Ranc Care Homes Limited

Brentwood Care Centre

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

We carried out an unannounced comprehensive inspection of this service on 3 December 2015. Following on from that inspection we received concerns in relation to the safe care and treatment of people and the managerial oversight of the service. As a result we undertook a focused inspection on 9th May 2016 to look into those concerns. This report only covers our findings in relation to those topics at that time. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Brentwood Care Centre on our website at www.cqc.org.uk.

Brentwood Care Centre is a nursing home registered to provide accommodation, personal and nursing care to 112 people. On the day of our inspection 82 people were using the service, living in four separate units including a dementia unit and a nursing unit.

During the inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the safe management of medicines, risk management, staffing, and the way in which the quality and safety of the service was monitored. You can see what action we told the provider to take at the back of the full version of the report.

There was a registered manager in post at the time of inspection though since our visit a new manager has been appointed. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the time of inspection we found that risks to people were not consistently well managed. Assessments were not always up to date and did not hold sufficient detail to monitor and analyse people's health and wellbeing to keep them safe.

The management of medicines was not consistently safe. Records were not completed accurately and there were incidents where staff had not adhered to the medicine policy and procedure regarding administration of medicines.

There were insufficient numbers of staff to keep people safe and a lack of managerial oversight which meant that the skills and competency levels of staff had not been consistently monitored and assessed.

Record keeping was not of an adequate standard and there were ineffective systems in place to monitor quality and drive improvement.

The registered manager was open and transparent and responded promptly to our requests for information. However they did not always provide us with statutory notifications in a timely fashion, nor was the information received always accurate.

The manager was well-thought of by staff and took a hands-on approach. They were able to demonstrate how they used accidents and incidents as opportunities for staff learning and development.

Safe recruitment practices were followed.

After our inspection the Provider informed us that they had appointed a new registered manager. The provider acknowledged the failings of the service identified during our inspection and prior to receiving a copy of our report were pro-active in providing us with their own action plan which identified many of the same concerns that we had found and set out how the areas requiring improvement would be addressed.

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 consistently safe.

Risks to people were not well managed.

People who lived at the service were put at risk because medicines were not
managed safely.

There were not always enough staff on duty to cover both the emergency and routine work of the service.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality monitoring arrangements were in place but inconsistently applied.

There were inadequate audits in place to monitor where people had fallen. As a result risks had not been identified and remedial measures had not been put in place.

People were being put at risk because the competence of nursing staff was not adequately evaluated.

Brentwood Care Centre

Detailed findings

Background to this inspection

We previously carried out an unannounced comprehensive inspection on 3rd December 2015 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider met the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the quality of the service and to provide a rating under the Care Act. 2014. At that time Brentwood Care Centre was awarded a rating of 'Good' in all five key questions.

In response to information of concern we had received regarding the safe care and treatment of people we carried out an unannounced focused inspection of Brentwood Care Centre on 9th May 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. As the concerns which had been raised related largely to the provision of nursing care we focused our inspection on the nursing unit which provides specialist nursing care to people with complex needs, some of whom were living with dementia. We inspected the service against two of the five questions we ask about services: is the service safe? And is it well-led?

The inspection was undertaken by two inspectors. Before our inspection we reviewed all the information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events, which the provider is required to send us by law. We also reviewed information received from relatives of people who used the service, representatives of the local authority and health and community services regarding the level of care provided at Brentwood Care Centre.

During the inspection we spoke with the registered manager, the regional manager and four members of staff including nursing and care staff who worked on the nursing unit. We spoke with two people who used the service and one relative. Following on from the inspection we spoke with three relatives who had provided feedback on how people were being looked after. We also received feedback from five health and social care professionals. We reviewed various documents including four people's care records and other documents central to people's health and well-being. These included staff training records, supervision and appraisals, minutes of meetings, staff recruitment and personnel files, medication records and quality audits.

Requires Improvement

Is the service safe?

Our findings

At the time of the inspection we had received information of concern about whether people were receiving safe care and treatment at the service. Areas of concern included how risk was managed, medicine management, information sharing, staffing levels and staff competencies to support people safely.

