DSRE Services Limited

Brownhill Lodge

Inspection report

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Date of inspection visit:
20 November 2018
21 November 2018

Date of publication:
24 January 2019

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 20 and 21 November 2018 and was unannounced.

Brownhill lodge is a 'care home' providing residential care for older people with dementia. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Brownhill lodge accommodates up to 21 people. There were 18 people using the service at the time of our inspection.

At our last inspection of this service on 21 June 2016 the service was rated Good. At this inspection we found the service remained Good. The service demonstrated they continued to meet the regulations and fundamental standards. The last inspection rating of the service was displayed correctly in the communal area of the service.

The service had a registered manager in post. 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.

Staff knew how to keep people safe. The service had clear procedures to support staff to recognise and respond to abuse. The registered manager and staff completed safeguarding training. Staff completed risk assessments for every person who used the service and they were up to date with detailed guidance for staff to reduce risks.

The service had an effective system to manage accidents and incidents, and to prevent them happening again. The provider recognised people's need for stimulation and social interaction. People had end-of-life care plans in place to ensure their preferences at the end of their lives were met. Staff completed daily care records to show what support and care they provided to each person.

The provider carried out comprehensive background checks of staff before they started working and there were enough staff to provide support to people. Medicines were managed safely and people were receiving their medicines as prescribed. Staff received medicines management training and their competency was checked. All medicines were stored safely. The service had arrangements to deal with emergencies and staff were aware of the provider's infection control procedures and they maintained the premises safely.

The provider trained staff to support people and meet their needs. People told us that staff were knowledgeable about their roles and that they were satisfied with the way staff looked after them. The provider supported staff through regular supervision and yearly appraisal.

The registered manager and staff understood their roles and responsibilities under the Mental Capacity Act

2005 Deprivation of Liberty Safeguards . People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. People consented to their care before they were delivered.

Staff assessed people's nutritional needs and supported them to maintain a balanced diet. Staff supported people to access the healthcare services they required, and monitored their healthcare appointments. The registered manager and staff liaised with external health and social care professionals to meet people's needs.

People or their relatives, where appropriate, were involved in the assessment, planning and review of their care. Staff considered people's choices, health and social care needs, and their general wellbeing.

Staff supported people in a way which was kind, caring, and respectful. Staff protected people's privacy and dignity.

The service had a clear policy and procedure about managing complaints. People knew how to complain and told us they would do so if necessary. The provider sought the views of people and staff to improve the service. Staff felt supported by the registered manager. The provider had effective systems and processes to assess and monitor the quality of the care people received which helped drive service improvements. The provider worked effectively with health and social care professionals, and commissioners.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Brownhill Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 20 and 21 November 2018 and was unannounced. A specialist nurse advisor and one inspector inspected on 20 November 2018. The inspector and an expert by experience returned to the service on 21 November 2018 to complete the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

This service was selected to be part of our national review, looking at the quality of oral health care support for people living in care homes. The inspection team included a dental inspector who looked in detail at how well the service supported people with their oral health. This includes support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019.

Before the inspection we looked at all the information we held about the service. This information included the statutory notifications that the service sent to the Care Quality Commission. A notification is information about important events that the service is required to send us by law. The provider had completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We also contacted health and social care professionals involved in people's support, and the local authority safeguarding team for their feedback about the service. We used this information to help inform our inspection planning.

During the inspection we spoke with eight people and two relatives, six members of staff, and the registered manager. We also spent time observing the support provided to people in communal areas, during meal times, and medication round.

We looked at eight people's care records and seven staff records. We also looked at records related to the

management of the service such as the quality audits, administration of medicines, accidents and incidents reports, Deprivation of Liberty Safeguards (DoLS) authorisations, health and safety records, and the provider's policies and procedures.

Good

Is the service safe?

Our findings

People told us they felt safe and that staff and the registered manager treated them well. One person told us, "I feel very safe." Another person said, "I feel very safe, I have never had any problems."

The service had a policy and procedure for safeguarding adults from abuse. The registered manager and staff understood what abuse was, the types of abuse, and the signs to look for. Staff knew what to do if they suspected abuse. This included reporting their concerns to the registered manager, the local authority safeguarding team, and the Care Quality Commission (CQC) where necessary. Staff told us they completed safeguarding training. The training records we looked at confirmed this. Staff knew the procedure for whistle-blowing and said they would use it if they needed to. One member of staff told us, "If we find anything like hitting, shouting, pulling the client, change of mood, then I will straight away inform the manager. If they don't listen, I will inform the social worker." The service maintained records of safeguarding alerts and monitored their progress to enable learning from the outcomes when known. The registered manager implemented performance improvement plans for staff to make sure they used incidents as an opportunity for learning. The service worked in cooperation with the local authority, in relation to safeguarding investigations and they notified the CQC of these as they were required to do.

