a charitable organisation that provides care services nationally.

There is a registered manager. 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 told us they were happy living at Brookside House, there was a friendly and welcoming attitude from the registered manager and care staff. There was an ethos that this was people's homes and that they should be central to any decisions made about what took place there. The registered manager told staff to keep any stresses of running the service in the office and that it should not affect people in their home.

People told us they felt safe at the service and we saw that staff had a good understanding of safeguarding adults and the management team had ensured people understood their rights to a safe and happy life at the service. This had included people living at the service attending safeguarding training and making reporting concerns easier for people to do. Any complaints or concerned raised were responded to and addressed appropriately by the registered manager.

We observed staff to be respectful and proactive they offered support in a caring manner. There were conversations between staff and people whilst undertaking tasks and this promoted a friendly atmosphere in the service.

There were enough staff to meet people's support needs and there were robust recruitment processes for permanent staff and checks of agency staff documentation before they worked in the service. Staff told us they were well supported by the management team and had received training to support them to undertake their work. Training had included workshops about specific medical conditions that affected some people and they had been invited to attend and share their experiences with other staff to promote greater understanding.

Senior staff were trained to administer medicines and medicine administration records were completed appropriately and were audited to ensure mistakes were not made. People's care plans described how they showed pain and staff asked people if they required their pain relief to ensure they were pain free. There were no descriptions of the medicines use and side effects in people's records however we found senior staff

were knowledgeable about people's medicines. The registered manager agreed to ensure medicine information was included in the records as good practice for staff reference.

The registered manager demonstrated they understood their responsibility to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff had received training and obtained people's consent before supporting them.

There was a variety of meaningful activities for people to attend both inside the service and in the local area. There was a focus on promoting people's independence and initiatives had taken place utilising assisted technology in a pilot project. People had their own flat with accessible kitchen and bathroom facilities and good support was given by staff to personalise their flats to their own specification.

People told us they were involved with their care planning and that care was provided as they wanted it to be. We saw that care plans were specific to people's needs, however care plans did not record people's involvement so we brought this to the manager's attention who agreed to address this.

There were robust systems of auditing by the service and the provider to ensure the standard of care given. Auditing by the provider included twice yearly visits by the resident's engagement officer to ensure people felt they received the care and support they needed.

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. Staff demonstrated they understood how to recognise signs of abuse and knew how to report concerns.

The service had risk assessments in place to protect people from hazards and abuse.

There were enough staff to meet people's needs and there was a robust recruitment processes.

Senior staff had received medicine administration training and there were no gaps or errors in medicine administration records. Regular medicines audits and spot checks took place to ensure errors did not occur.

Is the service effective?

Good

The service was effective. Staff could demonstrate an understanding of the Mental Capacity Act 2005, and the registered manager understood when Deprivation of Liberty Safeguards (DoLS) should be applied for.

Staff received training and supervision to equip them to provide appropriate support to people.

There was evidence of effective health care and nutritional needs were being met.

Is the service caring?

Good

The service was caring. Staff were kind and proactive in their approach to people.

Staff treated people with dignity and respect, and understood the need to make new people feel welcomed and supported.

People were included in their care planning and people's diversity needs were identified and supported.

Is the service responsive?

Good

The service was responsive. People had individualised care plans

that were reviewed and updated on a regular basis.

People were given choice of activities and supported to be independent where possible.

The service had systems in place to address complaints.

Is the service well-led?

Good

The service was well-led. There was a registered manager in post and staff said they were well supported by a strong management team.

There was evidence of monitoring and auditing of the quality of the service given by the registered manager and the provider.

Brookside House

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 30 November and 5 December 2016 and was unannounced.

The inspection team consisted of one adult social care 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.

Prior to our visit the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service. We also reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

At the time of our visit there were twenty one people living at the service and we spoke with fourteen of them and three visiting relatives. We looked at four people's care records and their associated documents. We observed the medicines administration for seven people and checked their medicines administration records. We looked at four staff personnel records this included recruitment, supervision and training documents. We spoke with the registered manager and deputy manager, two team leaders, three support staff, domestic staff and the cook, the activities co-ordinator and a volunteer. In addition we met the visiting Livability Quality Support Team members and the resident's engagement officer.

We spoke with one visiting health care professional and following our inspection we spoke with the commissioning body.

Good

Is the service safe?

