Abbeyfield Society (The)

Browns Field House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Browns Field House is a residential care home providing personal care to 15 adults at the time of the inspection. The service can support up to 29 people. Browns Field House accommodates people in one building over two floors. The provider was in a consultation period to close the service.

People's experience of using this service and what we found
Risks to people were not always identified, managed or reviewed to ensure people were safe and protected from harm. We could not be confident that staff always took the necessary action to ensure people received the care and support they required. People were not always protected from the risk of cross infection due to some poor infection prevention and control practices. Incidents and accidents were not always reported in a timely way to the manager. Analysis of incidents to identify patterns to learn lessons and prevent reoccurrence had not always taken place at a service level.
Staff had not always received the support they needed to carry out their role effectively. Not all staff had received/ completed inductions, supervisions and appraisals as expected. Senior staff told us they had not completed training to write and review care plans out their role. There was a high dependency on agency staff however where possible the same agency staff were used.

Oversight and audits had not been effective in identifying some areas for improvement and ensuring they were completed in a timely manner. Processes to monitor people's standards of care were not clear and we found gaps in recording and/or monitoring that had not been addressed. Lack of provider oversight had meant that it had not been identified that their policies and procedures were not always being followed.

Information about people was not always up to date and did not reflect their current needs. Care plans had not been regularly reviewed and updated as people's needs changed. Information about how people wanted to be supported at the end of their life was not always in place in a timely manner.

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.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence had good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and/or who are autistic.

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 (report published 06 August 2021).

Why we inspected
We received concerns in relation to the staffing levels and management of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We inspected and found there was a concern with reducing risks to people's safety and identifying areas for improvement and taking prompt action, so we widened the scope of the inspection to become a comprehensive inspection which included all of the key questions of safe, effective, caring, responsive and well-led.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

The provider has taken action to mitigate the immediate risks to people's health and safety.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Browns Field house on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 reducing risks to people, identifying areas for improvement and taking action in a timely manner, ensuring people records are reviewed and updated and that staff receive the support they need to carry out their roles effectively

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Browns Field House

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors carried out this inspection.

Service and service type
Browns Field House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Browns Field House is a care home without nursing care. 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. The provider had employed a consultant to manage the service through the consultation period about the future of the service. During the inspection the provider employed a second consultant to work in the service to provide management cover.

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. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with three people who lived at Browns Field House, we also observed the care and support people received in communal areas of the service. We also spoke with one relative of a person who lives in the service. We spoke with the nominated individual, the director of care operations, the providers consultant who was managing the service, the head of care, one team leader, one senior carer, two care assistants and a member of the housekeeping team and the care service administrator.

The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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

- Not all risks to people had been reduced where possible. This put their health and safety at risk.
- Action had not been taken in a timely manner to ensure risks to people in the event of a fire had been reduced. The service's fire risk assessment had not been reviewed when due in June 2022. The risk assessment had not been reviewed and updated after a small fire in the service, even though the risk remained. A fire drill had not been completed since March 2022. Not all staff had completed fire training. Personal emergency evacuation plans had not been reviewed and amended when people's needs had changed.
- People's risk assessments had not been reviewed to ensure that they held the current information. For example, we saw that although people had been weighed each month this information had not always been transferred to their malnutrition screening tool. It was not clear, and staff could not tell us if action had been taken when people continued to lose weight.
- Food and fluid and repositioning charts were in place to ensure people received the support they required. However, these had not been completed consistently and had not been reviewed by staff to identify any issues so appropriate action could be taken. For example, one person was due to be supported to reposition every hour as they had pressure ulcers on both hips. The records showed large gaps of up to seven hours in repositioning.
- Risk assessment guidance had not always been followed. For example, one person's risk assessment stated that they should be referred to the Falls team if they had three falls within a six-month period. The records showed that the person had sustained three falls within a six-month period, but they had not been referred to the Falls team.

The provider had failed to mitigate risks to people where possible. This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider advised that they were changing the way fire risk assessments were being reviewed and this was completed soon after the inspection.

Systems and processes to safeguard people from the risk of abuse

- Safeguarding policies were not always being followed to ensure people were protected from the risk of harm. One incident had not been reported to the local authority safeguarding team.
- Not all staff could give a comprehensive response about what action they would take if they suspected someone had been harmed.

● Information was displayed throughout the home about what action people could take if they thought someone was at risk of abuse or had been abused. One person told us, "Yes I feel safe here." Another person told us, "I feel safe and secure."

Staffing and recruitment

● Staff were recruited safely. Appropriate checks including Disclosure and Barring checks (DBS) had been made to ensure staff were safe to work with people. (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 was a high dependency use on agency staff. However, the manager tried to use staff that had worked in the service before and were familiar with people's needs. Team leaders told us that due to staff shortages they didn't get to work as many office hours as they normally would so updating and reviewing records had not always been completed.

