Brooklyn Care Limited

Brooklyn House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Brooklyn House is a 'care home'. People in care homes receive accommodation and personal care under a contractual agreement. CQC regulates both the premise and the care provided and both were looked at during this inspection. Brooklyn House accommodates up to 17 people in one adapted building. At the time of our inspection 15 people were using the service.

This inspection took place on 20 November 2017. The inspection was unannounced, this meant the staff and provider did not know we would be visiting. At the last inspection on 4 March 2015 the service was rated 'Good'. At this inspection we found that overall the service remained good. We found some areas for improvement but at the time of the inspection there was no impact to people's safety. Where we have found this we have made a recommendation. Further details can be found in the main body of the report.

Quality assurance systems were in place to identify areas for improvement but people's views about what improvements needed to be made was not included. We have made a recommendations about how the service ensures that it continuously improves.

The registered manager did not have a way of assessing how many staff were needed, and at the busiest time of the day there was not always enough staff available. We have made a recommendation about staffing levels.

Risk assessments were in place and covered most areas, however when people were at risk of choking or had bed rails in place, the risk assessment did not contain sufficient detail for staff to understand how to care for these people safely. We have made a recommendation about completing comprehensive risk assessments.

Checks were carried out on staff before they started work with people to assess their suitability to care for vulnerable people. Staff understood their role and responsibilities to keep people safe from harm.

Regular staff meetings had taken place, but only one meeting had been held with people to seek their views regarding their care and support. We have made a recommendation about holding regular staff meetings.

There was 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 received regular supervision and had been trained to meet people's needs. People were supported to have control of their day to day lives and staff supported them in the least restrictive way possible. Arrangements were made for people to see a GP and other healthcare professionals when they needed to do so. People had access to the food and drink they chose, when they wanted it.

People were cared for and supported by staff that understood their needs and knew them well. Staff treated people with dignity and respect and were sensitive to their needs regarding equality, diversity and human rights. The care and support people received was individual.

The service did not actively identify the information and communication needs of people with a disability or sensory loss, and no one at the service had been trained in how to do this. We have made a recommendation about staff training and development.

There was a clear management structure in place. The manager and other senior staff were well liked and respected by people and staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was not always safe.

At key times of the day, there were not enough staff to meet people's needs.

Risk assessments were in place but some of these needed to be more detailed and look at the risks posed to people who used bed rails or who were at risk of choking.

Staff were trained to give people their medicines in a safe way.

Is the service effective?

Good

The service remains effective.

Staff were appropriately trained to meet people's needs.

The dining experience for people was positive and people were supported to have adequate food and drinks.

People's healthcare needs were met and people were supported to have access to a variety of healthcare professionals and services.

Is the service caring?

Good

The service remains caring.

People and their relatives were positive about the care and support provided.

Staff were friendly, kind and caring towards the people they supported and had a good understanding and awareness of how to treat people with respect and dignity.

Is the service responsive?

Good

The service was not always responsive.

The service wasn't actively identifying the information and communication needs of people with a disability or sensory loss.

Complaints management was robust and people using the service and those acting on their behalf felt confident to raise concerns.

Is the service well-led?

Good

The service was not always well led.

People's views were not an integral part of the quality assurance process.

The registered manager did not notify the commission about an event that had taken place at the service.

The provider had made key links with organisations and looked at ways they would keep informed of best practice.

Brooklyn House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 comprehensive inspection took place on 20 November 2017 and was unannounced. The inspection was carried out by one adult social care inspector. We last inspected Brooklyn House on the 4 March 2015. At that time we found no breaches of the legal requirements.

Whilst some people were able to talk to us, others could not. During our inspection we observed how the staff interacted with people and we spent time observing the support and care provided to help us understand their experiences of living in the service. We observed care and support in the communal areas, the midday meal, and we looked around the service.

Prior to this inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We also reviewed the information the provider had given us in their 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 the improvements they plan to make.

Some people were able to talk with us about the service they received but others could not. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with three people, one family member, five staff, including the manager, deputy manager, two support workers, and the administrator. We also spoke with one health and social care professional. After the inspection, we contacted the local authority and asked them for some feedback. We have incorporated their views and comments into the main body of our report.

