Brookes Home Care Services Limited

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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

About the service
Brookes Home Care Services Ltd is a domiciliary care service which provides personal care and support to people in their own homes. At the time of the inspection there were 42 people using the service. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
We have made one recommendation regarding recruitment.

There were recruitment procedures, to ensure the right staff were employed and people were protected from harm. However, it was not clear these procedures were consistently followed. It was not clear from records viewed that some references for staff had been verified. The provider took immediate action to update records. People were protected from the risk of harm and abuse. There were effective systems and processes in place to minimise risks. People's relatives told us people were safe in the presence of care workers.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People were supported to maintain their independence. People's relatives told us about how care workers took time to support people to participate as fully as they could.
There were systems in place to ensure proper and safe use of medicines. We observed from records people received their medicines on time.

People received person centred care. Their needs were met through good organisation and delivery. Their assessments showed they had been involved in the assessment process.

Care workers were knowledgeable about people's needs. They had completed essential training and we saw from records they were up to date with it.

People were protected from the risks associated with poor infection control because the service had processes in place to reduce the risk of infection and cross contamination.

There were governance structures and systems which were regularly reviewed. There was a complaints procedure in place, which people and their relatives were aware of. Quality assurance processes such as audits and spot checks were in place.

There was a process in place to report, monitor and learn from accidents and incidents. Accidents were

documented timely in line with the service's policy and guidance.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for the service under the previous provider was good, published on 6 May 2020.

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our safe findings below.

Is the service caring?

Good

The service was caring.

Details are in our safe findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our safe findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our safe findings below.

Brookes Home Care Services Ltd

Detailed findings

Background to this inspection

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

Inspection team
The inspection team consisted of one inspector and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection. We visited the office location on 26 August 2022.

What we did before the inspection
Prior to the inspection we reviewed information and evidence we already held about this service, which had been collected via our ongoing monitoring of care services. This included notifications sent to us by the service. Notifications are changes, events or incidents that the provider is legally obliged to send to us without delay. This information helps support our inspections.

During the inspection
We spoke with 16 relatives of people who used the service to help us understand the experience of people who could not speak with us. We also spoke with four people using the service. We spoke with the registered manager, a care coordinator, a field supervisor and four care workers. We reviewed the care records of seven people using the service, personnel files of five care workers and other records about the management of the service.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Good. The rating for this key question has remained Good. This meant people were safe and protected from avoidable harm.

Staffing and recruitment
• There were recruitment procedures, to ensure the right staff were employed and people were protected from harm. However, it was not clear these procedures were consistently followed. For example, it was not clear from records viewed that references for staff had been verified. The provider took immediate action to update records.

We recommend the provider consider current guidance on recruitments standards to ensure safe recruitment procedures are always followed.

• Notwithstanding the above, staff recruitment checks including criminal checks with the Disclosure and Barring Service were carried out to ensure people were protected from being supported by unsuitable staff. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
• There were enough staff to support people's needs, and people told us staff arrived relatively on time. Feedback from people and they relatives included, "Staff are efficient and on time", "If they are running late which is very rare, they send me a text to let me know. Always stay for the full call" and "The carers arrive on time and stay the allocated amount of time."
• People had regular care workers and were happy with the care they received. Comments included, "We do have the same [care worker]. She does what my [relative] needs and is very friendly" and "My sister has only the one regular carer since she started."
• A couple of people said care workers went over and above helping them. People and their relatives spoke in complimentary terms about the willingness of staff to go an extra mile. The flexibility of staff brought about the most praise from relatives.

Systems and processes to safeguard people from the risk of abuse
• People were protected from the risk of harm and abuse. There were policies covering adult safeguarding, which were accessible to all staff. They outlined clearly who to go to for further guidance.
• Care workers had received up-to-date safeguarding training appropriate to their role. They knew how to identify and report concerns. They were aware they could notify the local authority, the Care Quality Commission and the police when needed.
• People's relatives told us people were safe in the presence of care workers. One relative told us, "My [relative] has been having care [several] times a day [for some time]. I trust the [care workers] completely." Another relative told us, "I feel my [relative] is 100% safe with this company. The communication is excellent."

