Brackley Fields Care Ltd

Brackley Fields Country House Retirement Home

Inspection report

Halse Road
Brackley
Northamptonshire
NN13 6EA

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01 August 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place over two days on 31 July and 1 August 2017.

Brackley Fields Country House Retirement Home is registered to provide accommodation and support with personal care for up to 34 people. At the time of this inspection there were 31 people living in the home.

There was a registered manager in post at the time of our inspection. 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 last inspection on 15 and 16 December 2016 we found that the provider was in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have sufficient arrangements in place to monitor the quality and safety of the care and support provided in the home. We asked the provider to make improvements to the governance of the service. During this inspection we found that actions required to improve the governance of the service had not been completed. At the last inspection we also found that sufficient numbers of staff were not consistently deployed to provide people with their care. We asked the provider to take action to make improvements to staffing levels. During this inspection we found that the required improvements had been made.

Ineffective quality assurance systems were in place to monitor the care and support people received. The improvements that were required to the service had not been identified, and there had been on-going shortfalls as a result.

Improvements that were required to fire safety procedures had not been acted upon in a timely manner and environmental audits had not identified on-going deficiencies in fire safety measures.

Adequate monitoring of people's falls had not been carried out; insufficient action had been taken to support people who were at high risk of falls. Improvements were required to ensure people received their medicines. People could not be assured that they would receive their prescribed medicines safely.

Staff did not always have the skills that they needed to provide people's care safely. Arrangements in place to ensure that staff had sufficient skills and knowledge to provide people with appropriate support were not sufficient. Staff had not been provided with sufficient training in key areas such as manual handing and first aid. There was a lack of oversight of staff training.

Improvements were required to ensure the staff adequately monitored people's nutritional needs. Some people had been identified as being at high risk of malnutrition. Staff did not follow the guidance to access appropriate medical advice. People were supported and encouraged to eat well and maintain a balanced diet. People were in the main supported to maintain good health, as staff had the knowledge and skills to

support them and there was prompt access to healthcare services when needed.

Staff were unclear of the lines of leadership and management of the service. There was a lack of confidence regarding how their concerns would be dealt with; staff were not always assured their concerns had been addressed. Staff were aware of the importance of managing complaints promptly in line with the provider's policy. People living in the home were confident that any issues would be addressed and that if they had concerns they would be listened to.

Recruitment procedures protected people from receiving unsafe care from care staff that were unsuitable to work at the service. People felt safe in the home and received care and support from staff that had a good understanding of their role in safeguarding people. Staffing levels ensured that people received the support they required at the times they needed it. People or their representative were involved in decisions about their care and support needs. Care plans were written in a person centred approach and detailed how people wished to be supported.

There were formal systems in place to assess people's capacity for decision making under the Mental Capacity Act 2005. Staff provided people with information to enable them to make informed decisions and encouraged people to make their own choices.

Staff were committed to the work they did and had good relationships with the people who lived in the home. People interacted in a relaxed way with staff, and enjoyed the time they spent with them. Staff listened and respected people's views about the way they wanted their support to be delivered. People participated in a range of activities and received the support they needed to help them do this. People were able to choose where they spent their time and what they did.

At this inspection we found the service to be in breach of two regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Details regarding the action we have taken can be found at the end of the inspection report.

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 always safe.

People were not always protected from environmental risks as measures in place to identify and reduce these risks were not always sufficient.

Improvements were required to ensure that sufficient action was taken to mitigate the risks to people at high risk of falls.

People could not be assured that they would receive their prescribed medicines safely.

People felt safe and comfortable in the home and staff were clear on their roles and responsibilities to safeguard them.

Staffing levels ensured that people's care and support needs were met.

Is the service effective?

Requires Improvement

The service was not always effective.

People's nutritional needs were not always monitored effectively.

Staff training had not been provided to new staff in key areas and there was a risk that staff would not have sufficient knowledge and skills to provide care to people safely.

People were supported to access appropriate health and social care professionals to ensure they received the care, support and treatment that they needed.

Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

People were encouraged to make decisions about how their care was provided and their privacy and dignity were protected and

promoted.

There were positive interactions between people receiving care and support and staff.

