Brenan House Residential Home

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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?	**Inadequate**

Summary of findings

Overall summary

About the service
Brenan House is a residential care home providing personal care to up to 16 older people in one large adapted building. At the time of our inspection there were 13 people using the service.

People's experience of using this service and what we found
People told us they felt safe living at the service. However, the improvements found at the last inspection had not been maintained and the quality of the service has deteriorated.

When people had been admitted to the service, potential risks to their health and welfare had not been assessed. Risk assessments had not been robust and there was no guidance for staff to mitigate the risks.

Accidents and incidents had been recorded but these had not been analysed for patterns and trends. Checks had been completed on the environment and equipment, however, not all fire checks had been recorded and staff had not completed fire drills.

Medicines had not always been managed safely, some people had not received their medicines as prescribed. Checks and audits had not been completed consistently, when shortfalls had been identified action had not always been taken. Staff had not received regular supervision and staff did not have up to date training.

The service was clean and odour free, however, the service was cluttered with equipment and furniture restricting people's use of communal space. There were enough staff to meet people's care needs but there was no opportunity provided for meaningful activities.

Quality assurance surveys had been sent to people and staff, but these had not been analysed and the results had not been acted on. People and staff had not been given the opportunity to attend meetings t make suggestions about the service.

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 requires improvement (published 12 November 2021). The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

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.

We carried out an unannounced comprehensive inspection of this service on 5 October 2021. Though no breaches of regulation were found further improvements were still required.

We undertook this focused inspection to check they had continued to make improvements and to confirm they had improved. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has not changed and remains Requires Improvements. This is based on the findings at this inspection.

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

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

Enforcement and Recommendations

We have identified breaches in relation to management of risk and good governance at this inspection.

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 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 well-led. Details are in our well-led findings below.	**Inadequate** 

Brenan House Residential Home

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
The inspection was undertaken by one inspector.

Service and service type
Brenan 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. Brenan 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 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. 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 6 people who used the service about their experience of the care provided. We spoke with four members of staff including the provider, registered manager, deputy manager and care worker. We observed staff interactions with people.

We reviewed a range of records. This included 4 people's care records and multiple medication records. We looked at 2 staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 Requires Improvement. The rating for this key question has remained 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

● Potential risks to people's health and welfare had not always been recognised, assessed and guidance in place for staff to mitigate the risk. When people had been recently admitted to the service, their care plans did not contain robust assessment of risks to their safety. There were some care plans in place, but these did not contain guidance for staff about how to support people safely. The registered manager had not used recognised assessment tools in line with best practice guidance to assess people's risk such as nutritional risk or skin integrity risk, when people had been admitted.

● Some people were living with diabetes and received insulin from the district nurse each morning. There was no guidance for staff about how the person may present if they were unwell. Staff had not been trained to monitor people's blood sugar and would be unable to check the level and act if the person became unwell. This had not been considered by the registered manager and no management strategy had been put in place. There was no guidance for staff about additional risks to people living with diabetes such as the risk of skin damage.

● Some people required assistance to move around the service safely. One person did not have access to their walking aid, this risk had not been assessed and there was no guidance for staff about how to support the person. When people had been assessed as needing the hoist to move safely, the guidance in people's care plans did not contain details about what sling to use and how to position the sling safely. However, each resident has their own sling and information is available in people's room.

● There had been checks to the environment and equipment people used to make sure they were safe. However, weekly and monthly fire checks had not been recorded since December 2022 and staff had not completed a fire drill in the past three years. Most people had a personal emergency evacuation plan (PEEP) in place, however, new admissions had not been assessed and PEEPs had not been completed.

The registered persons had failed to assess the risks to people's health and safety. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not always managed safely. The service used an electronic system to record the stock of people's medicines and when these had been administered. There were discrepancies between the number of tablets available in stock and the number on the system. Some of the discrepancies were record issues, the registered manager had disposed of medicines and had not updated the electronic system. However, two people had not received their medicines as prescribed, the medicines had been signed as administered but the stock available were incorrect and there was excess stock.

The registered persons had failed to managed medicines safely. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
At the last inspection, the analysis of accidents and incidents had continued to be an area of improvement. At this inspection, there had been no improvement.
● Accidents and incidents had been recorded, but analysis of these had not been consistent. In July 2022, audits were started, this included an investigation form with a section on lessons learnt and what action had been taken to reduce the risk of them happening again. However, the following months had not included these forms.
● The audits between August and December 2022 had not included any analysis of patterns and trends. There was no information about when and where the accidents had happened and if people had fallen more than once. There were no records of what action had been taken during this time.

