Mr and Mrs R Odedra

Bournbrook Manor Home Ltd

Inspection report

134a Bournbrook Road
Selly Park
Birmingham
West Midlands
B29 7DD

Tel: 01214723581

Date of inspection visit:
01 July 2021
05 July 2021

Date of publication:
13 August 2021

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Bournbrook Manor Home Ltd is a residential care home providing personal care to 19 younger and older people at the time of the inspection. The service can support up to 23 people.

People's experience of using this service and what we found
During the last inspection concerns were identified with the management of the home. During this inspection we found similar and additional concerns. The management team did not have the skills, knowledge and experience to ensure people's needs were identified and assessed.

People's known risks were not identified, assessed and mitigated, this included risks associated with choking. There was insufficient guidance for staff to follow if a person were to have a seizure. The provider's systems and processes to ensure known risks to people were assessed and mitigated were inadequate. This placed people at immediate risk of harm. Despite our findings people told us they felt safe.

Fire safety measures were not adequate to keep people safe. The provider's systems and processes to assess and mitigate fire risks had failed. We were not assured infection prevention control measures were safe and protected people from the risks associated with COVID-19. The provider's systems had not identified the government guidance around COVID-19 was not being followed.

It is a legal requirement for the provider to display the home's Care Quality Commission (CQC) rating on their website and in the home, the provider had failed to do this. The provider failed to comply with conditions on their registration, this included not having a manager registered with CQC.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and 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.

Based on our review of safe and well-led the service was not able to demonstrate how they were meeting the underpinning principles of right support, right care, right culture. Care plans were not person-centred to promote people's dignity. The ethos, values, attitudes and behaviours of leaders could not enable staff to ensure people using services lead inclusive and empowered lives. We asked the provider to review everyone's care plans to ensure people's needs and areas of risks were identified, and sufficient planning and risk mitigation was in place.

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

Rating at last inspection and update

The last rating for this service was requires improvement (published 19 March 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found there were not sufficient improvements made and the provider was still in breach of regulations. This service had been rated requires improvement for the last three consecutive inspections, with this rating being inadequate.

Why we inspected
We received concerns in relation to risk management, an incident where a person had choked and infection control. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report. You can see what immediate action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bournbrook Manor Home Ltd on our website at www.cqc.org.uk.

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.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, governance, failure to have suitably skilled and qualified people employed, failure to comply with conditions of registration and failure to display ratings at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This

means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Bournbrook Manor Home Ltd

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 Care Act 2014.

Inspection team
The inspection was carried out by one inspector and an assistant inspector for one day. One inspector went back to the home for a second day.

Service and service type
Bournbrook Manor Home Ltd is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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. The provider was not asked to complete 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. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with six members of staff including the provider, area manager, manager and care workers. We spoke with one professional and received feedback via email from one professional.

We reviewed a range of records. This included 19 people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• Prior to the inspection we received concerns about a person who had choked, and they did not have sufficient care plans and risk assessments. The manager told us there was one person who was identified as at risk of choking. However, there was no information about what food was safe for the person to eat.
• During the last inspection we identified concerns in relation to fire safety. During this inspection we found further fire safety concerns. There was a bin in the garden, sitting on wooden decking, which was overflowing with cigarette ends, paper and tin cans. In addition, there were cigarette ends on the wooden decking. The fire door leading from the decking back into the home was propped open meaning if there was a fire it may not be prevented from spreading.
• Following the first day of inspection we identified significant concerns in relation to fire safety and choking risks. We told the provider we were considering urgent action and they were required to give us a response. The response we received from the manager alerted us that someone else may be at risk of choking, therefore we returned to the home to review all 19 people's care plans and risk assessments in relation to choking risks.
• We identified an additional three people who were potentially at risk of choking without any care plan or risk assessment in place. This meant five people were at risk of choking. Two people had been referred to external agencies to assess their choking risk but there was no outcome or recommendations recorded. This placed people at significant risk of harm.
• During the first day of inspection, the manager told us no one was at risk of having seizures. However, on the second day of inspection we reviewed all 19 people's care plans and spoke to staff and identified three people who were at risk of experiencing seizures. There were no seizure plans, risk assessments or specific guidance for how staff could recognise if a person was having a seizure or what staff could do to keep them safe. This placed people at risk of harm.
• One person's care plan stated they could have a seizure for 15 minutes before staff needed to contact 999 for support. There was no recommendation from health professionals to say this was a safe amount of time and the NHS recommended guidance states 999 should be contacted for a seizure lasting more than five minutes. This placed the person at significant risk of harm.

The failure to identify, assess and mitigate risks placed people at immediate risk of harm. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We placed urgent conditions on the provider's registration informing them they must bring a skilled and experienced person into the home to review everyone's care plans and risk assessments and identify and

mitigate any risks. We raised a safeguarding concern to the local authority for all of the people identified as being at risk.

Preventing and controlling infection
• We were not assured infection prevention control measures were safe and protected people from the risks associated with COVID-19. For example, there were no general cleaning schedules, no high touch cleaning schedules, no record of cleaning, no temperature checks recorded for staff or people and no consistent record of when staff were tested for COVID-19 and what the outcome was.

This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We took urgent action following the first day of inspection and asked the provider for an action plan to address the shortfalls.

Learning lessons when things go wrong
• During the last inspection we found concerns in relation to fire safety, incident management and care plans lacking information. We took action and placed conditions on the providers registration. This meant they were required to send CQC an action plan with how they were addressing the issues. There had been some incident analysis, but this had only recently begun, and we found some incident forms lacked detail and contained inappropriate language. During this inspection we found continuing concerns around fire safety and care plans lacking detail. This meant lessons had not been learnt.

