Brookhouse Care Home Limited

Brook House Care Home

Inspection report

15 Bell Lane
Husbands Bosworth
Lutterworth
Leicestershire
LE17 6LA

Tel: 01858880247

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Brook House is a residential care home for up to 41 older people, some of whom are living with dementia. At the time of our inspection there were 30 people living there.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

A registered manager was 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. The registered manager was fully aware of their legal responsibilities and was committed to providing excellent leadership and support to staff.

Staff understood the need to undertake specific assessments where people lacked capacity to consent to their care and / or their day to day routines. It was not evidenced how decisions had been made in people's best interest or who had been involved in this process. We saw that people were supported in the least restrictive way possible.

People were safe and protected from the risk of harm. Risks to people's safety were assessed and we saw that care was delivered in a safe way. Safe recruitment procedures were followed and there were suitable numbers of staff available.

Person centred care plans were in place written in the persons voice. Written consent to care was not evidenced however we did see that consent to care was sought at point of delivery and relatives told us they had been involved in the care planning where required.

People had access to health and social care services when needed and were referred in a timely manner. People had access to medication when they needed it and medication was managed in a safe way.

People were treated with kindness, compassion, dignity and respect. They were supported by staff to engage in activities. The provider had built relationships with services in the local community that people regularly accessed. People were involved in decision making and supported and encouraged with choice giving them control of their lives.

People and their relatives spoke positively of the staff team. The Registered Manager was visible, approachable and highly regarded amongst people, relatives and the staff. People felt confident that concerns raised would be dealt with promptly.

Further information is in the detailed findings below.

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 remains good.

Is the service effective?

Requires Improvement

The service was not always effective

Pre-admission assessments were not fully recorded there was a risk that sufficient information would not be available for staff for the service.

Staff understood the need to undertake specific assessments where people lacked capacity to consent to their care. However. It was not evidenced how decisions had been made in people's best interest. People were supported in the least restrictive way possible.

People received support from staff that had the skills and experience to deliver care that met their needs.

People had access to healthcare services when required.

Is the service caring?

Good

The service remains good

Is the service responsive?

Good

The service remains good

Is the service well-led?

Good

The service remains good

Brook House 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 was a comprehensive unannounced inspection.

Inspection site visit activity started on 6 November 2018 and ended on 7 November. On the 12 November 2018 we spoke to people's relatives via the telephone.

The inspection team was made up of two Inspectors and an expert-by-experience in care of older people and dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of care, older people and dementia care services.

We contacted Health watch and asked whether they had received any feedback about the service Health watch is an independent consumer champion for people who use health and social care services. We also contacted commissioners and asked them for their views about the service. Commissioners are people who work to find appropriate care and support services for people.

Before the inspection, we asked the provider to complete 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. The provider completed and returned the PIR and we considered this when we made judgements in this report.

We spoke with seven people, and five people's relatives. We also spoke with seven members of staff, including a housekeeper, an activities coordinator, a senior care worker, two care workers the registered manager and deputy care manager. We spoke with a doctor and a community nurse who were visiting the home during the inspection.

We reviewed seven peoples care plans and risk assessments. We looked at four staff files, we also looked at policies and procedures, health and safety records, staff training, safeguarding and medicines records.

Good

Is the service safe?

Our findings

People told us they were safe. One person told us when asked "Oh yes, very safe. It's a nice company of people here". Another person said. "Always been safe, no problems at all".

There were processes in place to minimise the risk of abuse. Staff had received training in safeguarding and were aware of safeguarding procedures. One staff member told us, "There is a poster showing the safeguarding information in the staff office." When asked about reporting safeguarding another staff member told us, "Would report to management, then directors, then CQC and could whistle blow." The provider had worked with the local safeguarding authority to carry out safeguarding investigations as needed.

There were individual risk assessments in place to support people to stay safe. For example, where a person had been identified as at risk of falls at night. A sensor mat was in place to alert staff when the person was getting up so that they could provide them with support. One member of staff told us, "If we know people are on the move we can just be alert should they need us without restricting them."

There were enough staff to keep people safe and provide support in a safe way. One person told us, "I use my bell but not very often, they seem to be quick answering." Another person said, "I've used my call bell once, they came quickly." Our observations during the inspection demonstrated that there were sufficient care staff on duty to provide people's care and that call bells were answered promptly. We reviewed staffing deployment records such as staffing rotas and call bell records. These showed that consistent numbers of staff were deployed to meet peoples needs and call bells were answered promptly.

