Runwood Homes Limited

# Braywood Gardens

## Inspection report

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12 August 2020
13 August 2020
14 August 2020
17 August 2020
01 October 2020

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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
Braywood Gardens is a residential care home providing personal care to 75 people aged 65 and over at the time of the inspection. The service can support up to 99 people.

Braywood Gardens is a purpose-built care home which accommodates people across seven units over two floors.

People's experience of using this service and what we found
People living in the service were not safe and were placed at risk of harm. People experienced high level of falls and there was poor pressure area management. Risk management, staffing levels and poor infection control processes at the service put people at risk. Safe medicines management and administration was not effectively ensured and people did not always receive their medicines as prescribed. Records relating to people's care did not always contain sufficient information and guidance to enable staff to provide the safe care and support people required.

We received mixed feedback from both people and their relatives regarding their opinions of the quality of the care and support they received and the response to any concerns they had raised. Most people said they waited long periods of time for support and our observations indicated there were not enough staff to meet people's needs safely.

The leadership, management and governance arrangements did not provide assurance the service was well-led, that people were safe, and their care and support needs could be met. Lessons were not being learned, and improvements were not made when things went wrong.

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 October 2019) and there were multiple breaches in 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 enough improvement had not been made/ sustained, and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to infection control, staffing, management and risk. As a result, we undertook a focused inspection on 12 August 2020 to review the key questions of safe and well-led only. Following this we received further concerns that potentially meant service users were at risk and undertook a second day of inspection on 01 October 2020.

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 action we have asked the provider to take at the end of this full report. The provider has already taken steps to mitigate the risks.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Braywood Gardens 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 management of risk, medicines, infection control, staffing and 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 have met with the provider prior to 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.

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.

# Braywood Gardens

**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 provider's infection prevention and control measures in place. This was conducted as part of our Thematic Review of infection prevention and control in care homes.

Inspection team
On 12 August 2020 the inspection was carried out by three inspectors and an assistant inspector. A further inspector assisting the team in making telephone calls to staff and relatives on 13, 14 & 17 August 2020. On 1 October 2020 the inspection was carried out by two inspectors.

Service and service type
Braywood gardens 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.

Notice of inspection
This inspection was unannounced but we did announce our arrival before entering the premises because we needed to check the current Covid-19 status for people and staff in the service.

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 care commissioners and external health (and adult social care) professionals who work with the service. This information helps support our inspections. We used all of this information to plan

our inspection.

During the inspection
On the 12 August 2020 we spoke with four people who used the service about their experience of the care provided. We spoke with twelve members of staff including the registered manager, deputy manager, care team leaders, care workers and domestic assistants. We reviewed a range of records including multiple medicine records.

As part of this inspection we looked at the provider's infection prevention and control measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak.

We made phone calls to seven relatives to ask about their experience of the service. We made phone calls to eleven staff to ask them about how they cared for people and their experience of working at Braywood Gardens. We sought further information from the provider, that we were unable to review on site, to inform our inspection judgements. This included care records, staff training data and care policies. We also sought additional feedback from healthcare professionals.

We sent a letter to the provider outlining the concerns we found during the first day of inspection, which they responded to with details of their action to ensure people's safety at the service. However, following the subsequent receipt of further ongoing concerns relating to people's care, we carried out a second visit to the service on the 01 October 2020.

On the 01 October 2020 we spoke with eleven members of staff, including care workers, care team leaders, the deputy manager and regional manager. We also spoke with one visiting healthcare professional. We observed interactions between staff and people, including staff giving people their medicines. We spoke with five people who used the service about their experience of the care provided.

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.

Staffing and recruitment
At our last inspection the provider had failed to ensure there were enough staff to meet people's needs and ensure their safety. This resulted in a breach of Regulation 18 of the Health and Social care act 2008 (Regulated Activities) Regulation 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