Using medicines safely

● People received safe support with their medicines provided by trained staff.

● Staff recorded what support they provided on medicines administration records (MAR) for each individual. They also ensured information about prescriber's directions, was available in people's care documentation and adhered to. Medicines were regularly checked and stored safely.

Preventing and controlling infection

● Although the provider's infection prevention and control policy was up to date this was not always being followed by staff. For example, we saw that two staff members were not following the policy of wearing nail varnish and/or false nails. We also saw a staff member remove their mask to communicate with a person who was have difficultly hearing them. However, when we talked to the same person, we were able to write questions down for them to read. The staff stated that the person did actually have a wipe board they could use to communicate.

● We were assured that the provider was preventing visitors from catching and spreading infections. We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● The provider's approach to visiting aligned with government guidance. People were able to have visits from their friends and families.

Learning lessons when things go wrong

● Analysis, review and action in response to accidents and incidents had not always been taken at the service level.

●The provider had a system in place for analysing accidents and incidents for patterns and trends. This information was then sent to the manager. However, the manager at Browns Field House had not been aware of the analysis on our first day of the inspection.

● The provider informed us that improvements were being made to the accidents and incident process so all information entered into the electronic system would be reviewed weekly.This meant the provider could ensure any necessary action had been taken to prevent a recurrence.

Requires Improvement

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. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Assessments had been completed prior to moving into the service to establish if people's needs could be met. There had been no new recent admissions to the service as the provider was in a consultation period to close the service.
- People's care plans did not always reflect people's changing needs. Not all care plans had been regularly reviewed or updated.

Staff support: induction, training, skills and experience

- Staff did not always receive the training and support they required to carry out their role effectively.
- Staff inductions were not always completed in a timely manner. Not all staff had received regular supervisions or an annual appraisal. Staff had not received training in supporting people with a learning disability and autism.

The provider had failed to ensure staff received the necessary training and support to carry out their roles. This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider stated that there had been a recent change to their e-learning provider. This included a new course that would be available to all staff about supporting people with a learning disability and autism.

Supporting people to eat and drink enough to maintain a balanced diet

- People had an initial nutritional assessment completed on admission and their preferences were recorded. When needed people had been referred to healthcare professional for assessments regarding eating and drinking.
- The people we spoke with told us the food was considered to be good. People were encouraged to be independent throughout the meal and adapted equipment and utensils were available. Staff supporting people to eat did so at a pace that suited the person and encouraged and reassured the person when needed.
- It was not always clear from the records how much thickener was needed to be added to drinks for people at risk of choking.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live

healthier lives, access healthcare services and support
● People told us that they could see a GP when they needed and the staff supported them to arrange this.
● It was not always clear if people had been referred to the relevant healthcare professionals. Although care plan and risk assessment reviews identified the need for referrals the records and staff did not always know if these had been completed.

Adapting service, design, decoration to meet people's needs
● The environment was equipped with aids and adaptations to meet people's needs. There were regular health and safety checks in place to ensure all the equipment staff used to support people was safe and in full working order.
● People were encouraged to personalise their rooms with pictures and personal furniture when they moved in.

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

We checked whether the service was working within the principles of the MCA , whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Capacity assessments had been completed where it had been identified that people may lack capacity to make particular decisions.
● Best interest decisions had been made with people who were important to the person. People were still supported to have as much choice and control as they were able to in all other areas of
their daily life and we saw and heard staff ask people how they wanted to be supported and how to spend their time.

Requires Improvement

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. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- Staff did not always use respectful language when talking about people or making entries in their daily notes. For example, one person who had been displaying distressed behaviour was referred to as "having a tantrum."
- Staff sometimes missed opportunities to communicate with people. We observed staff repeatedly walking by people in the communal areas without acknowledging them. One person was seen to be leaning right over with their head nearly on their plate. However, several staff walked by without assisting the person or checking if they needed support.
- Some positive staff interactions were seen with people. Staff acknowledged and spoke to one person who was living with dementia. They spoke in a sensitive manner and engaged in conversation with them and respected their conversation.
- People spoke positively about the staff. One person told us, "The support is absolutely wonderful. It's very dignified when they help me with washing."

Supporting people to express their views and be involved in making decisions about their care

- People were encouraged to make decisions about their care and how they spent their time.
- Staff understood that others could be important to supporting people to make decisions. We saw that the manager involved people's relatives when appropriate in making decisions about the care and support a person required. One person told us, "I really fancied a kipper so the staff went out especially and bought me one to have for my breakfast."
- Visitors were welcomed and there were no restrictions. Family and friends continued to play an important role in people's lives.