Assessing risk, safety monitoring and management
• There were adequate systems to assess, monitor and manage risks to people's safety. Comprehensive risk assessments were carried out for people. People's care files contained a range of risk assessments. In all examples, the assessments provided information about how to support people to ensure risks were reduced. For example, a care plan of one person identified complications of diabetes and how to prevent them. The care plan identified the common causes, signs and symptoms of low or high blood sugar.
• The same approach was repeated across the range of risk assessments in place. These had been kept under review to ensure people's safety and wellbeing were monitored and managed appropriately.

Using medicines safely
• There were systems in place to ensure proper and safe use of medicines. There was a medicine policy in place and staff were trained in the administration of medicines and had their competency to do so spot checked.
• Medicine Administration Records (MARs) were in place for people who were provided support with their medicines. There were no gaps in the MARs, which provided assurance medicines were being given as prescribed.
• A relative told us, "[My relative] always gets her medication on time. [The care workers] explain what is being given and why. They record what has been given on a chart in the folder." Another relative said, "They give medicines from a dossett box and they get on to the pharmacy when running low to prompt them."

Preventing and controlling infection
• People were protected from the risks associated with poor infection control because the service had processes in place to reduce the risk of infection and cross contamination. Care workers were supplied with appropriate personal protective equipment (PPE), including gloves and aprons. They had also completed training in infection control prevention.
• People's relatives told us care workers followed appropriate procedures for minimising risks that could arise from poor hygiene and cleanliness. One relative told us, "[The care workers] wear masks and aprons. They leave [my relative's] room as tidy as they can and ensure the bed rails are in place before leaving."

Learning lessons when things go wrong
• There was a process in place to monitor any accidents and incidents. Accidents were documented timely in line with the service's policy and guidance. These were analysed by the care coordinator for any emerging themes. There were no incidents recorded at the time of the inspection.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Good. The rating for this key question has remained Good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed, before support plans and risk assessments were drawn up. Agreed goals of care were delivered in line with standards, guidance and the law. Relevant guidelines were in place, including those drawing from the National Institute of Health and Clinical Excellence (NICE).
• People's assessments covered a wide range of areas including their choices and preferences. People told us they received the care they needed, and their choices and preferences were responded to. A relative told us, "[The care worker] does make sure [my relative] has choice such as shower or a wash. This is the same when it comes to meals and drinks."

Staff support: induction, training, skills and experience
• Care workers had the appropriate skills and training. They demonstrated good knowledge and skills necessary for their role. We were able to view training matrices and documentation that confirmed the required competencies had been achieved.
• New staff completed an induction using the Care Certificate framework before starting work. The Care Certificate is a method of inducting care staff in the fundamental skills and knowledge expected within a care environment.
• We saw records confirming that supervision and support were being provided. Care workers who had been at the service for longer than a year also received an annual appraisal, including monthly spot checks to monitor their performance when supporting people.
• Relatives of people receiving care told us the care workers were skilled at their jobs and knew what to do. Their feedback included, "[The care workers] are really well trained to care for our [relative]."

Supporting people to eat and drink enough to maintain a balanced diet
• People's dietary needs were met. People's relatives told us care workers provided the necessary support to ensure people ate and drank in line with their preferences.
• A relative told us, "[My relative] can feed herself but the [care workers] always ask what [my relative] would like to eat and drink. They help her cook batch meals so there are always spare meals available. They record everything she has eaten or drunk and before leaving they ensure she has plenty of drinks and snacks to hand." Another relative said, "The [care workers] do breakfast and lunch. They always check that I have left [my relative] enough drinks and snacks to hand if [my relative] wants anything in between."

Supporting people to live healthier lives, access healthcare services and support
• People's health needs were met. Their care plans identified their needs and input from a range of professionals, including GP, district nurses and occupational specialists.

