Runwood Homes Limited

Brewster House

Inspection report

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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
Brewster House is a residential care home providing accommodation and personal care for up to 71 people. At the time of the inspection 66 people were living in the service, some of whom were living with dementia.

People's experience of using this service and what we found
People were not protected from the risk of harm. The provider had not appropriately assessed or recorded all risks to people's safety.

People were not protected from the risk of abuse. The provider had not ensured measures were promptly put in place to protect people during safeguarding investigations into allegations of abuse.

The provider had not ensured staffing levels, or the deployment of staff adequately met people's needs. We could not be assured people were being supported with sufficient food and fluid intake or were receiving appropriate support to manage their pressure care or their end of life care needs.

People had not always received appropriate support with their personal care and this placed them at risk from infection and illness.

The provider did not have adequate oversight of the service and systems in place to monitor people's safety and the quality of the care provided were not effective.

The culture of the service was not positive. Staff spoke of feeling bullied and unable to voice concerns. The provider had not always been open and honest when things went wrong and we received mixed feedback from relatives about their involvement with the service and the communication from the provider.

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

Rating at last inspection
The last rating for this service was Good (published 15 May 2018).

Why we inspected
We received concerns in relation to the management of safeguarding concerns, the understanding of people's health care needs and the culture of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

The inspection was also prompted in part by notification of a specific safeguarding incident. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

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 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 Good 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 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 Brewster House on our website at www.cqc.org.uk.

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 the management of risk, how the provider protects people from the risk of abuse, staffing and oversight of the service.

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

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Brewster 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 Care Act 2014.

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 carried out by an inspector, an inspection manager, an assistant inspector and an Expert by Experience who conducted telephone calls to obtain feedback from people's relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Brewster House 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, at the time of the inspection, the registered manager had recently left the service and management support was provided by a regional manager.

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. 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. We used this information to plan our inspection.

During the inspection
We spoke with two people who used the service and 15 relatives about their experience of the care provided. We spoke with seven members of staff including the regional manager, deputy manager, senior care workers and care workers. We spoke with two visiting health professionals. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included seven people's care records, monitoring charts and medicines records. We looked at four 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.

After the inspection
We continued to seek clarification from the provider to validate evidence found and we reviewed training data and quality assurance records.

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

- People were not kept safe from the risk of harm.
- The provider was not able to demonstrate people were receiving sufficient food and fluids. During the inspection we observed many people sitting alone with food placed nearby but not eaten. For people who required encouragement to eat and drink, there was no interaction from staff, and we observed staff clearing away uneaten meals from in front of people who had received no prompting or support to eat.
- Staff were not completing people's food and fluid monitoring charts at the time people were eating. This meant we could not be assured they were an accurate reflection of what people had actually eaten. Several food and fluid charts were missing, and staff were unable to locate them. People's weight monitoring charts were not up to date and this meant the provider may not promptly identify when people were losing weight.
- People's care records and risk assessments were not up to date and did not contain all relevant information needed to support the person safely. For example, one person's pressure care risk assessment did not contain any information about how to use their pressure relieving aids and another person's care plan contained no information about equipment used to assist their breathing.
- People with pressure care needs were not always being supported to reposition as frequently as needed and staff were not completing the repositioning charts at the time people were being supported. Staff told us the charts were all completed later in the day. This meant we could not be assured they were an accurate record of the support people received.
- People receiving end of life care did not always have up to date care plans in place to guide staff on how to support them in their final days. There was no information about end of life mouth care and no mouth care equipment was seen in people's rooms. Staff told us they checked on people who were receiving end of life care every 30 minutes, however no records were in place to evidence this and no interaction was observed during the inspection.
- The provider had not ensured people had personalised evacuation plans in place in case of a fire. A general overview of people's needs was in place, but this did not identify what support people would need to evacuate safely.

Risks to people's safety were not assessed or managed appropriately. This was a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- The provider had not taken appropriate action to ensure risks to people were mitigated during safeguarding investigations into allegations of abuse. This meant we could not be assured people were protected from the risk of abuse.

● The provider had not always submitted safeguarding notifications to the local authority or CQC in a timely manner and had not kept the local authority or CQC updated during their investigations into safeguarding concerns.
● Staff told us they did not feel comfortable raising concerns with the managers in the service and when concerns had been raised, these were not acted upon. One member of staff told us, "Concerns were raised with the manager months ago and nothing was done."

People were not protected from the risk of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Relatives told us they did not always feel there were enough staff in place to support people's needs. One relative said, "The staff are always busy, and they've not got enough time with people." Another relative told us, "I pressed [person's] call bell on one occasion and it took twenty minutes for someone to come."
● Staff told us there was not enough staff on shift to support people. One member of staff said, "Sometimes we're not able to assist people that need repositioning and people who need help with their continence are left as there's not enough staff to assist. People are still in bed at 11am due to staff shortages."
● During the inspection we observed many people alone in communal areas without staff and many people in bed with no evidence of regular staff interaction. The provider told us they calculated staffing levels by using a dependency tool based on people's needs. However, our observations and the feedback we received demonstrated staffing levels or the deployment of staff in the service did not meet people's needs.
● The provider had not ensured all staff had up to date, relevant training. This meant staff may not have the appropriate knowledge and skills to support people safely.
● The provider had not always ensured safe recruitment processes were followed. Recruitment files did not always evidence applicant's full employment history and Disclosure and Barring (DBS) checks were not always renewed in line with good practice.