People were not consistently safe because staff did not adequately assess and monitor risk. We looked at four care plans and noticed a disparity between the information gathered for people living at the service permanently compared to those staying at the service temporarily 'on respite'. People using the service for shorter periods had care plans which lacked sufficient detail which could potentially place them at risk. For example, we looked at the care records for one person on respite who was identified as at risk of malnutrition and was significantly underweight. The person had not been weighed regularly as prescribed in their care plan and a MUST (malnutrition universal screening tool) record had not been completed. 'MUST' is a tool used to monitor people's weight to alert the service as to whether people required increased nutrition or additional input from health professionals. We found that food and fluid charts were kept but there was no evidence that the information gathered had been monitored and analysed, therefore risks to the person with regard to their nutrition were not reviewed effectively. No action had been taken to minimise the risks, for example, provision of additional nutritional support nor had referrals been made to external health professionals such as the dietician.

People had charts for monitoring food and fluid intake and their physical observations such as temperature and blood pressure. However, we saw evidence that these charts were not always filled in completely or accurately and the information obtained was not used constructively. This meant that the service failed to record sufficient and accurate information to monitor, assess and take action to mitigate risks to people's health to support them safely.

We spoke to staff and the management team about our concerns. They explained that people staying at the service for respite had a condensed care plan with less detailed information due to the fact that they were only at the home on a temporary basis. However, given that the service had accepted people who had complex nursing needs and required palliative care we found that the information contained within the care plans and the care provided was not sufficient to keep people safe.

Medicines were not always managed safely. During our inspection we became aware of mistakes which had occurred in the administration and management of people's medicines. Regular competency checks had not been completed for all nursing staff to monitor whether they had the skills to administer and record medicines safely. Staff had not always followed the provider's policy for correct administration of medicines which put people at risk. We saw ineffective recording of the quantities of people's medicines. In addition the record-keeping for disposal of medicines was not up to date. We spoke with the unit manager of the nursing unit who advised that a monthly medication audit was due to be implemented by themselves but this had not yet happened as they were new to the service.

We discussed our findings with the registered manager who provided us with their own medication audits

which had highlighted similar concerns to our own. They told us an action plan was being put in place to improve medicine management but this plan was not yet embedded. We did find that the manager had taken action where individuals were found to have made medicine errors. Those staff had received additional supervisions and training in response to mistakes that had been made.

We had been notified of an incident where it was identified that a member of the nursing staff had failed to respond appropriately when managing an emergency situation. An investigation into the incident by the registered manager found that plans for responding to emergencies and untoward events were not shared and understood by all nursing staff. We found that access to training in basic life support was patchy and there was a lack of monitoring of the competencies of staff on the nursing unit. This meant that the manager could not assure themselves that staff had the skills and abilities to support people safely in emergency situations. Staff training was predominantly provided via E-learning which included basic life support training. The member of staff responsible for running the practical session which supplemented this training had left so only one of the nurses on the nursing unit had completed the practical element of the course. We discussed this with the registered manager during our inspection who advised us that they were organising a one off practical based life support session in response to the recent incident.

This was a breach of Regulation 12 (1) (2) (a) (c) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us they used a dependency tool to assess staffing levels on each unit in order to ensure there were enough staff to keep people safe. This was completed monthly or more often if something changed, for example if new people came onto a unit or if a person's needs increased. However staff told us they felt that there were not always enough workers which resulted in them being hurried and not being able to spend enough time with people to meet their needs and keep people safe. A nurse told us, "There are enough nursing staff unless something critical happens." After the inspection we received additional information of concern regarding staffing levels. We spoke with health and social care professionals who informed us that the one to one supervision which had been commissioned to keep a person safe who was considered to be at very high risk of falls had not always been provided by the service due to insufficient staffing levels. These inconsistencies in one to one support were confirmed by the registered manager. We also received feedback from two relatives of people who used the service who told us they felt that there were not enough staff to keep their family members safe.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information around risk was shared between staff through the use of both formal and informal hand-over processes. This included verbal hand-overs during walkarounds and written handover sheets which were updated throughout the day to provide information to staff as they came on shift. Concerns had been raised by healthcare professionals that advice given by them was not being shared with staff due to poor recording of the information provided after health visits. We saw that this issue had been discussed in a group supervision session to highlight the correct recording procedures to all staff.

