Care Quality Commission

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Brockhampton Court Care Home with Nursing

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Brockhampton Court Care Home with Nursing is a care home providing personal and nursing care to a maximum of 58 older people and younger adults with physical disabilities within a large adapted building. At the time of our inspection, 39 people lived at the home.

People's experience of using this service and what we found
There were aspects of the home environment that required action to ensure it was safe. For example, windows were not restricted, unsafe areas were unlocked and communal bathrooms had hot water pipes exposed. People's medicines were not managed and stored in a safe way. The provider's representative recognised the seriousness of our concerns and took action to mitigate immediate risk.

People were safeguarded from the risk of abuse, and lessons were learnt following incidents and accidents. There were sufficient infection prevention and control arrangements in place and the home was clean. People told us staff were caring and kind. There were sufficient staff available to meet people's needs. Staff were recruited safely and had pre-employment checks to determine their suitability for employment.

The provider had systems in place to monitor the quality of the service, however, this was not always effective. People had access to information about how to raise a complaint and felt listened to. Staff worked with external healthcare professionals to follow their guidance and advice about how to support people following best practice. 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.

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 this service was good (published March 2021).

Why we inspected
The inspection was prompted in part due to concerns received about medicines, infection control and staffing and also in part by a notification of an incident following which a person using the service sustained a serious injury. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment of people at this inspection. Following our inspection, the provider took action to mitigate the risks identified and has sent us written and photographic evidence to confirm changes to the environment and management of medicines has been effective.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Care Quality Commission

Brockhampton Court Care Home with Nursing

Detailed findings

Background to this inspection

The 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection team consisted of 2 inspectors and an Expert 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
Brockhampton Court Care Home with Nursing is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under 1 contractual agreement dependent on their registration with us. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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 not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider completed a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 8 people about their experiences of what it was like living at Brockhampton Court Care Home with Nursing and 2 visiting relatives. We spoke with 11 staff including the manager, managing director, quality assurance manager, head of care, nurses, team lead and agency care staff.

We reviewed a range of records. This included samples of 3 people's care records and multiple medication records. A variety of records relating to the management of the service, audits, complaints, compliments and evidence of activities people were involved and people's overall feedback about the service were also viewed.

Requires Improvement

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. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● During the inspection we identified regular maintenance checks were not completed to ensure the environment was safe. This included finding some rooms that should not be accessible to people were unlocked. For example, sluice rooms, which are designed for the disposal of human waste, were not locked, which posed a health and safety risk to people. Also, hot water pipes were exposed in some communal bathrooms. This posed a risk to people scalding themselves.

● Appropriate window safety restrictors were not consistently fitted to the windows at the home. This issue had not been identified during any of the maintenance checks completed, and increased risks to people who could fall out of windows.

● People living at the home and their visitors had free access to a flat roof area which was being used as a balcony seating area. The barrier around this space was not sufficient to reduce the risk of people falling from height.

The provider had failed to robustly assess the environmental risks relating to the health safety and welfare of people. This was a breach of regulation 12 (2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In response to our concerns, the managing director arranged for window restrictors to be fitted, access to unsafe areas to be controlled and exposed hot water pipes to be covered immediately following our inspection.

Using medicines safely

● Medicines were not managed safely. We found records relating to the safe management of medicines were not always accurate. This increased the risks of people not having their medicines as prescribed.

● Checks on records and stock levels were not frequent enough to promptly identify potential medicine errors and medicines prescribed for people who had passed away were not disposed of in a timely manner.

The provider had failed to safely manage medicines. This was a breach of regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed medicines management with the management team, who advised they were reviewing how medicines were being overseen and would be increasing the frequency of their checks immediately.

● People confirmed their 'as required' medicine, such as pain relief, was offered. One person told us, "My

medication is complex but they [staff] manage well and I get the right things at right time. I would know if they were wrong."