• People's relatives told us care workers accompanied people or arranged visits to hospitals and appointments with GPs. A relative told us, "The [care workers] will contact me if they feel my [relative] is not her usual self. [The care worker] has on one occasion called the GP and then called me so I could get to my [relative] and await the GP." Another relative said, "When my [relative's] health was declining. the company contacted the [local authority] to push for a [much needed equipment]. The company was very helpful pushing for it. This has made a big difference."

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

• The service was working within the principles of the MCA. People told us care workers obtained consent before they could proceed with any task at hand. People or their representative signed care plans. These showed consent to care and treatment had been obtained.
• People's relatives told us care workers asked people if they needed any assistance. A relative told us, "My [relative] does not always respond to staff because of a [medical need]. However, staff talk to her telling her exactly what they are going to do. If [my relative] won't let them do something they call us." Another relative told us, "They let her make the decisions she can; what she wants to wear or give her three options of which meal to eat."

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question Good. The rating for this key question has remained Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Respecting and promoting people's privacy, dignity and independence
• People's relatives told us care workers were kind and caring. They said, "[Care workers] are really compassionate and even when my [relative] can't respond they ensure [my relative] knows exactly what they are going to do next. They understand [my relative's] different moods due to [a medical condition] and show a great deal of patience and compassion" and "The [care worker] is very kind and compassionate towards my [relative]. They go the extra mile, encouraging [relative] to undertake activities. When our [relative] feels tired or fatigued at times when this is much worse, the [care workers call me to discuss the situation."
• People's privacy was respected. The care plans described how people should be supported so their privacy and dignity were upheld. A relative told us, "The care workers] ensure my [relative] has privacy when using the toilet and when undertaking personal care." Another relative told us, "The [care workers] ensure doors are closed and they tell the family not to enter while they do my [relative's] personal care." A third relative told us, "It was there idea we put curtains up. We only had nets up, but they said it needs to be more private in the room."
• People could describe how the agency protected their dignity. A relative told us, "My relative [requires support with personal care] and [care workers] are very respectful [when carrying out the task]." For reasons related to dignity or specific cultural traditions, some people preferred to be supported by care workers of their own gender, which was supported. One person told us, "We were given an option of male or female and our preference is respected."
• People were supported to maintain their independence. People's relatives told us about how care workers took time to support people to participate as fully as they could. They told us, "The [care worker] encourage my [relative] to do things" and "The [care worker] does encourage my [relative] to do things and taking her out for short walks."
• Privacy and confidentiality were also maintained in the way information was handled. Care records were stored securely in locked cabinets in the office and, electronically. The service had updated its confidentiality policies to comply with General Data Protection Regulation (GDPR) law.

Ensuring people are well treated and supported; respecting equality and diversity
• The service respected people's diversity. Care workers had received equality and diversity training. They understood the importance of treating people fairly, regardless of differences. Relevant policies were in place, including, equality and diversity and Equalities Act 2010. This ensured people's individual needs were understood and reflected in the delivery of their care.
• People's relatives told us people were well treated. A relative told us, "[Care workers] are very caring. They

noticed when [my relative] was wheezing after a meal and were not happy to leave her. They contacted [professionals] and one of them stayed an extra half hour." Another relative told us, "The [care workers] are 100 % caring. They have really got to know [my relative]. They treat her like she is their mum. If they finish the care side early, they sit and chat with her. If they have cooked, they bring her things to try. They have built up a relationship with her."

Supporting people to express their views and be involved in making decisions about their care
• There were systems and processes to support people to make decisions. As addressed earlier, the service complied with the provisions of the MCA 2005. Care workers were aware of the need to seek people's consent before proceeding with care.
• The care coordinator maintained regular contact with people through telephone calls and reviews. This gave people opportunities to provide feedback about their care. Records showed people had been consulted about their care. A relative told us, "They call us for feedback, and I would contact them with any concerns."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question Good. The rating for this key question has remained Good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• People received person centred care. Care plans were written to reflect their choices, likes and dislikes. Their assessments showed they had been involved in the assessment process. A relative told us, "We were very much involved in the setting up of my [relative's] plan and we got exactly what we needed. They record everything they have done in the folder so we can also check on what they have done and when."

