Brook House Dorset Limited

Brook House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We undertook an unannounced inspection on 9 September 2015. The inspection continued on the 11 September and this was announced

The service is registered to provide accommodation and personal care for up to 10 adults. The service has eight single rooms and one double room that is used for single occupancy. When we carried out our inspection there were eight people living at the service. There are two bathrooms, one of which has a walk- in bath. The service has a lounge and dining area that people are free to use at any time. The accommodation is over two floors and the first floor can be accessed by a stair lift. The majority of the building would not be suitable for the use of a hoist to support people with moving and handling. Each room has a call bell fitted so that people can call for help when needed.

Summary of findings

The service has 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 that they feel safe living at the service and had confidence in the people who cared for them. They told us that there were always staff about to help them and they responded quickly to call bells. Staff told us that they had regular safeguarding training and knew how to recognise and report any signs of abuse. We looked at staff recruitment and found that staff were being recruited safely with all the necessary checks carried out. Staff files contained evidence of training, supervision and a yearly appraisal. Staff had received the mandatory training and in addition training specific to the needs of the people living in the service. An example was a person had moved to the service and had diabetes and staff recognised that they needed additional training to understand the condition and support the person.

Each person had care files that contained assessments of any risk to their health and wellbeing. Care plans were in place which detailed the care and support people needed to remain safe whilst having control and making choices about how they choose to live their lives. When we spoke to people using the service we found that the records didn't consistently reflect what we were being told or what we observed. We raised this with the registered manager who agreed to review the risk assessments and care files.

Medication was stored safely and records were being kept accurately. However, we were told that one person was self-medicating her insulin and risk assessments were not in place to ensure her safety.

Records for the maintenance and service of equipment was up to date, this included fire drills being held with all staff six monthly. Personal fire evacuation plans were not available to evidence on day of inspection. These are to ensure each person's individual risks are understood in the event of an emergency. We also found that the emergency contingency plan was not available to evidence. This would contain information on how the service would keep people safe in the event of a major incident which affected the running of the service.

We found the home clean in all areas other than one bedroom and the reasons for this and the actions taken were well recorded. The records demonstrated a good understanding of the person's history and the least restrictive measures taken to reduce any risk of infection.

People told us that they are always cared for by people they know and who knew them well. We spoke to a mental health professional who had supported a person moving into the service. They told us "The staff have taken time to understand him and his needs. They showed compassion and understanding".

Each person living at the service had a mental capacity assessment carried out prior to admission. We found that a mental health review had been carried out for one person by the community mental health team. The mental capacity review the service were carrying out each month did not reflect this information. Although senior staff have completed training more understanding is needed of the legislation. This is so that people who lack some mental capacity are safeguarded and decisions about their care and treatment are made in line with the legislation protecting their best interests. We discussed with the registered manager who told us he will arrange more refresher training for senior staff.

People told us that the food was good, one person said "Some food is very good, they make lovely sauces", another person told us "You're offered two choices for lunch". People's weight was monitored and the staff were aware of the support available from specialist dieticians should it be needed. People told us that they regularly have access to GP's, chiropodists, opticians, dentists and other health professionals.

People, their visitors and health and social care professionals all told us the service was caring. One health professional said "Would be happy for my mum to live in the home, the staff really know the residents". A GP told us "They look after people with care and love". One person told us "I have a little chat with the staff when they help me; it keeps me in touch with the real world".

Six people of the eight people living in the service spent most of their time in their rooms. Four of these people told us they enjoyed being in their room all the time. A visitor told us "I visit weekly; the person I visit doesn't want to go out but likes to be in their room. They enjoy music and do crosswords and have a daily newspaper".

Summary of findings

However another person told us “Don’t feel free enough. Could do with a change of scenery”. Although most people we spoke to were happy with how their time was spent not everybody felt they had been given the opportunity and support to make choices about doing things that interested them.

Earlier in the year we had received a concern about a lack of information when a person was transferred to hospital. We looked at the paperwork the service uses which includes information about why the emergency admission was needed. It also included a list of medication and a record of all the medication taken that day and important contact numbers. The information provided would ensure people get consistent health and medical care. At times people will be transferred to another service and not have the mental capacity to explain how they like to be supported with their care. Information added to the transfer information about the individual care and support needs of people would ensure consistency with person centred care.