Our findings

People told us they felt safe at Brookside House "I wouldn't want to be anywhere else" describing the home as "lovely like a real family." There was a safeguarding adult policy and procedure and we saw that the registered manager had reported safeguarding concerns to the appropriate bodies when required. Staff had received safeguarding training and could tell us how they would recognise signs of abuse and they knew how to report concerns. There were poster reminders for both people and staff to "Speak up" and report any concerns. The home had recognised that not everyone found it easy to speak up if they had a concern as such they had developed a 'red card' system. In the reception area there were red cards that people could use to flash at a staff member they felt comfortable talking to (including the registered manager and deputy manager) to indicate they wished to talk about something in private. This allowed people a discreet way of raising any complaint that included safeguarding adult concerns.

People had individual risk assessments these included 'My bed rails', 'How I get in and out of bed - to be checked whilst in bed, moving equipment in good order, call bell to be near me'. Some other risk assessments included communication, activities, eating and drinking and out in the community. Although most risk assessments seen contained good detail some were a little generic and stated for example "Staff to always ensure they are providing [X] with support and guidance that [X] requires to ensure risk is diminished." Whist this ensures support and guidance is given it may not always be clear how that would be done. We brought this to the attention of the registered manager who agreed to review to ensure clear instructions are given to staff in all instances.

The service had taken measures to ensure people's safety in the event of a fire. People had a Personal Emergency Evacuation Plan (PEEP) to inform staff if people required support in the event of a fire. There was a description of people's mobility such as use of a hoist or wheel chair although staff assistance was identified the number of staff required was not on the assessment. We brought to the attention of the registered manager who agreed to address this. There was a 'PEEP at a glance' poster that was a quick reference tool for staff with each person's support stated. Most people living at Brookside House had physical disabilities and they were assessed as being unable to use the stairs, as such, each person's flat contained an evacuation 'sledge' to be used by staff and the fire service when the lift was not safe to use. Another measure to keep one hearing impaired person safe, was a device called a 'deaf guard' placed under their pillow that vibrated with flashing lights should the fire alarms go off. In addition on their flat door a notice read "I am deaf and require full assistance" thus alerting staff of their need for support. There were also 'easy read' fire procedures displayed and handed out to all the people living at the home for their reference in the event of a fire.

One relative told us "the maintenance man here is first class." The home was well maintained and checks to ensure environmental safety were undertaken. For example fire alarms were tested each week and this included the 'deaf guard'. Fire extinguishers had been serviced in November 2015 and scheduled for servicing, both fire extinguishers and fire blankets had a visual check each week.

There was a medicine administration policy and procedure that covered all aspects of medicine

administration including PRN (As and when needed medicines) and controlled drugs. We saw that medicines were kept securely at an appropriate temperature. Medicine administration records (MAR) seen were completed without gaps or errors. People were asked if they required pain relief as per their MAR and people's care plans stated for example "I am able to ask for pain relief." Senior support staff administered medicines and they had received appropriate training and yearly refreshers. There was no description in people's records of what medicines were used to treat and what side effects to look out for however staff administering were able to tell us what each medicine administered was used for. We brought to the attention of the registered manager that this would be good practice reference for staff. We observed that one staff member administered ear drops to one person and eye drops to another they did not wash their hands or use protective gloves as is appropriate to avoid cross infection. The registered manager agreed to address this with all staff administering medicines.

However throughout the rest of our visit we saw good hygiene control measures with staff using protective equipment such as disposable gloves and aprons. The home was clean and free from mal odour.

The service had a robust recruitment policy and procedure. Staff completed an application form and attended an interview. Prior to employment staff completed a Disclosure and Barring Service (DBS) check to ensure there was no history of criminal activity and these were renewed every three years as a good practice measure. Staff provided references from former employers and proof of identity to ensure they were safe to work with vulnerable adults. One person did not have references in their recruitment file as they had worked at the service for a long time and they were filed elsewhere. The registered manager sent the references to us immediately following our inspection.

One relative told us "The staff – particularly the manager have been lovely – they have no hesitation of staying beyond their shift hours if a situation demands it." During our inspection we saw there were enough staff on duty to meet the needs of the people in service, as such no one was kept waiting when call bells were pulled. People received support to eat their meals and were administered medicines in a timely manner. This was despite the fact that the lift had broken down during our second day's visit and lunch was carried to people to eat in their rooms whilst repairs took place. Staff confirmed if they were short staffed the management team would use bank or agency staff to support the staff group. The registered manager explained they used one staffing agency only and they have meet with them to discuss their staffing need and they now always see the agency staff profile, DBS confirmation and training certificates to ensure there has been a robust recruitment process by the agency.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found that the registered manager understood their responsibility to work to the MCA and had received MCA and DoLS training. We saw that people's records contained consent forms signed to say they consented to all aspects of their care and treatment. The registered manager explained that currently all people living at the home were assumed to have capacity as there had been no indication otherwise. As such no DoLS applications had been made. However the registered manager was able to demonstrate to us they understood when a DoLS application should be made on behalf of a person. Staff were able to tell us examples of when they obtained people's consent before acting. One staff member gave an example of a person who was reluctant to drink enough fluids. "[X] understands the importance of drinking enough, however we can't force [X]" describing they encourage and record fluids taken and refused, raising the matter if the fluid intake is low.