We looked at the care records of four people using the service, three staff personnel files and training

records for all staff, staff duty rotas and other records relating to the management of the service.

Good

Is the service safe?

Our findings

People were not always supported by a sufficient number of staff and the registered manager could not demonstrate how they calculated safe staffing levels. The registered manager said, "We do not use a dependency tool for staff. I look and see who works well together." We found that this approach was not effective because it did not consider the competence of staff allocated to the particular shift. For example, a recent safeguarding incident had occurred because staff allocated to the night shift were not competent to administer a person's medicines.

We inspected staff rotas. We found that during the day there were two care staff and one senior on shift. Staff told us that the senior on shift usually dealt with health professionals and updated care records rather than delivering 'hands on care' to people. At the time of the inspection there were 10 people who needed two staff to support them. This meant at certain times of the day some people would have to wait to be supported. One staff member said, "Sometimes we are a bit pushed. Most people have a high level of dependency. A lot of people need hoisting and help to eat. We do need more staff at key times."

On the day of the inspection, there were two members of staff providing care to people. The manager was supported by a deputy and an administrator, and they also assisted with care during key times of the day. Although improvements were required we did not see any impact on people during our inspection.

We recommend that the provider looks at best practice around how to calculate staffing levels and increase staffing numbers as required.

Risk assessments were in place but some of these needed to be more detailed in order to provide a robust overview of the risk posed. For example, we looked at the risk assessments for three people who had bed rails in place. They lacked sufficient detail and did not consider how mobile the person was and if using bed rails could result in them sustaining an injury. We looked at the care plans for people who needed help to eat and drink safely. There were no risk assessments to assess the risk of choking for these people. Although improvements were required we did not see any impact on people during our inspection.

We recommend that the service seek advice and guidance from a reputable source regarding assessing risk for people at risk of choking and for when bed rails are used.

Other risk assessments covered areas important to people and aimed to protect people from harm. The risk assessments and management plans contained clear guidance for staff and, detailed the staff training and skills required to safely support the person. Staff had a good working knowledge of risk assessments and measures to be taken to keep people safe. Risk assessments and management plans were reviewed and included the involvement of relevant professionals.

People told us they felt safe and liked the staff that supported them. One person said, "Yes, I feel safe here. They meet my needs, these staff are good." Another person said, "Yes, the staff are really nice here, they do what they can to help you." We saw people were comfortable with staff and actively sought out their

company. Relatives and health and social care professionals told us the service kept people safe.

Staff had received training in safeguarding of vulnerable adults and knew about the different types of abuse and what action to take when abuse was suspected. There was a safeguarding procedure for staff to follow with contact information for the local authority safeguarding team. Staff knew how to 'whistle blow' to alert management to poor practice.

Relevant checks were carried out before staff started work. These checks included a Disclosure and Barring Service (DBS) check. This allows employers to check an applicant's police record for any convictions that may prevent them from working with vulnerable people. References were obtained from previous employers. Recruitment procedures were understood and followed by the manager.

Medicines were stored securely and in line with the provider's policy. Individual protocols were in place identifying how people preferred to take their medicines. Some people were prescribed medicines to be given 'as required'. These were to be administered when people needed them for medical emergencies, pain relief or to reduce anxiety. Information was available for staff to know when and how these medicines should be offered to people. Staff had received training in administering medicines and had their competence assessed regularly.

We looked at the records of the administration of medicines. Staff were required to sign when the medicine had been administered and the person had taken them. After the incident had occurred where the person had not been given their medicine at night, the registered manager carried out a robust investigation and took action to make sure this did not occur in the future. For example, all of the staff involved had been given medicines refresher training and had their competency reassessed. Some staff had been moved to cover day shifts instead of night to help increase their confidence. The registered manager had introduced a new on call system in cases of emergency. The registered manager said, "One member of staff was moved to the day shift and their confidence has improved. Lessons have been learned and changes were made as a result."