People, their families and friends, health and social care professionals and the staff all told us they felt the service was well managed. The manager carries out regular quality audits, including health and safety, moving and handling, accidents and incidents and medication. The audits were up to date and any actions identified had been completed. The service has a complaints process and also annually asks people who use the service and their families to complete a quality assurance questionnaire to gather information about how people view the service. We saw that information gathered was acted upon to improve the experience for one person using 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?

Requires Improvement

People told us that they felt safe living at the service and have confidence in the staff that cares for them.

Staff had undertaken safeguarding training and understood how to recognise and report abuse.

Medication was stored safely and records were being kept accurately. However, one person was recorded as self-medicating her insulin and risk assessments were not in place to ensure her safety

Risk assessments and care files were not always reflecting what people told us and what we observed.

Staff had fire training and regularly carried out fire drills. Fire equipment was maintained and serviced regularly. Personal fire evacuation plans for the people living in the service were not available to evidence on day of inspection. These are needed to ensure each person's individual risks are understood in the event of a fire.

The emergency contingency plan was not available to evidence. This would contain information on how the service would keep people safe if a major incident occurred which affected the running of the service.

Is the service effective?

Requires Improvement

Staff were able to tell us that they have up to date training in both mandatory subjects and specialist training that is specific to people they are caring for. This enables staff to care effectively for the people living in the service.

People had access to an advocacy service and this had been used to support people with decisions about their care

Mental capacity assessments had been completed and were being reviewed regularly but did not reflect the findings of a mental health professional's review.

Is the service caring?

Good

The service was caring. People were treated with respect, understanding and compassion.

Staff had a good understanding of the people they cared for and supported them in decisions about how they liked to live their lives.

Is the service responsive?

Good

Health professionals told us that the service respond to health issues quickly and learn from lessons.

Care was delivered in a person centred way.

Summary of findings

A complaints procedure was in place and people knew about it and felt able to use it if necessary	
Is the service well-led? People we talked to told us they felt the service was well led. We observed the manager supporting staff in reviewing practice, listening to staffs views and supporting in finding solutions. We also found this in supervision and appraisal records. Regular audits of the service are carried out to ensure the service is safe and operating in line with legislation. Peoples views on the service are gathered regularly through a quality assurance process and where appropriate actions are taken to improve the quality of service to individuals	**Good**

Brook 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.

This inspection took place on 9 September 2015 and was unannounced. The inspection continued on the 11 September and this was announced. The inspection was carried out by a single inspector.

Before the inspection we looked at notifications we had received about the service. We spoke to the local authority contract monitoring team to get information on their experience of the service.

Before the inspection we did not request a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information from the provider during the inspection.

We spoke with seven people who use the service and four people who were visiting. We spoke with a GP, a district nurse and a healthcare assistant, a social worker and a specialist in the community mental health team who all had experience of the service. We spoke with the Registered Manager, Deputy Manager and two care workers. We reviewed three peoples care files and discussed with them their accuracy. We looked at health and safety records, maintenance records, medication records and management audits of the service. We observed the care practice and walked around the building. We looked at three staff files and looked at recruitment practice, supervision and training records.

Requires Improvement

Is the service safe?

Our findings

Medication was stored securely and records about medication administered to people were clear. The staff told us that one person self-administered their insulin injection each morning. They told us that they stored the insulin, draw up the correct amount and that the person then injected the insulin. A district nurse had supported the person with this and assessed them as competent over a year ago when they had moved to the service. However when we spoke with the person they told us "Staff inject me, it never hurts. Can't do it myself, can't see, you need to know the spot". The care records did not have a risk assessment in place to support the person's safety, including regular reviews of her competency to carry out the self-administration.

One person told us that staff supported them to access money from the bank as they liked to pay for their rent and shopping in cash. The provider had not made adequate arrangements to reduce the risks associated with supporting people with their finances. We raised this with the registered manager who agreed to review the arrangements and risks.

Personal fire evacuation plans for the people living in the service had not been completed. These are needed to ensure each person's individual risks are understood in the event of an emergency. We raised this with the registered manager who agreed to complete personal fire evacuation plans.

People's risks were not always assessed. We talked with a person about their mobility and they told us they used a zimmer frame. The zimmer frame was next to their chair. Their care plan, although it had been signed to show it was regularly reviewed did not mention the person's need for the zimmer frame.