- The provider did not ensure there were enough staff to meet people's needs safely.
- On both days of inspection, we observed a lack of staff. People were left unsupported for long periods of time, people were shouting for staff, pushing other people in wheelchairs and going into other people's rooms. We also saw that people did not always received their medicines in a timely manner. Due to staff being unable to provide the interaction people needed, people became unsettled and created a chaotic atmosphere at times.
- People said, "It's always a wait if I need anything, there's not enough of them [staff]", "I always have to wait, especially at night" and "I can press the buzzer it's about 15 minutes usually."
- There was a lack of consistency of staff. This meant staff did not have the opportunity to get to know people's needs. People said, "When they are short staffed it can be difficult, there are new staff with no experience, I have to spell out what I need that makes it hard each day" and "All the staff I knew have gone upstairs, at night there's only one staff, the staff seem to get moved or leave just when they get to know us it's a real shame."
- Healthcare professionals told us there was a lack of knowledge amongst the staff team on how to effectively manage risks from skin damage due to prolonged body pressure from immobility. Visiting health care professionals told us there were not enough staff to keep people safe.
- Staff explained due to insufficient staffing levels they were not always able to keep people safe from harm. They told us they were unable to reposition people as regularly as they were required to avoid worsening pressure sores or to be able to monitor people identified at risk of falling. We observed this on both days of inspection.
- Staff absences were not always covered. This was acknowledged by the registered manger, but there was not a sufficient system in place to avoid staff shortages and in turn safely support people.
- Due to poor management of staffing, people were left at increased risk of not having their needs met.

The provider failed to ensure there were sufficient numbers of staff deployed to meet people's needs. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● People were not sufficiently protected from risks associated with individual health conditions, environment or any equipment used for their care.

● Management of risk to people's safety from falls, pressure sores, choking and behaviours was found to be lacking. Although some risks had been assessed, care plans were not clear or coordinated. This led to staff being unclear on how to safely manage risk to people, which impacted people's health. People had experienced a high level of falls and had developed pressure sores as a result.

● Care equipment was not always effectively used for people's safety. Staff were not guided on how to check people's pressure relieving mattresses to ensure they were set at the correct setting for their individual body weight. On inspection these were found to be on the incorrect settings. This placed people at risk of developing pressure sores. Despite the risks being highlighted to the provider following the first day of inspection, people were found to still be at significant risk of harm on the second day of inspection.

● Staff told us when risks were escalated to management they were not always acted on. For example, when people needed equipment to mitigate risk, such as pressure sensor mats. The management team were slow to act, and sensor mats did not always remain in place when needed.

● Staff did not lock areas where hazardous cleaning products were stored. This left people at risk of coming in contact with dangerous substances.

● The provider had not effectively assessed, monitored or managed risks to consistently ensure people's safety, despite having these highlighted to them on the first day of inspection. This had resulted in a significant impact to people's health and welfare.

Using medicines safely

● Medicines were not managed or administered to ensure people's safety and comfort.

● Medicines rounds were lengthy, meaning the times people received their medicines varied and timings between medicines were not consistent or recorded. This meant people were at risk of not receiving their medicines as prescribed and were at risk of a possible overdose or their medical condition not being managed appropriately.

● Medicine records were not always accurately maintained. Medicine use was not always monitored and reviewed for people's safety when needed. This included both regular and as required medicines, such as for pain relief and any distress reduction.

● Medicine rooms were found to be untidy and unorganised. Medicines were not stored and disposed of as per the providers policy or following best practise guidance.

● Medication room audits were carried out by the provider, but these were inconsistent. The service was not following their own medication policies leaving people at risk of not receiving their medicines as they were prescribed by their GP.

Preventing and controlling infection

● People were not always protected from the risk of infection through cross contamination.

● Personal protective equipment (PPE) was not readily available, and staff told us they were only allocated one mask for the day. This is not in-line with current government guidelines for controlling the spread of Covid-19. We raised this with the provider following the first day who assured us that masks were now available throughout the home. However, on the second day we found essential PPE to still be inaccessible to staff.

● Staff were working across units increasing the risk of cross contamination during the pandemic.

● Staff were seen not to be following the provider's own policies to prevent the spread of Covid-19. For example, entering rooms without full PPE of people who had been identified to be at risk of having Covid-19.

● The environment and mobility equipment were observed to be unclean. For example, we observed no cleaning between breakfast and lunch in dining rooms.

● People were not always protected against the risk of infection.

The provider failed to ensure that people received care and treatment in a safe way and protect them from the risk of harm. This is 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; Learning lessons when things go wrong
● People were not always protected from the risk of harm or abuse. The provider did not ensure effective measures for the prevention and review of any safety incidents.
● The local authority had investigated several safeguarding concerns and found people were not always protected from avoidable harm and neglect.
● The provider had not learnt from previous incidents and safeguarding outcomes as action had not been effectively taken to stop these from reoccurring. Staff felt discouraged from raising concerns and said there was a culture of blame.
● People said they felt safe from the risk of abuse. Staff had received training in safeguarding and could explain the processes.