Health and safety risks relating to the environment had been identified and action was taken to keep people safe. The risk of fire had been assessed and equipment regularly inspected and maintained. Plans were in place to ensure people were safe when using the bathrooms and kitchen. Checks had been carried out on electrical equipment. Hot water temperatures were monitored to ensure people were not at risk of scalding. Plans were in place to keep people safe in the event of emergencies. These included personal evacuation plans in the event of a fire.

Records of any accidents and incidents were completed. These were analysed and looked at what had happened before, during and after the event. Preventative measures to be taken to reduce the risk of reoccurrence were then identified. We saw the manager regularly reviewed these to identify any themes or trends.

Staff had access to the equipment they needed to prevent and control infection. This included protective gloves and aprons. The provider had an Infection prevention and control policy and staff had received training in food hygiene. Cleaning materials were stored securely to ensure the safety of people.

Good

Is the service effective?

Our findings

People told us their needs were met. One person said, "They do the things that you want them to, that is enough for you." We observed staff provide care people required, when they wanted and needed it. Health and social care professionals we spoke with confirmed they felt the service met people's needs. They said, "Staff are knowledgeable and well informed. This home is usually very calm. I have no concerns."

A policy was in place in relation to protected characteristics under the Equality Act. The Equality Act covers the same groups that were protected by existing equality legislation; age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity. These are now called `protected characteristics´.

An accessible communication policy was in place but the provider had not implemented this into care practice. For example, the policy stated that they would identify and share information or communication needs relating to a disability, impairment or sensory loss. Records did not flag up when people required accessible information and communication support. The registered manager told us they were going to complete some additional training in this area.

People were cared for by staff who had received the training required to meet people's needs. We viewed the training records for all staff. These identified when staff had received training in specific areas and, when they were next due to receive an update. All staff received core training which included; first aid, infection control, fire safety, food hygiene, equality and diversity, administration of medicines and safeguarding vulnerable adults. In addition, the provider offered additional training such as experiential learning in relation to dementia. This training aims to equip staff with an understanding of what it is like to have dementia.

Newly appointed staff completed induction training,including the completion of the Care Certificate. The Care Certificate was introduced in April 2015 for all new staff working in care and is a nationally recognised qualification.

Staff received the support required to effectively carry out their role. Staff told us they received regular supervision and records showed that supervisions were held regularly. Supervision meetings are one to one meetings a staff member has with their supervisor.

People chose what they wanted to eat and we saw people had access to a variety of drinks throughout the day. Meal times were flexible and we saw people choosing when and where they wanted to eat and drink. Some people sat together at tables. Others choose to stay in the lounge and some decided to eat in their rooms. We observed, one person changed their mind about what they had wanted to eat, so staff asked them what they would prefer and made them something else instead. All of the people we spoke with told us that the food was good.

Some people had been identified as being at risk of malnutrition and there was detailed guidance in place

relating to the processes staff would need to follow to make sure the person was being supported to eat in the correct way. People's weights were regularly monitored and information from speech and language teams (SLT) were clearly recorded. Staff were knowledgeable regarding this and people's food and fluid intake was carefully monitored. When people were at risk of choking, information for staff about how to manage this in the event of emergency was not available.

People's day to day health needs were being met. People's care records showed relevant health and social care professionals were involved with people's care. Plans were in place to meet people's needs and were regularly reviewed. There were detailed communication records in place and records of hospital appointments. People had health plans in place that described how they could maintain a healthy lifestyle. People were registered with the local GP surgery and staff assisted them to make and attend appointments when needed. One health professional said, "They pick up on people's deteriorating health needs quickly and get us involved. They always carry out our instructions."

The accommodation was safe, clean, well maintained, odour free and appropriate for people's needs. One of the bathrooms downstairs was not in use and the registered manager told us that this was going to be refurbished shortly. People had access to appropriate space. The garden and outdoor area was in good condition and could be easily accessed.

People told us that they had been involved in choosing the pictures to be displayed around the home and had a choice of bedding. The carpet in the corridors had recently been removed and changed to more hard wearing flooring. During this process, consideration had been made to when this work was carried out to ensure minimal disruption to the people living there. Because most people living at the service had dementia or other cognitive impairments, we recommend that any future improvements should consider best practice around dementia friendly environments.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this are called the Deprivation of Liberty Safeguards (DoLS).