People told us that they feel safe living at the service. They told us that they had confidence in the skills of the people that provided care to them. They told us they would be able to raise concerns if they needed. Staff was able to tell us that they had regular safeguarding training and had a good understanding of whistleblowing. Training and supervision records evidenced training and staff understanding. We saw notices around the service giving information on what to do if you suspect abuse and who to report this too. We looked at a staff file for a person who was being recruited to the service and all the mandatory checks had been carried out to ensure the person was fit to work with vulnerable people.

People were supported to manage risks in a non-discriminatory way. For example a person choose to participate in activities which increased their risk of falls. The persons care plan explained the risk and actions taken to reduce this. This included making changes to the layout of the person's room to make moving about easier and having a call bell next to them. We spoke with the person about this and they told us they were happy with how they lived and how staff supported them.

Records for the maintenance of equipment and the premises, including fire equipment were up to date. The last fire service inspection was 3 February 2012 and the service met regulations. Records showed us that a practice fire drill was carried out with all five staff every six months. The service did not have an emergency contingency plan which would need to contain information on how the service would keep people safe in the event of a major incident which affected the running of the service. We were told that a verbal arrangement is in place with another residential home. We discussed this with the registered manager who agreed to review the arrangements and risks and produce an emergency contingency plan.

People and their visitors told us that there were always enough staff in the service and they had the skills to support them with their care. We spoke with a person about support through the night who told us, "I have a bell and they come quickly". Another person told us, "I'm a poor sleeper and there is always somebody about through the night".

We spoke to a member of staff who was able to tell us about safe practice in using personal protective equipment to reduce the risk of infection. We found the home to be clean in both public areas, bathrooms and peoples own rooms. However one person's room did have an unpleasant odour. We were able to look in the persons care plan and see that the person had a history of storing uneaten food and continence materials around his room and was often not happy for staff to remove them. When we spoke to staff they had a good understanding of this person's life history and the background to this behaviour. The care records explained the approach staff needed to support the person and reduce infection risks.

Requires Improvement

Is the service safe?

We recommended the service consider professional guidance in relation to supporting people to self-administer medication.

Requires Improvement

Is the service effective?

Our findings

Mental capacity assessments had been completed before people started using the service. The registered manager told us that all the people living at the service had the mental capacity to make decisions about their care. One person's file contained information from a review carried out on 26 March 2015 by the mental health community team. The mental health specialists report stated that the person had cognitive impairment and memory loss. The mental capacity review the service carried out each month did not reflect this information. The registered manager and deputy manager had completed training in November 2013 on the Mental Capacity Act. Although senior staff have completed training they were not following the principles of the act. This is to ensure that people who lack some mental capacity are safeguarded and decisions about their care and treatment are made in line with the legislation protecting their best interests. We discussed this with the registered manager who told us they would arrange more refresher training for themselves.

People told us that they are always cared for by staff who they knew well. Staff had a good knowledge of the care and support needs of people living at the service. This included knowledge of a person's life history, how they like to live their lives, and their physical and mental health. We spoke with a specialist mental health professional that had supported a person moving into the service. They told us "The staff have taken time to understand their needs. They showed compassion and understanding".

The three staff files we looked at contained information on completed training and had supporting certificates. Training was provided both by external providers, such as the NHS for medication training, and e-learning. Training included mandatory subjects and there was training specific to people living at the service. Staff, as part of their annual appraisal, identified a need for training on diabetes. This was because a person with diabetes had moved to the service. Staff completed this training. A care worker told us that training was always available and they had refresher training regularly. One file we looked at was for a person who was in the process of starting employment. The registered manager told us that he had organised for them to complete their care certificate induction externally prior to starting work. We saw evidence of this on their staff file. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training.

Each of the care files we looked at had a consent form signed by the person living at the service. The consent was for the care and support plan, sharing information with other professionals, entering their room, requesting GP and other health professional's visits. It also explained that somebody could withdraw their consent at any time. Two files contained information about people being supported by an independent voluntary advocate in decisions about their care. The notice board displayed information about the advocacy service and how to contact them. Two files we looked at had detailed information about people being involved in decisions about consenting to health care. One example was a person who had an annual outpatient appointment at the hospital. The records stated that after speaking to her GP and Optician she had made a decision not to attend the appointments and asked staff to cancel it on their behalf.

