Brainerd Limited

# Brainerd Limited Domiciliary Care Service

## Inspection report

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Date of inspection visit:
22 March 2018

Date of publication:
18 April 2018

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

Brainerd Limited Domiciliary Care Service is domiciliary (home care) service registered with the Commission in November 2015. The provider also provides a supported living service. Personal care was provided to one person at the time of the inspection.

Domiciliary care services provide personal care to people living in their own houses and flats in the community. No one was in receipt of this service at the time of the inspection. This service also provides care and support to people living in 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care. Brainerd Limited Domiciliary Care Service is registered to provide personal care to older and younger people and people who have learning disabilities. Some people had additional services offered by the provider including domestic, recreational and companionship help.

This inspection took place on 22 March 2018. Advance notice was given (over a week) as the service is small and we needed to be sure the registered manager would be available when we visited the agency offices. This was the first inspection of the service. We found all areas were good.

The service had two registered managers. 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 service was well-led with person-centred values and a vision to provide high quality care. The management team were open and approachable. The provider and registered manager listened to feedback and reflected on how the service could be further improved.

People were protected from harm and discrimination. People's human rights were protected because the code of practice in relation to the Mental Capacity Act 2005 (MCA) was understood and followed. People's nutritional needs were met because staff followed people's support plans to make sure people were eating and drinking enough and potential risks were known.

People were treated equally and fairly. Staff adapted their communication methods dependent upon people's needs, for example simple questions, flash cards and/or pictures. Verbal information and explanations about care were given to people with cognitive difficulties and the service had plans in place to develop written support plans in pictorial formats. People were supported by staff who were compassionate, kind and caring. All staff demonstrated kindness for people through their conversations and interactions. People were supported by a consistent staff group who knew them well. People's privacy and dignity was promoted. As far as possible, people were actively involved in making choices and decisions about how they wanted to live their lives. People were protected from abuse because staff understood what

action to take if they were concerned someone was being abused or mistreated.

People had support plans which described how they liked their needs met and their individual routines. People had regular reviews to ensure the service provided to them changed as they did.

Risks associated with people's care and living environment were effectively managed to ensure their freedom was promoted. People's independence was encouraged and staff helped people feel valued by engaging in everyday tasks where they were able to.

The provider and management team wanted to ensure the right staff were employed, so recruitment practices were safe and ensured that checks had been undertaken. Staff underwent a thorough induction and ongoing training to meet people's needs effectively.  People's medicines were managed safely.

People received care from staff who had undertaken training to be able to meet their unique needs. People were supported to access health care professionals to maintain their health and wellbeing. People led full and active lives enjoying a variety of individualised activities such as cricket, walks, bakery visits.

Safe infection control practices were followed. People, and those who mattered to them were involved in decisions about their care.

There had been no complaints made to the service but polices and procedures were in place should people, relatives or professionals wish to raise concerns.

## 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

There were sufficient staff employed to meet people's needs safely.

Staff were recruited safely.

People were protected by staff who could identify abuse and who would act to protect people.

People had risk assessments in place to mitigate risks associated with living at the service.

Staff followed safe infection control procedures.

### Is the service effective?

Good

The service was effective.

People received support from staff who knew them well and had the knowledge and skills to meet their needs.

Staff were well supported and felt confident contacting the management team to ask advice.

Staff had a good understanding of the Mental Capacity Act and promoted choice and independence whenever possible.

### Is the service caring?

Good

The service was caring.

People were looked after by staff who treated them with kindness and respect.

People, family and professionals spoke highly of staff. Staff spoke about the people they were looking after with fondness.

People had as much control as possible of their care and staff listened to them.

People said staff protected their dignity.

People were supported in their decisions and given information and explanations in an accessible format if required. The service had plans to develop this further.

## Is the service responsive?

Good

The service was responsive.

Care records were written to reflect people's individual needs and were regularly reviewed and updated.

People received personalised care and support, which was responsive to their changing needs.