Requires Improvement

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. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

- Although care plans were in place staff told us they had not had time to update them for several months due to staffing issues. This meant we could not be confident that information reflected people's current needs. Staff told us that changes in people's needs were included in the handovers from staff between shifts, but records showed that this wasn't always the case.
- Staff did not always follow the information in people's care plans. For example, one person's care plan and risk assessment stated that they should have a sugar free diet. However, the records showed that they were having food and drinks containing sugar. Staff told us that the person could have occasional food and drinks with sugar. In response to our feedback the manager contacted the GP who stated that the person did not need a sugar free diet.
- Important information was missing from some care plans. For example, it had been identified that a person was at risk of dehydration and should have their fluid intake recorded. However, there was no information about what their target fluid intake should be, who was responsible for monitoring the intake records or what action should be taken if they did not meet the required amounts.
- Care plan audits had identified the need for extra information to be included, so that staff had the required information to meet people's needs. However, the care plans had not been updated. For example, one person who had (a medical condition) did not have a care plan in place to ensure staff knew what action to take if there was a a medical emergency.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The manager was aware of the accessible communication standards and information was available in different formats. Staff communicated with each person in the manner that best suited their needs. We saw staff bent down to be at eye level with whoever they spoke with and listened to what people had to say.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were encouraged and supported to maintain and build relationships with their friends and family.
- The provider employed staff to specifically support people to engage with activities that interested them.

Life history information was available to staff to help them identify what activities people would enjoy. Entertainment such as singers regularly visited the service.

Improving care quality in response to complaints or concerns

●The provider had a complaints procedure in place that was displayed throughout the service.

● The manager stated that only one complaint had been received since they had been employed. The complaint was being investigated and action was being taken.

● The provider stated that the internal complaints procedure was being updated so that any complaints would be recorded on their electronic system so that they could be reviewed and assessed by senior management and any action taken if necessary.

End of life care and support

● End of life care plans were not always updated in a timely manner.

● We received positive feedback from one person's family members. They told us, "End of life care is very good, gentle and staff are frequently talking with [family member], they are considerate, kind and maintaining dignity, [family member] feels in a quiet and gentle place. It is reassuring to me and my sister knowing [family member] is being cared for at an important time of their life."

Inadequate

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 inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

- The provider and manager (at the time of the inspection) of Browns Fields House had not identified the areas for improvements that we identified during the inspection.
- During the inspection process we sought assurances for immediate concerns to people's health and welfare. Although the provider submitted an action plan with several points for immediate action, they were not all actioned as stated. This meant we had to take further action to ensure people's health and safety was not being placed at risk.
- Although the procedures were in place to monitor the quality of the service these were not always being followed. Where audits had been carried out, the identified improvements had not always been made.
- Action had not been taken to ensure that staff had the training and support they required to carry out their role effectively. Not all safeguarding incidents had been reported to the appropriate agencies.
- The manager and provider had not carried out checks to a good quality, safe care and support was not always being delivered to people. Action had not been taken to ensure fire drills and risk assessments were completed. Checks had not been carried out on the information to be used in the event of an emergency to demonstrate that it was current and reflected the support people required if they needed emergency evacuation. Care plans and risk assessments had not been regularly reviewed and updated so that they contained accurate information. Monitoring charts such as the intake of food and people's monthly weights were not always being checked to see if any action was needed.
- Although the provider had oversight of the accidents and incidents the manager had not used this analysis or checked some accident and incident reports to see if action was needed to prevent a reoccurrence. When people needed to be referred to healthcare professionals it was not clear if this had been done.

The lack of oversight meant there had been a failure to assess, monitor and improve the quality and safety of the service being provided. This was a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Not all notifications were submitted to the commission. This is because incidents had not always been picked up by the staff team, or management team, and they therefore had not been reported upon. Incidents that had been identified, had statutory notifications completed and submitted.

Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There was a lack of opportunity for people and relatives to share their experience about the service. The manager was not aware of any regular meetings with people or their families or any other consultation to ask people's views on the service.
- The service was supported by a GP practice and district nursing team.
- The local authority had found it difficult at first to engage with the consultation to close the service as there had been very little notice about the first consultation meeting with the provider, people and their relatives.

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 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff had received the training and support they required to carry out their role effectively.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and welfare were not adequately assessed and where reasonably practicable mitigated.

The enforcement action we took:

We served a warning notice on the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to monitor and improve the quality and safety of the services provided. The provider failed to maintain accurate, complete and up to date records.

The enforcement action we took:

We served a warning notice on the provider