Staff completed risk assessments for every person who used the service. These included manual handling risks, falls, eating and drinking, pressure sore prevention and wound care. The risk assessments we reviewed, were all up to date and had detailed guidance for staff to reduce risks. For example, where the risk of pressure sores was identified, staff sought the advice of the tissue viability nurse (TVN). A risk management plan included the support people needed to prevent pressure sores and the use of correct equipment. Staff monitored people's skin regularly and records we saw confirmed this. In another example, where a person was identified at risk of falls, their risk management plan stated what equipment should be used to help prevent falls and we observed that this was put in place. In a third example, where a person was identified at risk of epileptic seizures, staff spoken with were aware of the protocols to follow. We observed staff transferring people using best practice moving and handling techniques. Hoists were used and staff communicated with people clearly. They worked in a pair as required for hoisting people safely. Staff confirmed they were trained and updated yearly with lifting and manual handling training. One member of staff told us, "I always transfer with another staff and I have been trained.''

The service had a system to manage accidents and incidents to reduce them happening again. Staff completed accidents and incidents records. These included actions staff took to respond and minimise future risks, and who they notified, such as a relative or healthcare professional. The registered manager saw each incident record and monitored them. Records we looked at showed examples of changes made after incidents occurred. For example, following an incident of a fall the person was referred to the hospital and to their GP for their medicines to be reviewed and improve their mobility. We noted that their care plan had subsequently been updated to include further guidance for staff on how best to support them, and records showed that this had been discussed with staff during staff meeting.

Staff administered prescribed medicine to people safely and in a timely manner. One person told us, "The

staff help me with my medicines and they would explain it to me." Another person said, "Staff give me my medicine and it is on time." The medicines trolley was locked at all times. The provider trained and assessed the competency of staff authorised to administer medicines. Medicines administration records (MARs) were up to date and the medicine administered was clearly recorded. The service had PRN (as required) medicine protocols in place for any medicines that people had been prescribed but did not need routinely. The protocols gave information about when the medicines should be given. Regular medicines checks were carried out by the registered manager and if areas of improvement were identified these were put into an action plan.

People were supported by sufficient numbers of effectively deployed staff. The provider carried out a dependency assessment to identify staffing levels required to meet the needs of people using the service. The dependency assessment was kept under regular review to determine if the service needed to change staffing levels to meet people's needs. The staff rota showed that staffing levels were consistently maintained, to meet the assessed needs of the people. If they needed extra support to help people, the registered manager arranged additional staff to cover.
The provider carried out comprehensive background checks of staff before they started work. These checks included qualifications and experience, employment history and any gaps in employment, references, criminal records checks, health declaration, and proof of identification. This ensured staff who worked with people were suitable to do so.

The service had arrangements in place to deal with emergencies. The service carried out regular fire drills and records we saw confirmed this. Staff completed personal emergency evacuation plans (PEEPs) for every person who used the service. These included contact numbers for emergency services and provided advice for staff on what to do in a range of possible emergency situations. Staff received first aid and fire awareness training so that they could support people safely in an emergency.

People lived in a clean and safe environment. Staff were aware of the provider's infection control procedures. We observed staff using personal protective equipment such as gloves, and aprons to prevent the spread of infection. There was an infection control policy in place. The home smelt fresh and the bedrooms and communal areas were kept clean and tidy. We saw the floor areas were uncluttered with enough space for manoeuvring chairs and hoists. Staff and external agencies where this was necessary carried out safety checks for fire, gas safety, hoists, slings, portable appliances, emergency lighting and electrical equipment installed.

Good

Is the service effective?

Our findings

The provider trained staff to support people and meet their needs. Staff told us they completed comprehensive induction training when they started work, and a period of shadowing an experienced member of staff. Records showed induction training was completed in line with the Care Certificate which is a nationally recognised way of training staff new to social care. Staff told us they had completed mandatory training identified by the provider. The mandatory training covered areas from basic life support, food safety, health and safety, infection control, safeguarding vulnerable adults, moving and handling and the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff told us the training programmes enabled them to deliver the care and support people needed. The service provided refresher training to staff as and when they needed. Staff training records we saw confirmed this.

Records showed the provider supported staff through regular supervision and a yearly appraisal. They included discussions about staff members' wellbeing and sickness absence, their roles and responsibilities, and their training and development plans. Staff told us they felt supported and could approach the registered manager, at any time for support.

People's needs were assessed prior to their admission to ensure the provider could meet these. The assessments involved people and feedback from relatives, where appropriate and covered medical conditions, physical and mental health, personal care, mobility, nutrition and skin care needs. The assessment considered the level of support they required, their choices and preferences, day-to-day needs and any identified areas in which they needed support. This information was used as the basis for developing personalised care plans to meet their individual needs.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. The registered manager knew the conditions under which an authorisation may be required to deprive a person of their liberty in the best interests under DoLS. Records showed that appropriate applications had been made, and authorisations were adhered to.