People were involved in the planning of their care and their views and wishes were listened to and acted on.

People and those who mattered to them knew how to make a complaint and raise any concerns. The service had not received any written complaints however these would be taken seriously and acted on them in a timely and appropriate manner.

## Is the service well-led?

Good

The service was well led.

There was a positive culture in the service. The management team provided strong leadership and led by example.

The provider and registered manager had clear visions and values about how they wished the service to be provided and these values were understood and shared with the staff team.

People's, family and professional feedback about the service was sought and their views were valued and acted upon.

Staff were motivated and inspired to develop and provide quality care.

Quality assurance systems drove improvement and raised standards of care.

# Brainerd Limited Domiciliary Care Service

**Detailed findings**

## Background to this inspection

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

The inspection took place on March 22 2018, was announced and undertaken by one inspector.

Prior to the inspection we looked at the information we held about the service such as notifications and previous reports. We spoke with the local authority and commissioners. Due to technical problems, the provider was not able to complete a Provider Information Return. 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.

During the inspection we spoke with the nominated individual who was also one of the registered managers and the other registered manager. The service supported one person with complex learning difficulties in their own home 24/7. We therefore spoke with the management team about how they cared for the person, read the support plans in relation to the person and reviewed their medicine management.

We looked at records relating to the running of the service, for example a volunteers recruitment file, compliments and feedback from the family member and professionals involved with the person. We also looked at the providers recruitment, induction and training processes.

Good

# Is the service safe?

## Our findings

The service provided safe care. People, relatives and professionals said the service was safe.

The systems, process and practices at Brainerd Limited Domiciliary Care Service enabled people to remain safe. People were kept safe by staff who understood how to identify the signs of abuse and what action they would need to take if they witnessed or suspected that someone was being mistreated. This included an understanding of which external agencies they would need to alert. There was an up to date safeguarding policy aligned with the local areas. Staff were aware of and prevented people being discriminated against and monitored people's behaviour for any signs which might indicate they were unhappy. Records and the management team confirmed that they had undergone training in this area, knew how to safeguard people and care for their property and belongings. Staff all confirmed they would not hesitate to raise concerns. Professional feedback shared, "Supportive and caring with [person's name] ] – this enabled them to feel safe which led to [person's name] being able to move on from mum after five months."

People were supported by staff that were safely recruited. Records showed that the necessary checks were undertaken prior to an applicant commencing their employment, to help ensure the right staff were employed to keep vulnerable people safe. The management team advised that wherever possible people were involved in the process and they had an opportunity to meet staff who might be applying to work with them. They told us, "If [person's name] claps on your hand, they approve". The service employed volunteers to work with people and they followed the same recruitment checks. Staff values, experience and hobbies were considered at interview to help match staff to people. The registered manager shared, "We have a face to face chat with new staff, talk about their background, check their documents etc – we check if [person's name] feels comfortable with the new staff member, are they understanding, on [person's name's] level and patient".

People were kept safe by sufficient numbers of staff which meant there was adequate cover for sickness and unforeseen events. There was a flexible, stable staff team; this helped to provide continuity for people. Staff worked as a team to meet people's needs so people were supported by staff they knew. Contingency plans were being reviewed but the management team told us they all lived in the vicinity so in an emergency they could be available quickly. The team that worked with people was very small so consistency of staff provided stability and continuity.

Staff were protected whilst lone working, for example when staff joined the organisation they were informed of what action they should take to ensure their safety. A lone working policy was in place and an on call service to support staff safety. Some people had their own vehicles. Staff vehicle MOTs and car insurance were checked to ensure people were safe if they were travelling with staff.

People were supported by staff who managed risk effectively. Staff knew the signs of when people were becoming distressed or agitated and how to distract and de-escalate these situations. Since being with the provider, professionals shared how people's previous behaviours which could be challenging for staff, had lessened.

Staff gave people time, space and kept their distance when required by observing people's non-verbal cues. Some people had complex behaviours and staff explained how they knew by the person's mannerisms if they were content or not.