Newer staff confirmed they had received an induction. Describing they found care plans easy to follow and had shadowed experienced staff for two weeks before commencing work on their own. They were in the process of completing their probationary period and said they had found staff "helpful" and the registered manager "approachable and willing to talk." We saw that there were some gaps between supervision sessions longer than the supervision policy stated however all staff spoken with confirmed they had received supervision throughout the year and felt adequate support had been given.

A staff member told us "We do a lot of training here". All support staff had received training in core subjects this included emergency first aid at work, food hygiene, nutrition and hydration, health and safety, fire awareness, infection control, MCA and DoLS, moving and handling and safeguarding adults. Staff demonstrated they were knowledgeable about people's support needs and had attended workshops to understand people's medical conditions including spina bifida and multiple sclerosis awareness. Some people with these conditions had chosen to attend the workshops to share their experience and to participate in the training. The service found people were interested in the training provided to staff and had opened attendance to people who use the service as well as staff. As such people could for example attend safeguarding adults training alongside staff members to create a greater depth of understanding in the service. A visiting health care professional confirmed that staff took note of new treatments when shown. Key staff had attended training such as pressure ulcer care, diabetes care and catheter care, the registered manager explained the training matrix identified future training for the staff and this would be provided.

A visiting health care professional described the support staff as 'proactive' in getting the appropriate

medical support for people. People told us health care professionals visited on a regular basis; this included the GP, optician, podiatrist, dentist and physiotherapist. People's records indicated that people were supported to have occupational therapist support for changing support needs, speech and language therapist referrals when they had difficulty swallowing and people who required dressings and catheter care had regular district nurse support.

There was daily monitoring for people who had skin integrity concerns and instructions to staff to report to the seniors if the skin was red. Regular reviews of people's Waterlow (skin integrity) risk assessment had taken place. We saw one person's turning chart records were not always filled in every four hours as stated. The registered manager explained this was because they sometimes had asked not to be disturbed when sleeping. However this was not clear from the recording sheets. The registered manager who said they would change the recording to reflect when the person had asked not to be disturbed.

Some people had fluid charts when their fluid intake required monitoring to ensure they drank enough and action was taken to encourage more fluids when the intake was low. People who had a diagnosis of diabetes were supported to attend clinic appointments such as diabetic eye checks. Monthly weight monitoring took place to ensure people had maintained a healthy weight. People's care plans also highlighted their emotional support needs. Staff were therefore aware that some people required additional support because they had for example a progressive illness and plans stated when it might be appropriate to call the GP and refer to mental health support professionals.

There was a large print weekly menu distributed at the beginning of each week to give people time to make their choice. The menu rotated through four weeks offering a good choice to people. People could change their order up to two hours before the meal was served and could order something that was not on the menu provided they gave the cooks enough time to source the food items. People told us that the food served was "good" and "nice". We saw that portions were a good size and that people were offered second helpings. One person told us they liked a sandwich in the late evening and this was provided each evening for them. Following lunch the cook checked with people if they enjoyed their meal and the service asked for feedback with regard to the menus and made adjustments accordingly.

The service catered for people's dietary requirements this included people who required pureed food, diabetic and vegetarian diets. People were supported to remain hydrated. There were drink making facilities in each flat and fridges to store drinks. In the communal lounge there was an accessible kitchenette with a water cooler, tea and coffee making facilities. Tea and coffee were served at intervals throughout the day and we observed at lunch time the cold drinks trolley contained a number of different juices, squash, diet coke, water and lemonade to allow a wide choice. People who required support to drink were promptly offered support by staff who also gave people straws so they could drink independently.

The service was accessible for people with disabilities. There was a lift from the ground floor entrance to the upper floor. People flats were on the ground and upper floor and were adapted for their use with accessible bathroom and toilet. Each flat contained a cooker, washing machine and fridge with a work surface and sink that could be height adjusted according to people's need. A programme of updating the flats that was well underway with many completed with new flooring and equipment. There was an outside seating place at the front of the building but the garden at the back of the building was not accessible to people. This was because there was a considerable drop at the back of the building and the lift did not go to the basement and garden level. The garden required work undertaken to make it accessible for wheel chair users. The registered manager told us 'The Livability Home Design Appeal' had raised funds for a second lift to allow access to the garden and the under used basement area. This work was planned to start in summer 2017.