Policies and procedures were in place and staff had received training on the MCA and DoLS. Care plans contained an assessment of people's capacity to make specific decisions. These were individual to the person and identified when the person was most likely to be able to make a decision and how it should be explained to maximise their understanding.

Some people had been assessed as not having the capacity to consent to their care arrangements. They were also subject to continual supervision to ensure they were safe and their needs were met. The manager and staff had recognised this amounted to a deprivation of their liberty and had submitted applications to the appropriate authorities.

Staff actively encouraged people to make their own day to day choices and decisions. We saw they asked for

people's consent before providing care and support, gave them options to determine what they wanted to do and, respected their decision if they changed their mind. Care records gave clear information to staff about where and how people could be supported to make those decisions.

Good

Is the service caring?

Our findings

People told us the staff were caring. One person said "The staff are caring. They are very nice." Another person said, "The staff are kind they can't do enough for you."

We saw people were treated in a kind, caring and respectful way by staff. Staff were friendly, sensitive and discreet when providing care and support to people. They clearly knew people well and respected them and were able to tell us about people's interests and individual preferences.

During the inspection, we saw that whilst the staff were very busy, they did deliver care in a compassionate and personal way. We observed a number of positive interactions and saw how these contributed towards people's wellbeing. A person started to touch a member of staff's side and said, "Is this my lunch. I think this is my lunch." The staff member responded well to this well by saying, "No, I am not your lunch that's my body." They both laughed at this.

Staff spoke to people in a calm and sensitive manner and used appropriate body language and gestures. One person with dementia became confused and asked where their car was. Staff responded well to them by telling them not to worry it's in the car park. This immediately reassured them and they spoke about other things.

Staff used every moment as an opportunity to provoke a memory. For example, at lunchtime we saw staff asking someone what the fruit was in the trifle. The person couldn't remember so they kept having mouthfuls to try and guess again. This was a good way of encouraging this person to eat.

People were supported to maintain relationships with family and friends. People's care records contained contact details and arrangements. Staff said they felt it important to help people to keep in touch with their families and friends. People who did not have any direct involvement from family members were supported to access advocacy services.

Staff knew what stimuli may make people agitated and what to do to reassure people. We saw that staff understood how to speak with people and hold conversations at the pace that the person understood. One staff member told us that some people may lose track when they were having a conversation but that offering a gentle reminder of the last sentence was often enough to jog their memory.

Staff looked for different ways to communicate with people. One staff member explained, "[Name] isn't able to speak using many words, but they use their eyes and they point. You develop an understanding about how they communicate."

Staff we spoke with said they felt the care people received was good and, when asked, all said they would be happy for a relative of theirs to use the service. One staff member said, "Yes the care is good. We care for them very well. We laugh with them and we cry with them. If we had more staff it would an improvement as we would have more time to spend with them, just to sit and chat."

Promoting people's independence was a theme running through people's care records and our discussions with staff. One staff member explained, "We encourage [Name] because they would happily let you do everything for them, but they have so much ability. We really try to encourage them to do as much for themselves as they can."

People were treated with dignity and respect. Staff knocked on people's doors and sought permission before they entered people's own rooms. Staff told us what they did to make sure people's privacy and dignity was maintained. This included keeping people's doors closed whilst they received care. Telling them what personal care they were providing and explaining what they were doing throughout. Staff carefully and sensitively sought people's views. This was achieved by observation of people's reactions and where possible discussion with keyworkers and regular care plan reviews which were clearly recorded.

People's care records included an assessment of their needs in relation to equality and diversity and we found the provider looked at ways to meet people's cultural and religious needs. For example, by supporting people to participate in religious activities that were important to them.

Good

Is the service responsive?

Our findings

The registered manager told us that making sure the detail surrounding people's preferences at the end of their life was currently being reviewed to make sure there was enough guidance for staff on what to do if this occurred. Whilst some had plans in place other people did not. Some people had information about decisions people had made on hospitalisation and where appropriate a Do Not Attempt Resuscitation Record (DNAR) was in place. A DNAR is a way of recording the decision a person, or others make on their behalf if they were not to be resuscitated in the event of a sudden cardiac collapse.