The provider had not ensured there were enough suitably qualified, competent and experienced staff to support people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection
● The provider had not ensured all infection risks were managed appropriately. Some people who were living with dementia, were observed to have faeces under their fingernails and we saw people eating finger food with hands that had heavily soiled fingernails. This placed people at risk of cross infection and illness.
● People were seen wearing unclean clothing and lying in unclean bedding. The environment was not always clean; we observed floors in communal areas and in people's bedrooms which were stained and tacky under foot.
● Staff had followed appropriate infection prevention and control (IPC) measures in relation to the management of COVID-19. Staff were observed wearing the correct personal protective equipment (PPE) and the provider ensured regular testing was completed in line with government guidance. Relatives told us they had been able to visit the service regularly since the easing of lockdown restrictions.

Using medicines safely
● The provider had not always ensured appropriate medicines administration records (MARs) were in place for people who required topical creams for the management of pressure care. This meant we could not be sure people were being supported with their creams as prescribed and this increased the risk of a pressure

wound developing.
● Staff completed regular checks on the stock of medicines to ensure these were correct. The provider completed a monthly medicines audit to monitor administration processes; however, this had failed to identify the concerns we found with the recording of topical cream administration.
● People's care plans contained information about how they liked to be supported with their medicines and protocols were in place for as and when needed medicines such as pain relief.

Learning lessons when things go wrong
● The provider had not always ensured incident reports were completed appropriately. We found several incidents where people had become distressed whilst being supported and where staff had been physically hurt during the incident. These had been recorded in people's daily notes but not reported as an incident. This meant the provider did not have oversight of these incidents and had not put measures in place to support people and prevent a reoccurrence.
● The provider had implemented a Lessons Learnt bulletin to share with staff; however, staff meeting minutes evidenced a number of similar concerns continued to be raised at each meeting without any clear action taken to address these.

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 Good. 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; 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's systems for monitoring the safety and quality of the service were not effective and had not identified the concerns we found at inspection.
- The provider had not always identified or responded to safeguarding incidents appropriately and had not been open and honest when things went wrong. The provider had not kept CQC or the local authority updated during safeguarding investigations and had not told them about changes to the management arrangements in the service. This was despite concerns being raised about the oversight of the service and the impact of this on the safety of people living in the home.
- The provider had not taken prompt action when concerns were highlighted. Gaps in care planning and risk assessments which were highlighted during day one of the inspection and during visits from the local authority, had not been rectified when we returned to the service two weeks later.

The provider had not ensured effective processes were in place to monitor the safety and quality of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider did not promote a positive culture in the service. Staff spoke of feeling bullied and unable to talk to managers about their concerns. One member of staff said, "You're expected to do a lot, it's hard. Sometimes there's support and other times there isn't, so the staff don't stay. I don't feel supported by the manager." Another said, "There was bullying of myself and other staff at Brewster House, staff are leaving because of this."
- Staff supervision records demonstrated staff had told managers they felt bullied and had also asked for additional training and support to help them to do their job. However, these concerns had not been addressed appropriately and there was no evidence of any additional training or support being offered.
- People's care was not person-centred, and people were not supported to achieve good outcomes. During the inspection we did not see staff engaging with people in any meaningful activities and many people were left alone for prolonged periods. During the second day of the inspection staff told us, "We have done loads of showers" and explained this was the reason so many people were in pyjamas in the afternoon. We did not

see any evidence people had been offered a choice about when they were supported or that they were being supported in line with their personal preferences.

● We received mixed feedback from relatives about how involved they felt with the service. One relative told us, "I've never been asked for feedback, no, but they let me know about ongoing changes and issues." Another relative said, "No I don't feel involved. I haven't even had phone calls when there've been any incidents."

Continuous learning and improving care; Working in partnership with others

● The Provider had worked in partnership with other healthcare professionals to meet people's needs. People's care plans evidenced regular health visits had taken place, though some records of these visits lacked detail. Visiting health professionals told us staff listened to their feedback to improve people's care. A community nurse told us, "We have a full handover at the end of every visit, the staff are always willing and helpful."

● Following the inspection, the provider sent an action plan responding to the concerns raised, outlining the areas for immediate improvement and setting a timescale for how these improvements would be implemented.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's safety were not assessed or managed appropriately. This was a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from the risk of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured effective processes were in place to monitor the safety and quality of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had not ensured there were enough suitably qualified, competent and experienced staff to support people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014