People received their medicines safely. Senior members of staff administered people's medicines from a locked dispensary and had clear guidance and training on how to manage this safely. Fridge and room temperatures were recorded daily. Medicines that were no longer required were stored and disposed of safely. Stock checks took place during each medicine round which meant that any errors would be quickly identified.

People were protected by the prevention and control of infection. People told us the home was regularly cleaned. One person said, "They are good when cleaning it [their room]. They moved me to another room when they shampooed my carpet." We spoke to a person's relative who told us the home was, "Absolutely spotless." During the inspection, we saw that all areas of the home were clean and fresh. There was a planned system of cleaning in place, cleaning records were completed and these were monitored by the registered manager.

Staff were aware of the principles of infection control. Personal protective equipment was readily available to staff and we saw that it was used when needed. There was information around the home detailing hand washing and infection prevention.

Lessons were learned and improvements made when things went wrong. For example, the service had

experienced a small deliberate fire in a waste bin in the car park. They had dealt with the incident appropriately and had had purpose built lockable bin storage put in place to prevent this from happening again.

Systems were in place to ensure the premises were safe for people. Health and safety audits were in place and fire alarm tests were carried out weekly. Staff could explain the action to be taken in the event of the fire alarm sounding. Each person had a personal evacuation plan (PEEP) in place that was available in a quick grab file. The level of assistance they required in an emergency was indicated by a colour code on their door.

Equipment used to support people, such as hoists were regularly maintained. People had their own hoist slings which we found to be clean and in good condition.

Requires Improvement

Is the service effective?

Our findings

People had pre- admission assessments before they began using the service to check that their needs could be met. Staff told us "[Registered manager] goes out to assess people before they come in and staff see the pre- assessment in the care plan."

We found some of the pre-admission assessments had not been fully completed. We discussed our concerns with the registered manager. They explained that they gained in depth information regarding people's choices and needs before agreeing to provide their care, but acknowledged that this had not always been recorded fully. The information gathered was used to produce a plan of care for the person and this was shared with staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 make decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA.) The 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. Systems were implemented to ensure that people's capacity to consent to their care and support was considered and thorough assessments were in place where required. However, best interest checklists were not consistently completed. There was a lack of documented evidence of how or why decisions had been made in people's best interest or who had been involved in this process.

Since our inspection the Registered Manger has advised us that peoples best interest decision information has been reviewed and completed. These improvements need to be sustained and embedded in practice.

Staff had received training in MCA and they were able to demonstrate an understanding of the key principles of the act and described how these informed their practice. They told us how they supported people to make their own choices and asked for people's consent before providing their support. One staff member told us "People with dementia sometimes don't have the capacity to understand, but some people are able to make their own decisions, we advise and help them, we can't tell them they can't do what they want to do." We saw that people were supported by staff with making choices. The provider had followed the legal process when applying for DoLS authorisations to place restrictions on people's freedom to keep them safe.

Staff had received the training they required to do their jobs effectively and they received regular supervision. Four members of staff had gained extra qualifications to provide training in manual handling and medicines so that immediate extra support was available to staff should they need it.

Over half of the staff had achieved a level 2 Diploma or above in Health and Social Care and senior members off staff were starting to study for level 5. Staff had an induction period and were supported to understand each person's needs. A more robust induction in line with the Care Certificate had just been introduced. A staff member told us "Management are supportive, always in close contact and we can get support when needed." Another staff member told us they had required extra support on induction and this was made available to them straight away.

People were supported to maintain a balanced diet. Food and fluid records were kept for people who required their intake to be monitored. People had been assessed for risk of malnutrition and where required staff supported people with eating and drinking. People were involved in choosing the menu and alternatives were offered if people wanted something different to the food on the menu. One person told us "I think the food is fairly good. We get asked the day before. Occasionally I don't want what's offered and they will do me something else" A relative told us, "[The food is] absolutely first class they will always find her something that she likes to eat."

We saw that food was served hot and nicely presented at dining tables. There were snacks available throughout the day and fruit bowls placed in communal areas. People told us, "The food's not bad. I have what I'm given, I'm not fussy. There's a menu, you choose what you want." Another person told us, "The food is very good. I get to choose the day before." They always offer an alternative if you don't like the choice." We saw that drinks were available at meal times and regularly throughout the day. There were picture menu cards available to help people with choice.

People had access to healthcare services when required. This included chiropody, dental care and opticians. Staff were knowledgeable about people's healthcare needs.