Records showed that people's mental capacity had been assessed relating to specific decisions about the support they received where staff suspected they may not have capacity to make the decision for

themselves. Assessments had been completed in accordance with the requirements of the MCA. Where people had been assessed as lacking capacity we saw that the relevant decision had been made in their best interests, with the involvement of staff, relatives and/or healthcare professionals, where appropriate. For example, about the use of seat belts and bed rails.

Staff asked for people's consent, where they had the capacity to consent to their care. One person told us, "Yes, staff will ask my permission before they do something." Another person said, "Staff would let me know what they are going to do." Records were clear on people's choices and preferences about their care provision and how staff sought their consent before giving them care in relation to giving them a wash, shower or personal care. Staff we spoke with understood the importance of gaining people's consent before they supported people.

Staff assessed people's nutritional needs and supported them to have a balanced diet. People told us they had enough to eat and drink. One person told us, "I get plenty to eat and drink." Another person said, "I get enough to eat and drink, and there is something different every day." Staff recorded people's dietary needs in their care plan and shared this information with kitchen staff to ensure people received the right kind of diet in line with their preferences and needs. We saw people were offered a variety of diets to meet their specific needs. For example, where required people's food was chopped pureed, had a low sugar diet, low fat or low salt. The chef told us, "I am aware of people's dietary needs and I get information from the staff about who is on a special diet."

The service protected people from the risk of malnutrition and dehydration. Staff completed nutritional assessments for each person and monitored their weights as required. We saw action had been taken where risks associated with nutrition had been identified. For example, where people were at risk of malnutrition, records showed that staff sought advice from a dietician and completed food and fluid charts to monitor people's intake. We saw during the inspection that staff ensured people were kept hydrated. Drinks and snacks were available and offered to people throughout the day. People received appropriate support to eat and drink. Interactions between people and staff during a lunchtime meal we observed were positive and the atmosphere was relaxed and not rushed. People who needed help to eat and drink were supported adequately. Staff had meaningful conversation with people, and helped those who took their time and encouraged them to finish their meal. One person told us, "The staff would support me to eat."

Staff supported people to access healthcare services. One person told us, "The staff come with me to my appointments." Another person said, "The GP would come here to see me." The service had strong links and worked in partnership with local healthcare professionals including a GP surgery, district nurses, Speech and Language Therapy Team (SALT) and dietician. We saw the contact details of external healthcare professionals in every person's care record. Staff completed health action plans for everyone who used the service and monitored their healthcare appointments. The staff attended healthcare appointments with people to support them where needed.

The service met people's needs by suitable adaptation and design of the premises. The registered manager told us that they had refurbished some parts of the communal area and were in the process of doing the rest of it. People's bedrooms were well-furnished and personalised. Doorways and hall ways were wide for easy movement and easy access to other parts of the premises. There was enough communal area so that people and their relatives could meet in privacy. Some people had brought personalised items from their previous home which had been used to make their rooms familiar and comfortable. There were door guards on bedrooms which automatically released in the event of the fire alarm being triggered.

Staff worked with other services to ensure effective joint-working. The registered manager told us they

ensured people had a copy of their personal profile sheet, to carry with them when they went to hospital with a red bag. This red bag contained people's personal profile which included information about their health conditions, medicines, GP and next of kin details; care required, and their own clothes and slippers. This enabled people to receive well-coordinated care and support when they used other services.

Good

Is the service caring?

Our findings

People told us that staff were kind and treated them with respect. One person told us, "Staff are very kind."

People were cared for by staff who were kind and caring. We observed staff communicating with people in a caring and compassionate manner throughout the time of our inspection. Staff took time to talk to people on a one to one basis, talking softly and in a dignified manner. For example, when a person was distressed, staff pro-actively engaged with them, using touch as a form of reassurance, by holding their hands, by maintaining eye contact with them, and talking to them at their own pace which was positively received.

People and their relatives were involved in the assessment, planning and review of their care. Staff completed care plans for every person, which described the person's likes, dislikes, life stories, career history, their interests and hobbies, family and friends. Staff told us this background knowledge of the person was useful to them when interacting with people to ensure their individual needs were met.

People were supported to be as independent in their care as possible. Staff told us how they promoted independence by encouraging people to do what they could for themselves. One staff member said "Sometime, they [people] don't eat. I encourage them by giving them a spoon in their hands and ask them to eat." Another staff member said, "I encourage them to walk and not use a wheelchair all the time. I encourage them to stand up and use a walker, and I will be behind them and they are fine with it."

Staff respected people's choices and preferences. For example, staff respected people's decisions about the choice of food, clothing, where they wanted to spend their time; such as in their own room, the lounge or walking about in the home.