Good

Is the service caring?

Our findings

Whilst at the service we heard a lot of laughter in the lounge and people sat in groups talking and interacting with each other and staff. We saw staff were very engaged and warm towards people and knew their preferences and always checked what people might like. People were active and involved, nobody was left out. Recognising that not all people found it easy to start a conversation with others, the home used a 'green card' system. Should someone feel like a chat they could show a green card and staff would come to sit and talk with them initiating a conversation. This ensured shy people were included and not overlooked in what was a lively communal area.

New people were made welcome. The maintenance worker had supported one person who had lived at the service for a month to organise their flat just as they wanted it. Pictures and shelves had been put on walls for them and it already looked homely and personalised. The person told us they were pleased with their flat and were happy they had moved there. We saw staff and managers making a point of talking to this person throughout both inspection days and showed an interest in what they were doing to help them settle in.

We observed staff supporting people to eat and drink. Staff supported people very carefully, sitting next to them and chatted with people all the while, it was not just a task to be performed but a social event. Staff supported people to maintain their dignity, they were observant and anticipated people's needs for example one staff member saw a person required support to put on a clothes protector when eating and said" Would you like it tightened a bit ?" checking with them "there we go, is that okay now?".

We saw staff knocking on people's doors before asking if they could come in and people's care plans stated how people liked staff to enter their flats "I like for staff to knock on the door and wait for a response – if I do not answer I would like them to ask again" also "I like staff to tell me when they are leaving my flat".

The service had a Christian ethos and people's care plans contained people's diversity support needs for example one person's care plan stated "I am Hindu and am practicing my faith- staff to support me to a place of worship of my choice- staff to be respecting of my religious views". Our visit was prior to Christmas and celebrations were advertised for the Christmas party. The service had used volunteers to ensure the party contained traditional Christmas activities such as carol singing but also offered a display by Indian dancers for people in recognition of people's different cultural backgrounds.

The registered manager and staff understood that people with physical disabilities may require support to undertake their life choices and worked with people and their relatives to achieve those choices. As such just prior to our inspection the registered manager and staff supported two peoples choice to marry. This included arranging the hen and stag nights, service, transport, and reception. Relatives told us "Both my husband and I are so grateful to see them both so content". They continued "I don't think you could find a nicer place – we are always made welcome here at whatever time."

The home was proactive in trying out assistive technology to give people greater independence and was part of a pilot project that gave people tablets in their flats and offered technology support. People could,

for example communicate independently with friends and family without staff support through Skype. People were very positive about being able to do this. The technology could also be used by staff to monitor, for example, that a flat was at an appropriate temperature and avoided unnecessary intrusion when people wanted some space without staff knocking on their door.

All people we spoke with told us that care from staff was given as they wished it to be given and told us they had been fully involved in their care planning. We saw plans were individualised however the actual care plans were not signed and did not always state people and their relatives had been involved. We raised this with the registered manager who agreed to address this to reflect people's input.

Care plans contained end of life wishes giving in some instances names of the pastor and place of interment. One person had a Do Not Attempt Resuscitation form with their wishes in the event of their death.

Good

Is the service responsive?

Our findings

Care plans were individualised and specified how people wished to be supported. The plans gave a brief history, likes and dislikes. Support was detailed for example "Staff to open letters in front of me and hold up so I can read them" and "Likes to sleep on their side". Instructions for personal care were also detailed "Dry my skin with a patting motion as I have sensitive skin". People had very personalised flats contained their items of interest and full support was given to make people's flats as they wished them to be.

The registered manager told us "We promote independence, there is a big push to involve people" An example given was encouraging some people to use their own washing machines in their flats. We saw that one person had done their own washing with encouragement and the registered manager praised the person when they said they had done their washing. Another measure taken to promote independence was the inclusion of people in health and safety training with staff. One action resulting from this was first aid boxes placed in accessible positions in the corridors where people could help them self to a plaster without having to ask a staff member.