People received support from healthcare professionals when needed and staff followed the advice they provided. We spoke to a community nurse who was visiting the home, they told us that people's health care needs were well managed. They said, "We are contacted when needed, we don't have any concerns about the home, staff follow our advice when given." One person told us, "There's a team of doctors that come, I think it's by request. There is a surgery here on a Friday I think. chiropodist is six weekly. I went to my own dentist in [Name of town] last week." Another person told us. "They get the Dr for you straight away if you need it, or take you there."

The design and decoration of the premises was suitable for people's needs. There were newly refurbished adapted bathrooms and communal areas were easily accessible for all levels of mobility. There was a lift in place to access the second floor. The garden had been designed to be accessible to people with all levels of mobility. There were picture labels on communal rooms to help people find their way around and people had a photo of themselves on their room door to assist with orientation.

Good

Is the service caring?

Our findings

Staff treated people with kindness, care and compassion. One person told us, "The staff are gentle and kind, never unkind, no concerns about any of them. Always respectful to me." Another person said, "I've always felt very welcome here, they always say hello. Always offer me tea and biscuits."

We saw that staff knew people by name and knew them well. One person told us, "The staff are very good, they've got time for you, they'll talk to you, explain things to you, they're kind." Staff had time and were able to make conversation and share humour with people and knew names of people's relatives.

Relatives were welcome to join people for meals, which we saw that people enjoyed. A relative told us, "[I am] welcome at all times, whatever the time of day."

People that were supported to eat by staff were treated with respect and dignity and weren't rushed. A relative told us, "I have never heard any staff loose their patience or cool." The relative also said, "[Family member] has a smile in her sleep, incredible staff, mother is content."

People were actively involved in decision making. There were records showing monthly residents' meetings where people were encouraged to get involved with ideas and plans for activities and meal choices. One person told us, "We do have residents' meetings it's mentioned in the newsletter. I've never been to one." And another person told us, "I go to residents' meetings, you can say what you like, they deal with it." Meeting minutes were available at our inspection.

People were listened to and able to make their own choices. For example, one person requested a specific day out to attend an activity they were interested in, the service fully supported this. A family member described this as having a positive impact on the person.

We saw that monthly newsletters were in communal areas around the home for people to read. The newsletters contained stories, details of past and upcoming activities and horoscopes.

People were supported to celebrate special occasions. For example. the chef was given a list each month of people's birthdays and made a cake for each person. The service hosted a birthday tea for people and their relatives or they could choose to celebrate however they wished.

People's privacy was protected and promoted. Staff knocked and waited before entering rooms and did not interrupt people when they had visitors. When assisting people to the bathroom staff were discrete. Personal information was stored safely in locked cabinets.

People's protected characteristics had been considered and their equality and diversity was respected and promoted. Some people were living with dementia and information was available in easy to read format if required and signage around the home was designed to support people with orientation. This included easy to read clocks and information on the date, season, and weather displayed in communal areas. The service

also had twin rooms available that could be utilised by same sex couples if required.

Good

Is the service responsive?

Our findings

People received care and support that was responsive to their needs and staff were committed to providing individualised support. Care plans were reviewed monthly and changes made when needed. We saw that people were asked by staff what they wanted to do or where they would like to go and their choices were supported.

People had care plans in place that were written with them at the centre. These were not signed by people or their representative. However, we saw that person centred care plans were being followed and that staff sought peoples consent each time they provided support. Relatives told us they had been involved in care planning where required.

We recommend that the service review people's care plans to ensure documented consent for care is sought and recorded by people or their representative in line with the services own recording requirements.

We saw information in one person's care plan that described how staff could provide them with reassurance by using flash cards to promote happy memories and a tablet computer to watch their favourite television program. We saw this technique used successfully for the person during our inspection.

We received mixed feedback from people about the activities that were available. One person told us "I've seen aerobics, arts and crafts, sing songs. I saw around three activities a week. There were fireworks yesterday. They also do massaging hands." Another person said "We don't have activities every day, I wish they did, it would help pass the day. They have craft and cooking sometimes during the week. I mainly write letters and watch TV."

At the time of our inspection the Registered Manager, staff and provider were working together to provide more activities that were focused on people as individuals. Fundraising was underway for a fully integrated portable, adjustable interactive table that could be used in the same way as a smart phone or tablet. The technology when available would be able to store people's personal preferences from a wide range of interactive activities.

Our findings showed that people had choice and access to a range of activities. There were two activities coordinators deployed in the home and there were planned group activities in place. The service also accessed regular external activity providers, for example weekly exercise classes and art and crafts. There was also a hair and beauty room that was in use during our inspection. Staff took time to chat with people and there were activities such as books and tactile objects placed around that we saw people use. People were supported to visit the local café, pub and church.