The registered persons had failed to all that is reasonably practicable to mitigate risks. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service was cluttered and there was additional furniture and equipment stored in communal areas. The bathroom had equipment stored in it including in the bath, people were unable to access it and staff would not be able to clean the room thoroughly. The equipment was moved during the inspection.
● 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 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.

Visitors were welcomed into the service and visited people when they wanted. People were supported to go out with family and friends

Staffing and recruitment
● There were enough staff to meet people's care needs. The registered manager had not used a dependency calculator to assess how many staff were required to support people safely. There was a risk that when there were new admissions to the service there would not be enough staff available. People did not have access to regular meaningful activities as staff were occupied with providing care and support.
● There was a core staff group who had worked at the service for a long time and knew people well. Agency staff were employed to cover any shortfalls and the registered manager covered care shifts when required.

We recommend the registered persons source a dependency tool to ensure people are supported safely when changes take place.

● Staff were recruited safely. There was an effective system in place to recruit staff, checks had been

completed to make sure staff were suitable to work with people. There were appropriate checks in place such as full employment history, references from previous employers. Disclosure and Barring Service (DBS) checks had been completed and provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. People's capacity to make decisions had been assessed and recorded if people did not have capacity.
● Staff gave people choices about what they would like to do and what they would like to eat, and staff respected their wishes. People told us, they were supported to make decisions and given choices.

Systems and processes to safeguard people from the risk of abuse
● There were systems in place to protect people from abuse and discrimination. Staff understood their responsibility to report any concerns and where to report these. Staff were able to describe the signs and symptoms they would look for. Staff were confident the registered manager would take the appropriate action.
● Staff understood the whistleblowing policy and knew how to raise concerns with outside agencies. The registered manager understood their responsibility to report any concerns to the local safeguarding authority.

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

At the last inspection, improvement was needed in the recording of checks and audits. Action plans had not been put in place to maintain improvements within the service. At this inspection there had been no improvement.

- The improvements made at the last inspection had not been sustained and at this inspection the service was now in breach of regulations. There were significant shortfalls in the oversight of the service by the registered manager, who was also one of the providers.
- Since July 2022, the registered manager had employed a deputy manager and an administrator, to support them, both had left before the inspection. Their roles had been to complete checks and audits on the quality of the service. The audits had not always been detailed and effective in identifying shortfalls. When shortfalls had been identified such as the lack of fire drills, the registered manager had not always acted. There had been limited audits completed in December 2022 and none in January 2023. There was a new deputy manager in post who had started shortly before the inspection.
- The registered manager had completed the care plans for the new admissions to service. They had not identified the risks to people's health and welfare and had not acted to reduce the risk. Staff had not received supervision or appraisals since the last inspection, the deputy manager told us they had just started to complete supervisions. Staff training had not been updated, there was an online system of courses for staff to complete. The training matrix was completely out of date as it still showed previous staff, the registered manager told us training needed to be updated but had not known the extent of the shortfall. The registered manager did not know that staff were now required to complete training to support people with a learning disability and autism.
- The registered manager had not checked staff had undertaken their roles effectively. They had not been aware that checks had not been recorded such as fire checks and water temperatures in December 2022 and January 2023.
- The registered manager had not acted when communal areas and the bathroom had become so cluttered people were unable to use them. This limited where people who shared a room could have a quiet space to meet visitors. The registered manager told us staff would move the equipment out of the bathroom when people wanted to use it, but everyone liked a shower, there was a risk people would not be offered a bath because of the clutter.

● Quality assurance surveys had been given to people and staff. Only half the people had returned their survey, the responses were mainly positive and the people who responded were happy overall. There had been no analysis of the results to identify any actions that needed to be taken or checked everyone had been offered the opportunity to be supported to complete the survey. Staff had identified that some training was needed, but this had not been put in place.
● The registered manager had not held staff or resident meetings. They had not had the opportunity to express their thoughts about the service or make suggestions.

The registered persons had failed to assess, monitor, improve the service and mitigate risks. The registered persons had failed to act on feedback. This is a breach of regulation 17 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
● People told us the registered manager was approachable and they were able to raise any concerns with them and these would be dealt with.
● There was a complaints policy in place but there had been no formal complaints since the last inspection.
● Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications to CQC in an appropriate and timely manner in line with guidance.

Working in partnership with others
● The service worked with other healthcare professionals, people were supported to attend appointments and follow guidance.

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 registered persons had failed to assess the risks to people's health and safety. The registered persons had failed to managed medicines safely. The registered persons had failed to all that is reasonably practicable to mitigate risks. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to assess, monitor, improve the service and mitigate risks. The registered persons had failed to act on feedback. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed a condition