Using medicines safely
• Generally, we found that people received their medicines as prescribed. However, one person's tablets did not balance with what should have been in stock. This meant it was not clear if they had received their medicines safely. The manager said they would investigate this to determine if it was an issue with the records or if the person had received an incorrect dose of medicine. The provider failed to update us on the outcome of their investigation and therefore we were obliged to make a safeguarding alert to the local authority.
• Where people required medicines on an 'as and when required' (PRN) basis, there were protocols in place to guide staff about how to administer these medicines safely. However, some of these protocols lacked detail in relation to when staff should offer the medicines to people.

Staffing and recruitment
• Staff were recruited safely. Pre-employment checks had been undertaken to ensure staff were suitable for their role.
• We did not receive any concerns about staff levels. We observed staff supporting people throughout the day and people did not raise any concerns about the amount of staff.

Systems and processes to safeguard people from the risk of abuse
• People told us they felt safe.
• Where allegations of abuse had occurred, the management team notified the relevant authorities as needed. This meant that incidents could be investigated.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated 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

At our last inspection the provider's systems were either not in place or not robust enough to demonstrate good governance and oversight. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider continues to be in breach of regulation 17.

• During the last inspection concerns were identified with the management of the home, fire safety and poor care planning. The manager, who had been in post for 12 months, had recently left and the previous manager had returned to support the home. During this inspection there were significant concerns identified in regard to the management of the home, fire safety, infection prevention control and poor care planning and risk assessments. This placed people at significant risk of harm and meant there was a lack of continuous learning and improvement.
• The provider's systems and processes to assess and mitigate fire risks had failed. A fire risk assessment had been completed by an external agency, followed by an internal review. One assessment identified a large number of cigarette ends on the wooden decking and the other identified the bin in the garden to be a fire risk if not emptied. The management team failed to implement any checks on the outside smoking area to ensure these risks were mitigated, despite this area being identified as a fire risk twice over a six-month period.
• The provider's systems and processes to ensure known risks for people were assessed and mitigated was inadequate. Following an incident where a person choked, the manager told CQC they had reviewed everyone's care plan to ensure no one else was at risk of choking. The manager had told us only one person was currently at risk of choking. We identified a total of five people who were potentially at risk of choking. This meant the systems and processes in place to identify, assess and mitigate known risks had failed.
• The provider's systems had not identified the government guidance around COVID-19 was not being followed. The provider's processes to monitor staff practice in relation to COVID-19 prevention were ineffective. The provider was not aware the home was not up to date with current government guidance on how to manage the impact of COVID-19. This meant staff and service users were exposed to the risks associated with contracting COVID-19.

The lack of robust quality assurance meant people were at risk of receiving poor quality care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We placed urgent conditions on the provider's registration informing them they must bring a skilled and experienced person into the home to review everyone's care plans and risk assessments and identify and mitigate any risks.

• It is a legal requirement for the provider to display the home's CQC rating on their website and in the home. The website was not displaying the homes ratings, however the provider resolved this on the first day of inspection. The ratings were also not displayed in the home in a clearly visible location, the manager said they would resolve this. When we returned for the second visit to the home the ratings were still not displayed. The provider has told us the ratings are now displayed.

A failure to display the homes current CQC rating was a breach of regulation 20A (Requirement as to display of performance assessments) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• It is a condition of the provider's registration to have an individual who is registered with CQC as a manager at the home. Although there have been managers in post, there has been no registered manager in post since June 2020. The provider has a condition on their registration requiring them to undertake audits and mitigate fire risks and to ensure accurate information is recorded about people's individual care needs and treatment. During this inspection we found the provider had failed to comply with these conditions.

A failure to comply with the conditions of registration is an offence (Section 33) of the Health and Social Care Act 2008.

At our last inspection the manager was not consistently notifying us of incidents in line with legal requirements. This was a breach of regulation 18 of the Care Quality Commission Registration Regulations 2009.

Enough improvement had been made at this inspection and incidents had been notified, therefore the provider was no longer in breach of regulation 18.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The management team did not have the skills, knowledge and experience to ensure people's needs were identified and assessed to ensure good outcomes for them. We told the provider they needed to bring someone who was skilled and experienced into the home to review all peoples care plans and risk assessments.

This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The management team could not always demonstrate they reviewed staff practices to ensure a positive culture. We receive whistleblowing concerns that staff were sleeping on night shifts. The provider did not have any checks in place, prior to us raising this, to check the night staff's practice and conduct.

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

• The provider evidenced they shared information with necessary people following incidents. This meant they complied with their duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• External professionals told us they had a good working relationship with the staff in the home. This showed the home were working in partnership with others.
• People's protected characteristics, as identified in the Equality Act 2010, were recorded in their care plan. This included people's gender, religion, ethnicity and disability.

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 The failure to identify, assess and mitigate risks placed people at immediate risk of harm. In addition, we were not assured infection prevention control measures were safe and protected people from the risks associated with COVID-19.

The enforcement action we took:

We imposed urgent conditions on the provider registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of robust quality assurance meant people were at risk of receiving poor quality care.

The enforcement action we took:

We placed urgent conditions on the provider's registration informing them they must bring a skilled and experienced person into the home to review everyone's care plans and risk assessments and identify and mitigate any risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The management team did not have the skills, knowledge and experience to ensure people's needs were identified and assessed to ensure good outcomes for them.

The enforcement action we took:

We imposed urgent conditions on the providers registration.