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 we found quality assurance and audit processes had not always been effective in identifying and addressing areas for improvement at the service. This resulted in a breach of Regulation 17 of the Health and Social care act 2008 (Regulated Activities) Regulation 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

● The provider did not ensure effective assessment, monitoring or mitigation of risks leading to significant negative impacts on people, including high number of falls and pressure sores. This was found to be the case on both days of inspection.
● Essential safety checks on the service were found to be incomplete. These included staff having not completed fire evacuation drills, water temperature checks were not dated, window restrictor and emergency lighting records were not completed regularly, and fridge temperature checks were not always carried out.
● Records required for people's care were inconsistent and missing details. Care plans were insufficient to ensure staff could support the service users safely. For example, one person's care plan stated they needed thin fluids when they required a prescribed thickener to ensure the person did not choke.
● We reviewed quality monitoring audits and found where improvement actions had been identified and marked as completed, they had not actually been completed. The registered manager was aware of this and said they had informed the staff to complete the actions, but each month was finding they weren't always being completed. The registered manager stated they had been addressing this through individual staff disciplinary procedures, but this had not been effective, as improvements were still not being completed.
● There was a lack of learning and effective reflective practice following incidents. Recommendations, to improve the quality of care, from both internal and external investigations were not always carried out.
● Following the first day of inspection we sent a letter to the provider with our most urgent concerns that placed service users at risk of imminent harm. To which we received assurances the concerns would be addressed promptly. However, there was a lack of effective action from the provider to ensure people's safety and people therefore remained at risk from receiving care that was not always safe or well led.

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; Working in partnership with others

● There was not an inclusive or transparent culture. Staff did not feel comfortable to raise concerns with management and people and their relatives did not feel included. Management were not working collaboratively with other professionals to the detriment of people using the service.

● People said the staff were caring but picked up on the atmosphere in the home. One said, "There's an atmosphere of discontent but we don't know why, but you can see staff are not happy". People also said they did not see the manager to raise their concerns, in particular concerns over staffing. People said they no longer felt involved in the service. They confirmed this was because activities and opportunities to speak up, such as residents' meetings, had discontinued.

● Whistleblowing or raising concerns was not encouraged. Staff said, "everyone suffers if someone has reported an issue". Staff were scared to raise concerns both internally and externally.

● Staff said as a team they supported each other but morale was low; management were not approachable, and they felt bullied and excluded. Some staff said that if they do speak up, sometimes they feel listened to, but nothing gets put into action.

● Professionals, such as GPs and DN's said that the service and in particular the management did not engage with them effectively to the detriment of people. This continued to be the feedback we received on the second day of inspection.

The provider failed to ensure that their systems and processes operated effectively to improve the quality and safety of the service they provided to people. This was a breach of Regulation 17 of the Health and Social care act 2008 (Regulated Activities) Regulation 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

● Relatives told us if any incidents or accidents had occurred, they were informed which is in line with the duty of candour. However, we found these were not always investigated and acted on effectively to fully ensure the quality or safety of people's care.

● The provider did submit statutory notifications to CQC which is a legal requirement to update the commission about important events when they happen in the service. However, we found there were delays in sending the notifications and they were not always completed accurately, to provide reassurance of the safety of people's care at the service.

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<br><br>People were at significant risk of harm from falls, pressure areas and their environment. Medicines management and administration was poor. Infection control and PPE were not in line with guidance leaving people at significant risk of infection during the pandemic. Reg 12 (a) (b) (g) (h) (i) |

**The enforcement action we took:**

We took action to restrict admissions to the home and imposed conditions on the registration of the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The service lacked the oversight and leadership to effectively manage risk leaving people at risk of harm. Reg 17 (2) (a) (b) (c) (e) (f) |

**The enforcement action we took:**

We took action to restrict admissions to the home and imposed conditions on the registration of the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Failure to ensure staffing was adequate to safely meet the need of people. Reg 18 (1) |

**The enforcement action we took:**

We took action to restrict admissions to the home and imposed conditions on the registration of the provider.