The monthly newsletter showed that the service had organised a pamper morning, piano session, a choir performance and a firework display and there were photographs showing several residents enjoying these activities. A music performance and an Armistice day event was also due to take place.

There were resident pets which we saw had a positive impact on people who were enjoying the company of and petting the dog. We also saw people watching the bird and the fish with interest.

There was a complaints policy and procedure in place and information regarding how to make a complaint was detailed in the service user guide. A relative told us, "The manager has put a concerns board in the lounge, I made a comment about clothes going missing and they have since put a buttons system in place with room numbers on the buttons to solve the problem." A person told us, "Never complained about anything, no need to. I would speak to a carer I suppose." Another said, "I made a complaint yesterday. I went out at 08.30 and came back at teatime and my room hadn't been touched. They dealt with it immediately. It's happened before at odd times."

The Registered Manager told us that end of life care is promoted. However, at the time of our inspection no one was receiving end of life care. We saw do not attempt cardio pulmonary resuscitation (DNACPR) certificates for people where needed and these had been signed by a Doctor. DNACPR certificates were stored sensitively in an emergency grab file should they be needed and staff were aware which people DNACPR applied to. People had been asked about their choices and decisions regarding the end of their life and this was recorded in their care plans.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. For example, the service user guide and complaints procedure were available in easy read format and the newsletter included many photographs that helped to tell the story.

Good

Is the service well-led?

Our findings

There was a registered manager in post at the time of inspection 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 using the service, relatives and staff confirmed they had confidence in the way the service was managed. When we spoke with relatives they told us they were consulted on changes with conditions or care. One relative told us, "[The service is] totally open, I have the utmost trust for them, they keep us informed and are quick to notice changes [in health]."

The registered manager was visible, friendly, approachable and hands on, spending time talking to people and staff. Staff told us they felt well supported and confident in approaching the registered manager with any concerns or questions.

Training was in place for staff and they were well supported by senior members of the team. Staff could access extra training when required for their personal development and an open culture for sharing learning experience was evident through handover and meetings. A staff member told us, "Any training we need we just ask and we do it. They are really good; the shift is covered so we can attend training." A second staff member told us that they had received extra support in their role from the registered manager and that they were feeling much more confident as a result.

There were three handover sessions per day and a monthly staff meeting, we saw minutes of the last meeting, where discussions took place about CQC requirements, the service ethos and vision, staffing levels, service user concerns and employee of the month. We saw that all staff across shifts had access to meetings with the registered manager. This meant that information was shared and staff had the opportunity to discuss concerns and ask questions.

Staff felt empowered to carry out their duties to the best of their abilities. We Spoke to the chef who told us, "I am able to cook good food, because I am allowed to cook good food, I don't have a budget per head to keep to, I cook whatever the people want they choose the menu and I cook it." During our observations we saw a person ask for a particular type of cheese, this wasn't available and the person was offered a choice of several other cheeses. We later saw that the cheese they had requested had been added to the kitchen shopping list.

The Registered Manager had a clear vision of improving the service and had introduced a more robust 12-week induction schedule in line with the Care Certificate to better support staff. Some members of staff were starting their Level 5 Diploma in Health and Social Care, which would further improve the knowledge and skills of the senior staff team.

There was evidence of partnership working with community services for example, the Community Nurse

team and Occupational Therapy.

The Registered Manager attended monthly management information sharing forums and subscribes to professional publications to ensure their own skills and knowledge remained current.

Policies and procedures were in place that were reviewed annually we saw that these were embedded in practice. Quality Monitoring audits were carried out by the Registered Manager and Director. In the main these audits had resulted in appropriate action and improvements being made when needed. However, audits of peoples care files had not always identified areas where information had not been recorded. In response to our feedback the Registered Manager took action to resolve this.

The Registered Manager sought feedback from people, their relatives and staff through monthly meetings, surveys and compliment and complaint forms. Information gathered was used to improve service and experience. For example. A family member had documented that they would like to see more fruit readily available around the home. We saw that there were fruit bowls available in the communal areas, these were checked and replenished at regular intervals.

At the time of our inspection there were ongoing discussions with the provider to introduce an electronic care planning and monitoring system. The registered manager told us that the provider was open to ideas and improvements and the service received ongoing support from an onsite director.

The latest CQC inspection report rating was on display at the home. The display of the rating is a legal requirement, to inform people, those seeking information about the service and visitors of our judgments.