End of life plans that had been completed by the matron of the GP practice with people living in the service. This included 'do not actively resuscitate' orders that met current guidance. People were involved in these decisions.

People were offered food and drinks throughout the day. None of the people living in the service needed support with eating and drinking. People's weights were reviewed monthly by the Deputy Manager. A recent comment on a quality assurance questionnaire form was a resident requesting that they have fish every day. As a result of this each day a member of staff now ensures that they are offered fish as a meal option.

One person had diabetes and the district nurse regularly took bloods to monitor their wellbeing. We spoke to this person and they had a good understanding of what they could eat. They told me "I can eat anything within reason. Some food is very good, they make lovely sauces, you're not always asked what you would like but they've got a good cook". Another person we spoke to said to us "The food is quite good but no choice, just have what they give you". Another person told us "You're offered two choices for lunch". We observed a lunch being served. Seven people chose to eat their meal in their rooms and one person had their meal in the lounge. The service does have a dining room but during our inspection this was not used and

Requires Improvement

Is the service effective?

people told us they preferred meals in their rooms. The meal was well presented and looked and smelled appetising. We looked at the menu planner which on most days showed two choices for the main meal and also hot and cold choices for breakfast, teatime and supper. We discussed with a member of staff what alternatives were available and they told us "anything anybody wants we will get for them".

We spoke with a GP who told us "The home call us regularly, they let us know of any changes in people's health but equally are not time wasters. They try and offer a home for the rest of peoples life's albeit if not able to manage would support people to move on". People told us that they could access opticians, dentists, chiropody, GP's and other health professionals when they needed.

The building that the service operates from is on two floors and has a stair lift to assist people going up and down stairs. One person told us they enjoyed afternoons downstairs. They told us the stair lift has been fitted since they moved in which enabled them to access the lounge to meet their friend. Another person who lives upstairs and chooses to spend most of her time in her room told us she has poor mobility but said that if a member of staff helps she feels safe to use the stair lift. One room is particularly small and it is not possible to access the wardrobe so the person's clothes are stored in drawers and under the bed. The service had two bathrooms. One had a standard bath and the second had a walk in bath fitted. There were two small gardens that were accessible to people living at the service. The people met with visitors in their own rooms but there is also a lounge and dining room where people could meet family and friends.

Good

Is the service caring?

Our findings

People, their visitors and health and social care professionals all told us that the service was caring. One health professional said "I would be happy for my mum to live in the home; the staff really know the residents'. A GP told us "They look after people with care and love". A community mental health specialist told us their patient had been treated with compassion and understanding.

The service has a small family staff team of five people. People who lived at the service told us "I feel I could talk to the staff if I was unhappy". Another comment was "I have a little chat with the staff when they help me; it keeps me in touch with the real world". Other comments were "I feel so well looked after and I'm so comfy in my room". We observed staff and the people living at the service laughing and talking together and sharing stories about their families.

Staff had a good understanding of the history of people living in the service and how this impacted on how people wanted to live their lives. One person told us they liked their own company and preferred to look after themselves. Staff were able to tell us about how they had built trust with this person over time by respecting how they wished to live their life but working with them to improve their health and personal care. This person's mobility had decreased and they told us how the layout of their room had been changed to help them get around easier. They told us "I really trust the people who care for me and I like it here. The staff get my shopping for me, the food is really good, and everything is good". The care records supported the actions agreed between staff and this person. One care entry said 'Allowed me to speak to doctor about his medication'. This demonstrated that staff were caring for people in a person centred way and listening and respecting people views and wishes.

A person with a sensory impairment was supported by staff to enjoy their free time. The person had poor sight and told us "I only asked about talking books and they, (the staff), sorted it out for me. The library were bringing them too early in the day and so I've asked for them to come later".

Information was displayed in the lounge giving details of an advocacy service. Staff were also able to give us two examples of an advocacy service being used to support people. One person had recently moved to the service and an advocate had been involved in supporting them make decisions about their future.

People's privacy was respected. We saw staff knocking before entering bedrooms and ensuring bedroom doors were closed when a person requested this. Another person had requested she not be disturbed before 10.30 am and this was documented in her care file and staff were aware and respected this.