Only one meeting had been held with people to seek their views regarding their care and support, but we found that the provider used informal ways to seek feedback. For example, people told us that they had been involved in choosing the pictures to be displayed around the home. The registered manager explained that more meetings were scheduled to take place. One relative said, "No, there are no meetings, we would like this to happen more often."

The service responded to people's needs. Each person had detailed care plans in place that identified how their assessed needs were to be met. This included information on their background, hobbies and interests and likes and dislikes.

People's changing care needs were identified promptly and were reviewed with the involvement of other health and social care professionals where required. Staff confirmed any changes to people's care was discussed regularly at shift handovers to ensure they were responding to people's care and support needs. Staff told us this was important to ensure all staff were aware of any changes to people's care needs. A handover is where important information is shared between the staff during shift changeovers.

Care plans also included detailed assessments which took into account people's physical, mental, emotional and social needs. Care plans were regularly reviewed on set dates or when people's needs changed. Relevant health and social care professionals were involved where required. Professionals told us their advice was listened to and acted upon by staff.

Staff supported people in activities, such as quizzes, games and arts and crafts. Seasonal events were also celebrated. The registered manager looked at creative ways of enabling people to keep in touch with family and friends and some people used Skype calls to do this.

Staff helped people to remember significant events and people's rooms were personalised and photographs of family members and friends were on display. Staff had taken action to assist those people with memory loss to maintain their independence as much as possible. Each person had a memory board in their room which included things that were important to them.

People, their families and friends all said they felt able to raise any concerns they had with the registered manager or staff. There had not been any complaints regarding the service in the 12 months leading up to our inspection. The manager explained the process used if complaints were received.

Good

Is the service well-led?

Our findings

Staff spoke positively about the registered manager and described them as being open and approachable. The registered manager told us they were still developing their understanding of their role. They spoke passionately about the changes they would like make to improve outcomes for people. Plans were not in place specifying how changes were going to be made, and when this was going to be achieved.

The registered manager did not fully understand the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They did not always know when notifications had to be submitted to the CQC. These notifications inform us of events happening in the service. We found an example of a recent safeguarding incident that we had not been notified about. The registered manager submitted a notification to the commission following the inspection and assured us that they would make sure that notifications were submitted to the commission in the future.

Quality assurance systems were in place to identify areas for improvement and audits were completed by the registered manager which looked at a number of key areas. The provider had engaged the services of an external social care consultant who had completed a thorough review of the service earlier in the year. The registered manager told us that surveys had been undertaken, but that they were unable to locate them. We offered the registered manager extra time following the inspection to send this information to us.

The management structure was clear and understood by staff. The registered manager was assisted by a deputy and an administrator. Without exception we were told the manager and senior staff were supportive and approachable. Staff told us they were able to raise any concerns regarding poor practice and were confident these would be addressed. Individual staff were delegated 'functional roles'. These were areas of responsibility given to them which were then overseen by senior staff. Examples of these roles included; dementia, nutrition, and infection control. Staff we spoke with felt these roles were both helpful and helped them feel 'valued'.

The registered manager provided an on call system for staff to access advice and support if they manager was not present. This allowed staff access to a senior manager at all times for advice and support. Staff confirmed they were able to contact a senior person when needed.

The registered manager had made links with other organisations and looked at ways they would keep informed of best practice by working with the local authority to achieve this. We received positive feedback from the local authority they said, "The changes implemented to the service have been positive and there is a good staff team in place since the new owners took over last year. The owner regularly attends the manager's forums that we have set up in Tendring and is also sharing training with other providers in the area."

Staff meetings were held regularly. We looked at the minutes of previous meetings and saw a range of areas were discussed. These included; individual care and support arrangements and staff related issues. Staff told us they found these meetings helpful. Records of these meetings included action points which were

monitored by the manager to ensure they were completed.

A copy of the most recent report from CQC was on display at the service and accessible through the provider's website. This meant any current, or prospective users of the service, their family members, other professionals and the public could easily access the most current assessment of the provider's performance.