Staff understood the importance of a person's choice, regardless of disability, to take everyday risks (if they had the capacity to make those choices) and to keep people safe but not be intrusive when they monitored them in their home. Staff balanced actively supporting people's decisions so they had as much control and independence as possible with ensuring their safety at all times. For people unable to assess risks due to their learning needs, staff kept them safe. For example when crossing roads or supporting them with personal care, medicines or outings in the local area.

People had documentation in place relating to the management of risks associated with their care. The risk assessments were detailed and provided staff with specific information on all areas where risks had been identified. This included environmental risks within the person's home, community outings as well as risks in relation to their care and support needs. Safety measures were taken to keep people safe for example house repairs were undertaken promptly if required. Staff also supported the people we visited to make sure their appliances were serviced, for example gas checks.

People we met were safely supported with their medicines, and had care plans in place which detailed the medicine they were prescribed and the role staff were required to take. Staff who were responsible for administering medicines received training to ensure they were safe and followed the provider's medicine policy. Staff confirmed they understood the importance of safe administration and management of medicines. Following the inspection we made minor suggestions to improving medicine safety which included annual competency checks, clarity regarding side effects staff might observe for in relation to specific medicines people took and developing "as required" medicine protocols as needed. The management team said they would put these into practice.

People were protected from the risk of infection. People told us staff took the necessary precautions when undertaking personal care for example wearing gloves and aprons as necessary.

People were kept safe by staff who understood what action to take in the event of an incident and followed internal procedures for reporting and documenting these. Staff had received fire training and were aware of the exits in people's homes and emergency procedures to follow in the event of a fire. No incidents, injuries or safety issues had occurred at the service but processes were in place for recording these if they occurred.

The management team learned from reflection and events which had occurred. They explained how they improved their method of communication and no longer just had telephone calls with people but always had a written record of these conversations now.

Good

# Is the service effective?

## Our findings

The management team (Nominated Individual and Registered Manager) understood their responsibilities in relation to the legislative framework, The Mental Capacity Act 2005 (MCA). 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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interest and the least restrictive option available.

We spoke with staff about how they helped people make decisions to ensure consent was obtained. We spoke with the registered manager about more significant decisions such as dental treatment if people did not have the capacity to consent. They understood these more complex decisions would need to be made and recorded under the best interest process with professionals, family or advocates. Our discussions with staff evidenced they acted in people's best interests and they understood least restrictive principles, but the recording of this required development. The registered manager shared their ideas of developing more information for people in formats they would understand.

One person was under continuous supervision within their homes. Although staff did this in the least restrictive way, we asked the provider whether applications to the Court of Protection had been considered to ensure staff had the required legal authority for this level of monitoring. The management team would ensure this was considered.

When staff joined the organisation they received an induction which incorporated the care certificate standards. The care certificate was a recommendation from the 'Cavendish Review' to help improve the consistency of training of health care assistants and support workers in a social care setting. Staff new to care had the opportunity to shadow more experienced staff until they felt competent.

People were supported by staff that were trained to meet their needs. Staff underwent training in the subjects such as moving and handling, fire training, equality and diversity, learning disabilities and safeguarding. Some staff had undertaken further health and social care qualifications also. All staff confirmed the training was good.

Staff were supported by ongoing informal and formal face-to-face supervision, spot checks, competency checks and an annual appraisal. Staff were invited to come into the office regularly and staff and the management team confirmed an "open door" policy. Open discussions provided staff the opportunity to highlight areas of good practice, identify where support was needed and raise ideas on how the service could improve.

People's nutrition and hydration needs were met. People's care plans provided details to help staff know what people's nutritional likes and dislikes were. Staff gave good examples of how they worked with people to encourage healthier options when shopping. If people had particular dietary needs, for example they needed a high fibre diet, staff gave examples of food and meals they cooked for people.