Staff treated people with dignity, and that their privacy was respected. We saw staff knocked on people's bedrooms doors before entering people's rooms and they kept people's information confidential. We noticed people's bedroom doors were closed when staff delivered personal care. We saw people were well presented. Records showed staff received training in maintaining people's privacy and dignity.

Good

Is the service responsive?

Our findings

Staff recognised people's need for stimulation and supported people to follow their interests, and take part in activities. One person told us, "Yes, we have singing and music." Another person said, I do my art work and listen to music." Staff told us that they asked people what they would like to do and developed programmes to suit them. Activities on offer included musical events, birthday and valentine's day celebrations, quizzes, arts and crafts sessions.

Staff had developed care plans for people based upon their assessed needs. These contained information about their personal life and social history, their health and social care needs, allergies, family and friends, and contact details of health and social care professionals. They also included dependency assessments which identified the level of support people needed and the things they could do by themselves. Care plans were reviewed on a regular basis and reflective of people's current needs. One person told us, "The staff reviewed the care with me."

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People and their relatives were able to understand the information provided in the current standard and this met their needs.

Staff completed daily care records to show what support and care they provided to each person. They also completed a diary which listed the specific tasks for the day, such as who required a weight check, fluid and food intake monitoring, repositioning of people in the bed and skin care management. The service used a communication log to record key events such as changes to health and healthcare appointments for people. We saw there were no restrictions on visitor times and that all were made welcome. We saw staff addressed visitors in a friendly manner, and they were made to feel welcome and comfortable.

Staff completed Do Not Attempt Cardiopulmonary Resuscitation (DNAR) forms with the engagement of the person concerned and their relative where necessary. Their healthcare professional signed the forms too. Records showed people's end-of-life preferences had been discussed with them, and care plans were developed to ensure their preferences in this area were met.

People's care plans included details about their ethnicity, preferred faith and culture. One person told us, "Someone visits from the Church." The service was non-discriminatory and staff told us they would always seek to support people with any needs they had with regards to their disability, race, religion, sexual orientation or gender. Staff showed an understanding of equality and diversity. Staff supported people with their spiritual needs where requested. For example, the provider arranged activities for people, to meet their spiritual needs.

People told us they knew how to complain and would do so if necessary. They told us that they were confident that any concerns would be taken seriously. One person told us "The ladies [staff] in blue [uniform], they are the ones that I would tell if I have a complaint." The provider had a clear policy and

procedure for managing complaints and this was accessible to people and their relatives. The service had maintained a complaints log, which showed when concerns had been raised the registered manager had investigated and responded in a timely manner. The registered manager told us that there had been no reoccurrence of these issues following their timely resolution. Records we saw further confirmed this view.

Good

Is the service well-led?

Our findings

People commented positively about staff and the registered manager. One person told us, "The manager is lovely," Another person said, "It [the service] is a lovely place." A third person commented, "The staff would have listened to me."

The service had a registered manager in post. The registered manager knew of their responsibility under the Health and Social Care Act 2014 and had notified CQC of any significant events at the service. The registered manager understood their role and responsibilities and at the same time empowered and developed staff. Staff described the leadership at the service positively. Staff comments included; the manager is "very good", "very helpful", "I'm very comfortable to go to her to ask anything I need help with" "The manager is helping all of us with writing care plans, helping the residents in feeding if necessary, and then run to office work."

The last inspection rating of the service was displayed correctly in the communal area of the service.

There was a positive culture in the service, where people, their relatives and visiting professionals' opinion was sought to make service improvements. The registered manager encouraged and empowered people to be involved in service improvements through periodic meetings. Areas discussed at these meetings included menus, activities, care plan reviews and redecoration of the premises. As a result of these meetings the provider made improvements. We observed that people and staff were comfortable approaching the registered manager and their conversations were friendly and open. The registered manager had detailed knowledge about each person living at the home, and made sure they kept staff updated about any changes to people's needs. We saw the registered manager interacted with staff in a positive and supportive manner.

The registered manager held meetings with staff where staff shared learning and good practice so they understood what was expected of them at all levels. Records of staff meetings showed that areas discussed had included details of any changes in people's needs, guidance to staff about the day to day management of the service, discussions about co-ordinating with health and social care professionals. Staff also discussed the changes to people's needs during the daily shift handover meeting to ensure continuity of care.

The service had an effective system and process to assess and monitor the quality of the care people received. This included checks and audits covering areas such as accidents and incidents, staff observations, medicines audits, health and safety checks, pressure care and wound management, house maintenance, care planning and risk assessments, food and nutrition, and infection control. As a result of these checks and audits the provider made improvements, for example, care plans and risk management plans were up to date, staff refresher courses had been arranged, daily care records improved, and some parts of the premises had been redecorated where required and redecoration work was in progress.

Care records we saw showed that the service worked effectively with health and social care professionals and commissioners to ensure people's needs were met.