Concerns had been highlighted in respect of poor infection control in relation to catheter care. We discussed this with the registered manager who told us they had addressed the problem by changing equipment provider. We observed on the day of inspection that new catheter care equipment had been ordered and delivered to the service. Additional training had been arranged by the equipment provider to provide staff with guidance on how to use the new catheters.

Accidents and incidents were reported to the registered manager who kept a detailed log and took responsibility for resolving issues. Accidents and incidents were used as opportunities for learning. We saw that the registered manager had organised group supervisions and reflective teaching sessions so that staff and the service could learn from mistakes to improve people's safety.

Systems were in place to recruit staff safely because relevant checks were carried out before a new member of staff was employed. Checks were carried out on the suitability of applicants which included taking up references and Disclosure and Barring Service (DBS) checks were carried out to confirm that the member of staff was not prohibited from working with people who required care and support.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who was well thought of by staff and who took a hands-on approach and was visible in the service. The registered manager was responsible for notifying us of any significant events to help us monitor how the service kept people safe. However we found that this did not always happen in a timely fashion nor was the information provided always accurate. For example, the manager had not told us about a person who sustained a serious injury and the information we subsequently received regarding the incident was incorrect.

On the day of inspection we found the record keeping of the registered manager to be in disarray. They were unable to provide us in a timely manner with supporting documentation requested to evidence that they had completed observations or appraisals with nursing staff to assess their competency levels. For example, where a new member of nursing staff had been employed they were unable to provide written records of any observations having occurred despite being told that they had taken place. We were provided with several excellent examples of observations completed by the registered manager on care workers on other units demonstrating that the manager possessed the skills to be able to oversee and assess their staff. However managerial oversight of staff was inconsistent with the nursing unit worst affected. The registered manager told us that the reason for this was because they had relied on the skills and expertise of nursing staff who came to the service with a history of relevant past work experience and good references.

The registered manager had worked for some time at the service without the support of a deputy which may have been a contributing factor to why systems and processes to monitor quality were not always in place, current or fit for purpose. We found audits of care plans which had been completed which were of a good quality however they were not up to date. Medication audits had been completed but lacked action plans in response to areas that required improvement. There was a lack of monitoring and analysis of risks to people's health and safety, for example risk of falls. This meant that the service failed to identify any root causes of why people were falling and therefore failed to put adequate measures in place to reduce the risk of further falls and injury.

We found that whilst the manager had the necessary skills to monitor and assess staff and the quality of the service, these skills had not been consistently applied in practice. We saw evidence that improvements were planned, for example, the introduction of a new basic life support course and improved induction of nursing staff. However these improvements were reactive in response to failings of the service rather than the service taking a pro-active approach to drive improvements . We were informed that the provider had appointed a new quality monitoring area manager who was in the process of introducing improved quality assurance mechanisms across all services, for example a new style of audits. However these had not been implemented at Brentwood Care Centre as there were concerns regarding the manager's capacity to adopt the new processes and procedures as they lacked the support of a deputy manager. At the time of our inspection we saw that a deputy manager had recently been appointed as well as a unit manager of the nursing unit to provide the registered manager with additional support. However it was too early to measure the impact of the new management team on the quality of service provision.

This was a breach of Regulation 17 (2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We have been advised that since our inspection a new manager has been appointed. This has resulted in improvements with regard to prompt and accurate statutory notifications being submitted. The Provider has advised us that they have been working closely with the new manager taking positive steps to address the breaches we found with the implementation of new systems and processes to improve people's safety and increase managerial oversight. However, it is not possible to comment on any improvements made until our next inspection to ascertain whether the new processes and procedures have become embedded in practice.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Ineffective systems were in place to assess, record, monitor and mitigate risks to people. Medicines were not properly managed to ensure people's safety. The registered manager had failed to ensure that all staff had the necessary, qualifications, skills and experience to care for people safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager failed to adequately assess, monitor and improve the quality and safety of the service and had not maintained accurate and complete records in respect of the people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager had not ensured that sufficient numbers of staff were appropriately deployed to safely meet people's needs.