People's friends and relatives visiting the service told us they can visit at any time. They told us that staff always made them welcome and that they thought communication was good between staff and themselves. We spoke to a visitor from a local church who told us "When I visit I always ask 'Are you happy and are the staff kind' and I've never had any concerns".

The service keeps copies of compliments they receive. We saw evidence of cards were families had thanked staff for their kindness and care when supporting a loved one at the end of their life.

Good

Is the service responsive?

Our findings

The care files had information that had been gathered by the service prior to a person moving to the home. The information had been obtained from other professionals, the person themselves and their families. This information had been used to create an initial care plan that reflected how a person liked to live and the level of support they needed. It contained information about their health and medication and also the people important to them.

A visiting health professional told us "The home respond quickly to issues; as an example I've been asked to carry out a continence assessment on a person whose continence needs appear to be changing". After the inspection we called a district nurse who visits the service who told us "The home are quick to call if they have any concerns".

People told us they are supported to keep in touch with family and friends and their local community. One person told us that they have support every week to speak to their family on the phone. Another person told us that a music man visits regularly and that they really enjoy it. We also spoke with people who didn't feel supported in their interests and social activities. One person told us "I don't feel free enough. I could do with a change of scenery. I've never been asked what I would like to do, just go with the flow. It would be nice to go out but there is nobody to push my wheelchair". Another person told us that they had not been out for eight months as no family nearby to support. A visitor who told us, "I visit weekly; the person I visit doesn't want to go out but likes to be in her room. She enjoys music and does crosswords and has a daily newspaper". Staff told us that they drive a person to her fortnightly hair appointment and that they will always take people to visit family and friends if there in hospital or unwell. In each person's care plan is a record of how they have spent the day. Although most people we spoke with were happy with how their time was spent not everybody felt they had been given the opportunity to make choices about doing things that interested them.

We spoke with people at the service and their visitors and they told us that they would know who to speak to if they had a complaint and felt able to do this. We saw information on the notice board about how to make a complaint. When we went into people's rooms there was a copy of the homes guide for people living at the service explaining what they could expect and included how to make a complaint. We looked at the complaints log, there had been no complaints logged since the last inspection.

We talked to staff about how they ensure people get consistent, person centred care if they needed an emergency hospital admission. The service showed us the paperwork that they would provide which gave information about why the emergency admission was needed. When the admission is arranged by the GP they also provide information for the admitting staff at the hospital. The paperwork also included a list of medication and a record of all the medication taken that day. Information of contact details for family and other support is provided. The information provided when a person is transferred would give the hospital staff the information they need to ensure people get consistent health and medical care.

Good

Is the service well-led?

Our findings

People, their families and friends, health and social care professionals and the staff all told us they felt the service was well managed. During our two day inspection we observed the manager supporting staff in reviewing practice, listening to staffs views and together finding solutions. This was also what we found when we looked at staff supervision and appraisal records.

Talking to people who use the service and looking at care notes showed us that peoples wishes were respected when care and support was being provided. The manager and staff throughout our visit were very clear about the importance of people having choices about how they choose to live and gave us examples of how this is respected. We observed staff treating people with respect, dignity and compassion and other professionals we spoke to after our visit told us this was also their experience of the service. However, we discussed with the registered manager that more understanding is needed of the Mental Capacity Act. This is to ensure that people who lack mental capacity are safeguarded and decisions about their care and treatment are made in line with the legislation protecting their best interest.

The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

The manager carried out regular quality audits. We looked at completed audits for health and safety, infection control, moving and handling, accidents and incidents. There were also medication audits carried out by the home and an external audit completed six monthly by the local pharmacy. The audits were up to date and any actions identified had been completed. However, none of the quality audits had identified issues we had found with risk assessments and mental capacity act assessments.

We saw evidence of a completed quality assurance questionnaire that is given to residents and their families to gather information about people's views of the service. Overall the feedback on the questionnaires was very positive.

The registered manager is a member of the Dorset Care Association and attends training days and workshops to keep up to date with practice. In June the manager attended a 'Creating Inclusion Seminar' which explored ideas in reducing social isolation in care environments. We were told that this hadn't led to a change in current practice but was knowledge for any future opportunities.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.