• People's care files contained meaningful information that identified their abilities and the support required to maintain their independence. For example, people with diabetes had specific care plans outlining what the condition meant to them and how it affected them. This ensured they received care that met their needs.

• Care workers were knowledgeable about people's needs. They could describe people's preferences, likes and needs. Their knowledge of people's needs was also enhanced by the fact they had been allocated to the same people regularly, which meant they were familiarised with people's needs. A relative told us, "My [relative] has one regular care worker through the week and two on weekends. They are fantastic."

• Care plans were regularly reviewed to monitor whether they were up to date so that any necessary changes could be identified and acted on at an early stage. A relative told us, "The original care plan has been altered as [my relative's] needs have changed." Another relative said, "We have a care plan. Over the years due to a decline in [my relative's] health it has changed."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• Each person's preferred method of communication was highlighted in their care plans, which enabled staff to communicate with people in the way people preferred.

• People were matched with care workers on grounds of a mutual language. People spoke a range of languages, and the service employed staff who spoke as many languages. A relative told us, "They really try their best to find [care workers] who speak my [relative's] language as [my relative] doesn't speak or understand English." Another relative said, "Anything we asked for has been done. At the beginning we asked that our [relative] who is unable to verbally communicate, have one constant [care worker] which was supported. We are very happy with the consistency."

End of life care and support

• The service provided end of life care. All staff had completed end of life care training and were knowledgeable of what was required. A relative told us, "The care plan was done with the hospice. My [relative] is receiving end of life care; excellent care during a time of great need." Another relative said, "Originally they were caring for my [relative] who has since died. When my [other relative] needed care, I had no hesitation using them again."

Improving care quality in response to complaints or concerns
• There was a complaints policy and people's relatives confirmed they could complain if needed to. They told us, "Never had to make a complaint. Would not hesitate to if needed", "Never had to make a complaint or raise an issue", "I have not had to make any complaints or raise any issues, but I would know what to do should something arise" and "The supervisor is very helpful. Our complaint was handled sensitively and resolved to our satisfaction."

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Good. The rating for this key question has remained Good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

• There were systems to assess and monitor the quality and safety of the service. However, some improvements were required to improve management oversight. For example, the provider's own audits had not identified issues relating to recruitment. The registered manager and the care coordinator were open to the feedback provided during the inspection and took some immediate actions to make improvements.

• The service had a clear management structure consisting of the registered manager, a care coordinator and field supervisors. Staff were well informed of their roles and reporting structures. They told us the management was supportive. People's relatives also described the management in complimentary terms. One relative told us, "I have been dealing with [care coordinator]. She came to the house and introduced a new [care worker]. Since then she has regularly checked to see how we are getting on with the [care worker]. I am sure if an issue arose, she would resolve it to our satisfaction. She is approachable and so I would not be afraid to raise an issue should it ever arise."

• The service had a range of policies and procedures to ensure that care workers were provided with appropriate guidance to meet the needs of people. These addressed topics such as, medicines management, safeguarding, equality and diversity, sexuality, communication, and end of life care.

• The provider worked with other organisations to improve care and support for people using the service. They were involved in provider engagement groups organised by the Local Authority which aimed to help improve care services in the local area.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• The registered manager was knowledgeable about the characteristics that are protected by the Equality Act 2010, which we saw had been fully considered in relevant examples. As addressed earlier, there were practical provisions to support people's religious or cultural needs.

• The provider understood people's opinions mattered. There were a range of formal systems to seek people's input to improve and develop the service. Regular meetings and care reviews took place and people were free to express their views. People received regular unannounced spot checks and telephone calls. People's relatives told us, "I have filled in surveys in the past and get asked if everything is ok" and "I am involved in all decisions. The [care coordinator] does welfare calls to check if any changes are needed or if we have any concerns." This ensured they were consulted and given opportunities to comment about their

care.
• The provider told us they had complied with the duty of candour by being transparent with family members of people they supported. Duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. We had been notified of notifiable events and other issues.

Working in partnership with others
• The service worked in partnership with a range of health and social care agencies to provide care to people. These included, GPs, psychologists, district nurses, pharmacists and occupational therapists.