People were protected by staff who acted in their best interest to make prompt referrals to relevant healthcare services when changes to health or wellbeing had been identified. Staff knew people well and monitored people's health on a daily basis. If staff noted a change they would discuss this with the team and people's GP. Staff helped people to access health care professionals. One person had recently seen their doctor for a health check. Professional feedback included, "The provider was very proactive in ensuring [person's name] registered with a GP and medicines were arranged with the pharmacist."

Good

# Is the service caring?

## Our findings

The service was very caring. Family feedback said, "[Person's name] looks well and happy, never upset when I leave him." One person's sister said, "Lovely relationship has been developed over many years [person's name] has been in the setting." Professionals said, "Overwhelmed by the commitment and dedication towards [person's name]."

The service was a very small, family run business providing personal care to one person. The person was seen as part of their family and they mattered. The values of the organisation were to support people to be part of the community and provide inclusive care. The registered manager told us, "We go out for tea and coffee, to restaurants; they are like a family member."

The management team spoke of people in a caring, thoughtful way. They told us how much they loved their jobs and the people they cared for. They described the special bond people had with staff and how this had reduced behaviours which could be challenging for people and been a positive influence in people's lives. Staff maintained people's privacy and dignity when supporting them with personal care, sharing examples of closing people's curtains and giving privacy when they wished. For example, if they wanted to use the bathroom alone. Confidentiality, the Data Protection Act and personal boundaries were understood and respected by staff.

Staff ensured people were supported and cared for as they would their own family. Staff rotas were organised around people's needs and arranged so staff had time to listen to people, provide information and involve people in their care. The values of the organisation ensured the staff team were compassionate, respectful and empathetic and this was evidenced through our conversations with the office staff and the descriptions we heard about people's care. People, where possible, received their care from the same staff member or group of staff members; these were staff the person knew and trusted. This suited people's needs and those who found it more difficult to build relationships with new people. Our discussions with the office staff all demonstrated the management and staff team put people first.

Staff knew how people communicated, for example they explained how one person would posture and grunt when excited. They told us they observed people's facial expressions to assess if they were comfortable. They knew by a person's frown if they were taking too long when playing games, for example hide and seek. Staff knew keeping to people's routine and structure kept them happy such as not using the correct coloured pegs on the curtains or opening them in the way a person liked which could cause distress. Staff told us if one person put their jacket on that meant they wanted to go out. Professional feedback confirmed, "Staff know [person's name] very well – they pick up signs of them being unhappy and take action to try and resolve this."

People's social interests and preferences were recorded. The service offered an enabling service and supported people to do household chores, go shopping or to other activities if they wished in addition to offering personal care. We observed people were encouraged to be as independent as possible to develop life skills, for example by helping staff with small domestic jobs. Staff worked at people's own pace to enable

them to remain independent and care as much for themselves as possible.

People's care plans detailed family and friends who were important to them and they were involved in care decisions. This helped staff to be knowledgeable about people's family dynamics and enabled them to be involved as they wished. The service knew people's family very well. People and their relatives were encouraged to be involved in all aspects of care.

Staff shared people's special moments and joy and how the service had helped to improve their lives by promoting their independence and well-being. We saw pictures of Christmas and birthday parties arranged by the provider which demonstrated the kindness we experienced during the inspection.

Good

# Is the service responsive?

## Our findings

The service undertook their own assessment of people's strengths and needs. Comprehensive support plans were then developed based upon people's physical, emotional and social needs. If people had protected characteristics under the Equality Act the registered manager assured us the provider's policies reflected people be treated equally and fairly. This assessment process also helped to identify when staff required further training before they were able to support people. If people were coming into the community from a residential or family home setting, the service ensured all the necessary housing requirements were in place and the transition went as smooth as possible. Professional feedback included, "Person-centred and adaptive to [person's name's] needs"; "During the assessment and planning, we were involved through the whole process."