Systems and processes to safeguard people from the risk of abuse
● People and their relatives said they felt care was safe at Brockhampton Court. One person said, "I feel very safe, they [staff] are very careful and caring." Another person said, "The staff are all lovely, polite, clean and helpful."
● Staff understood how to raise concerns of suspected abuse. Records showed staff had received on going safeguarding training in order to enable them to identify and respond to safeguarding concerns.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● Staff at the service were working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Staffing and recruitment
● People told us they felt safe and were supported by a consistent group of permanent and agency staff who knew them well to ensure continuity of care. The management team told us they were actively recruiting for additional permanent staff.
● Staff were recruited safely. Recruitment files contained a completed application form, satisfactory references, photographic identification and a Disclosure and Barring Services (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
●People told us and we saw there were enough staff on shift to meet people's needs in a timely manner. Staffing levels were allocated in line with the provider's dependency tool. This is a system which determines how many staff are needed to meet people's assessed needs.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● At the time of our inspection, the home was classed as being in 'enhanced surveillance' as the home moved out of an outbreak of COVID-19. This meant people were not restricted from visiting their relatives or loved ones, however they were asked to wear a mask at all times within the home and to undergo a lateral flow test (LFT) to check they were not carrying COVID-19.

Learning lessons when things go wrong
● Accidents and incidents had been recorded on the home's electronic system. Documentation included what had happened, action taken, outcomes and lessons learned. Additional analysis had been completed to look for potential causes, patterns and trends to help prevent a reoccurrence.

Requires Improvement

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. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of 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
● We found shortfalls in the management of risks to people's safety and welfare including oversight of environmental risks and medicines management. These concerns had not been identified or resolved through any governance processes.
● A range of systems and processes were in place to assess the quality and performance of the home and care provided. However, we found there were several different staff tasked with completing their own audits and the manager failed to ensure they had effective oversight of the service. This posed the risk of information not being shared between staff leading to a failure to address any actions required.
● Safety checks and audits carried out by managers were not always robust. Managers had signed to say windows were safe for use, despite appropriate safety window restrictors not being fitted. This increased the risk of injury to people.

The provider's governance systems were not always robust in identifying shortfalls in a timely manner. This placed people at risk of receiving a poor service. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We shared our concerns with the managing director who, after the inspection, sent us comprehensive information in relation to the action that has and will continue to be taken in addressing our concerns. We will monitor this progress at the next inspection.

● 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. At the time of drafting this report, the home had been without a registered manager for over 18 months. The provider's representative assured us the provider was actively trying to recruit to this position.
● Despite these concerns we found no evidence that people had been harmed as a result of inconsistent governance systems. Staff we spoke with understood people's needs well.
● Staff told us they were given training to support them to deliver safe care. One staff member said, "I prefer working here rather than agency work as I feel more supported and we have better training."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● People and relatives told us staff and the manager were open and honest and any concerns had been

dealt with appropriately.
● The management team understood their duty of candour, although we found no instances of its use. We spoke with one relative who told us, "They [staff] do ring me and keep me informed if anything happens."
● The management team had acted on our urgent concerns during our inspection and was open to feedback on improving the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People told us there wasn't a choice of meal for lunch, however if they didn't like the option given, people told us they would be given an alternative if they requested it from the kitchen.
● People were given choices regarding where they would like to sit, or how they wished to spend their time. Staff were led by people; staff explored with people what they wanted to do and where they wanted to go. Staff were aware of people's preferences and what was important to them.
● Staff treated people with dignity and respect and the atmosphere in the home was calm. One person told us, "They [staff] are very good, they ask before doing anything, for example, 'would you like me to do your legs now?' They [staff] are very respectful and helpful."
● People were supported to maintain relationships with loved ones and relatives told us they were made to feel welcome.
● There was a system in place for the management of complaints.

Engaging and involving people using the service , the public and staff, fully considering their equality characteristics
● People told us they were regularly consulted about their care and any improvements the service could make. Where appropriate, families and healthcare professionals also had input.
● There was a positive person-centred culture in the home. Each person was treated as an individual with their own unique needs.
● Staff told us they enjoyed working at the service. One member of staff told us, "One thing I'm proud of is being able to make a difference to the lives of people and their families. I treat them [people living at the service] like I would expect my own family to be treated and it's their choice what we do and when."

Working in partnership with others
● The provider worked in partnership with other professionals, including physiotherapy, occupational therapy, dieticians and local GP's to ensure the best outcomes for people using the service.
● Team meetings were held, and staff received regular supervisions from managers. Staff we spoke with felt well supported by managers.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the premises were safe. This placed people at risk of harm. This was a breach of regulation 12 (2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure medicines were safely managed. This placed people at risk of harm. This was a breach of regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish systems to effectively assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (1) of the Health and Social Care Act 2088 (Regulated activities) Regulations 2014.