One person told us "It's a cheerful place and we go out quite a lot to places that really interest us – [X] likes going to the Air Museum and I like a good panto – sometimes we go to the pub for a boy's night out." Another person said the activities coordinator was "very inventive and took disability in her stride in planning holidays - I was in Southport this year (on holiday) meeting new people – it was fun but my friends are here." There was a three monthly agenda of trips and activities advertised in advance for people to choose from. The activities organiser was praised by people for arranging different activities that people suggested and for thinking up new ideas. There was a variety of activities at the home that included a quiz, coffee mornings, bingo, health and wellbeing sessions, yoga and games afternoons. Outside agencies were invited for occasional sessions as such Age Concern who were visiting to do Tai Chi with people. We saw that people were supported to join in, for example the yoga instructor visited a person who remained in their room as they did not feel up to joining the group. The service had been successful in negotiating with The Disability Foundation (A foundation that offers complimentary therapies to any person with any disability/ chronic illness, their families and carers) to provide complimentary therapy for nine months for people and also had recently won a local completion "In Edgware we care" for £500 worth of craft equipment for the home. The service also used volunteers to give a greater variety of skills and to assist with supporting the activities.

There was an adapted bus available for wheelchair users and people were supported to go out throughout the week. "We go swimming twice a week together" one person told us "It's the one thing I can safely do – and I'm good at it." In addition there had been trips to destinations such as the sea side, a canal trip on a barge adapted for wheelchair users "and an outing to a Christmas market was advertised over a number of days so people had a choice of dates.

There was a complaints policy and procedure in place and an accessible complaints form. Copies of the complaint procedure with the forms were displayed in the entrance. We saw that complaints made had been acknowledged and addressed with a written apology where appropriate. Action was then taken to

speak with the staff group and the resident's discussion group. Complaints were captured in one document to ensure that any trends were identified by the registered manager and reported to head office for scrutiny.

Good

Is the service well-led?

Our findings

People spoke highly of the registered manager "The manager tells us this is our home not hers." The deputy manager told us "We want any stresses about running the home to remain in the office it should not affect people living here as this is their home." A new member of staff told us that the management "try to make the work less stressful for staff they want the service to be calm for people". Both the registered manager and the deputy manager were proactive and committed to making positive changes for people living in the service. All staff spoke highly of the registered manager describing her as approachable and also found the deputy manager supportive in particular in managing the new computer system. One staff member said "It's great to have a strong management team." The registered manager explained herself and the deputy manager aimed to be visible and accessible to people in the service and as role models for staff.

The service placed emphasis on people's views being heard. A notice displayed the dates for the residents meetings for the year and the previous meeting minutes were displayed for all to read. This ensured people knew when the meetings were due and could prepare to attend. We saw that matters people raised in the meetings were actioned. For example one person had raised they would like eggs on the menu for breakfast more often. When we arrived at the service the registered manager had just cooked servings of scrambled egg for people and was working with people in the dining area alongside kitchen and support staff. There was also a suggestions box for people to use if they wished to write their ideas rather than speak up.

There was a quarterly Brookside House newsletter; the summer edition included telling people's news, service updates, advertising training events that people could attend, welcoming new people to the service and giving the Brookside word search containing the CQC values. Feedback regarding the service was also sought through the yearly resident's survey. The results for 2015 were on display in the reception area. During our inspection the Livability engagement officer visited and spoke with people in the home as part of her role asking questions about their experience to ascertain if they were happy and felt safe at the home and to ensure the standard of care given was good.

Staff confirmed that there were staff meetings about every two months and they felt comfortable raising any concerns. We observed that there was a daily staff handover to the on -coming shift. All care staff attended and each person was discussed and important information such as medicine changes were highlighted. Staff told us they also read through the communication book and diary to keep informed.

To ensure the quality of the service there were weekly checks of the environment by the maintenance worker, weekly medicines checks and spot checks by senior staff and a six monthly audit by the registered manager. People's care plans were on a computer system that flagged when a review was due this enabled the registered manager to monitor that each person's records were up to date. The registered manager kept a matrix of complaints, safeguarding referrals and incidents and accidents such as falls, these were sent to the Livability Health and Safety team for scrutiny and overview of trends in the service.

The Livability quality procurement department and service user engagement officer visited Brookside House twice a year. They had visited in June 2016 and their second visit coincided with our visit on the 30

November. They told us they looked at health and safety, quality and practice and service user participation. They had at their previous visit found actions required and an action plan had been produced with a ratings system of red, amber and green to denote urgency. As such their second visit on the 30 November was to validate the action plan and ensure actions identified had been addressed. In addition the team checked care files and daily notes remotely on the computer system to ensure a good standard.

The commissioning body confirmed that the registered manager at Brookside House was working closely with them and welcomed new ideas and initiatives. The registered manager told us that they found going to the local authority provider forums supportive as they could meet other providers and share good practice.