People had support plans in place which were individualised and encouraged choice and independence. Staff clearly knew people very well. Detailed support plans provided clear guidance and direction for staff about how to meet a person's needs, their likes, dislikes and routines. Support plans included information for staff about how people liked their personal care delivered and how to communicate with people, for example using Makaton and pictures. People's care plans were written using their preferred name.

People had easy read 'hospital passports' in place. These gave hospital staff important information about people's care needs in the event they required a hospital admission. These documents helped hospital staff be aware of people's health and communication needs. New support plans and one page profiles were being developed during the inspection.

Regular reviews were held with people's local authority. The registered manager advised if there was any change in need, support plans would be updated promptly.

The Accessible Information Standard is a framework put in place 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. We spoke with the registered manager and nominated individual about further enhancing the information in support plans, reviews and information guides so if people wished to have copies of their care and support plans these were in place. They were keen to develop this aspect of the service.

No complaints had been received by the service. A complaints procedure was available if required which detailed the process to be followed in the event of a complaint.

People receiving a service were middle aged adults. The registered manager told us developing and considering end of life needs was an area they would need to consider as people aged.

We spoke with staff about how personalised care was provided to people. Staff described people's daily routine in detail, their favourite clothes and how they liked to dress just like their favourite staff member. People's special toys were known and how listening to music on car journeys made people happy.

People chose what they wanted to wear, how they spent their time and what they liked to eat. Simple choices were given to support choice due to people's cognitive needs. Staff knew how people preferred their support. Staff described to us how people communicated their preferences by hand gestures and facial expressions. People's favourite things were known by staff for example we were told how one person loved fire engines and planes and we saw pictures of him at a major airport. Staff shared how one person also liked a particular type of biscuit and loved looking at photograph albums.

The service tried to match staff with people, for example age group, gender life experience and hobbies. This supported personalised care. Where people had special relationships with particular staff, every effort was made to enable these staff to support them on occasions which mattered.

Some people had an enabling service, in addition to the support staff gave them with personal care. Staff supported people with housework, cooking, shopping, and took them out to local places, for example cricket matches. We heard how people enjoyed a variety of activities including trips to their favourite bakery, where they were well known. The registered manager told us, "They are part of the community – [person's name's] parents never thought that would be possible."

Good

# Is the service well-led?

## Our findings

The provider was a small family run business. The provider had known people they supported for over 16 years. They had registered to provide personal care when people's needs had changed; the person had wanted to continue to be cared for by the same staff. They told us they planned to remain small and "like a close family". The service was run by the provider alongside the registered manager.

The provider told us they wanted to, "provide a reliable, quality service in the local vicinity – it's not about the money but the standard." The registered manager said, "I'm the manager, cleaner, carer – none of us are too good to do personal care – we pull our sleeves up and get on with it." Feedback from professionals confirmed this had been achieved, "A stable, reliable service." Other professional comments from March 2018 we reviewed included, "Passion and person-centred approach"; "Any differences of opinion and they are willing to listen and work closely with wider professionals" and "Learn from experience and address concerns quickly."

Conversations we had with the nominated individual and registered manager demonstrated a supportive, close knit team. There was a clear staff structure in place and staff knew their roles and responsibilities.

Policies and procedures were in place to help ensure service was well run. Checks were undertaken on people's homes, medicine, training needs and new staff. The service stayed abreast of changes, for example the changes in the law related to Data Protection.

High quality care was provided by a service which listened to feedback and responded to change where required. For example, the registered manager shared how all communication was now shared with the nominated individual and all email communication recorded to provide a clear record of conversations and decisions made.

Feedback was obtained from people, their family and professionals. This helped ensure on-going improvement to the service.

Local forums and training events which discussed best practice were attended by the registered manager and/or provider.

The small staff team were family members or volunteers. We spoke with the provider about ensuring all staff knew all ways of raising any concerns they might have as this was a family business. They confirmed staff were aware of whistleblowing processes and the local authority and commission's contact details.
The registered manager promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The management team were motivated and positive about the future. The visions and values of person centred care and inclusion were shared across the staff team.