Staff had a good understanding of people's needs and preferences.

Staff promoted peoples independence to ensure people were as involved and in control of their lives as much as possible.

Is the service responsive?

Good

The service was responsive.

People were assessed before they were admitted to the home to ensure that their needs could be met.

People received their care as planned.

People were supported to engage in activities that reflected their interests and supported their physical and mental well-being.

People using the service and their relatives knew how to raise a concern or make a complaint and a system for managing complaints was in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People were not assured of a good quality service as there were insufficient systems and processes in place to effectively monitor the quality of people's care.

A registered manager was in post and they were active and visible in the home. However there was a lack of clarity amongst staff regarding the leadership and management of the home.

Staff were aware of the vision and values of the service and were committed to working to these.

Brackley Fields Country House Retirement Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 31 July and 1 August 2017. The inspection was unannounced and was undertaken by one inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection had experience of co-ordinating care services for their relative.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also reviewed information sent to us by other agencies, including the local authority who commission services from the provider and Healthwatch. Healthwatch is an independent consumer champion for people who use health and social care services.

During this inspection we visited the home and spoke with five people who lived there, one relative and a doctor who regularly visits people in the home. We also looked at care records relating to four people. In total we spoke with nine members of staff, including senior care staff, care staff, housekeeping staff, the cook, the registered manager and the deputy manager. We looked at four records in relation to staff recruitment, as well as records related to staff training and the quality monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

People could not be assured that the environment they lived in was always safe. There were elements of the management of the environment and a lack of adherence to fire safety measures that required improvement.

On the first day of inspection we found that several fire doors were being manually wedged open. There was no procedure in place to ensure that these doors would close in the event of fire. During the inspection we viewed feedback from inspections by the local fire authority in 2014 and 2016 advising against this practice. The provider had not taken sufficient action to minimise the risks to people's safety in the event of a fire.

The provider had a policy in place to guide staff in the receipt, storage, administration, recording and disposal of medicines. We observed staff adhering to the policy when administering people's prescribed medicines. However, we found that for several weeks one person had not received their medicines as prescribed. The provider had failed to ensure that the person's medicines were administered as prescribed and this put the person's health and well-being at risk. We brought this to the attention of the deputy manager and they immediately sought medical advice on behalf of the person. The provider needs to ensure that their medicine procedures are embedded in practice.

People could not be assured that their needs were regularly reviewed so that risks were identified and acted upon as their needs changed. People's care plans and risk assessments did not consistently provide instructions to staff on how to mitigate risks associated with people's care and ensure people's continued safety. During the inspection we viewed the records of three people, who had experienced a high number of falls; insufficient action had been taken to minimise the risk of future falls. Staff were not aware of all people living at the home who were at high risk of falls, appropriate support had not been provided and insufficient action had been taken to maintain people's safety.

These concerns constitute a breach of regulation 12: Safe care and treatment of the HSCA 2008 (Regulated Activities) Regulations 2014.

During our inspections in June 2016 and December 2016 we raised concerns that there was no recorded monitoring of people's health and well-being at regular intervals following an accident or fall. People were at risk from injuries not identified at the time of the accident. During this inspection we found that staff did consistently monitor people's well-being following an accident. People's accidents had been recorded and timely medical intervention had been sought where necessary.

During our inspections in June 2016 and December 2016 we found that the provider was in breach of regulation 18: Staffing of the HSCA 2008 (Regulated Activities) Regulations 2014; as staffing levels were insufficient to meet all aspects of people's needs in a safe and consistent manner.

During this inspection we found that the provider had recruited a number of new staff and this had increased staffing levels across the home. There were enough staff to keep people safe and to meet their

needs. People told us that the staff were attentive and responded when they called them. One person said, "The staff give us really good care and are there when we need them." Another person's relative said "They come to check on [Name] every hour." Feedback about staffing at night was positive; one person's relative said "The night staff are particularly good and efficient." Staff told us that there were enough staff available to meet people's needs and provide on-going support throughout the day. One member of staff said "It can be busy, but we do have time to do everything needed and answer people's call bells when they ring for help." On the day of our inspection we observed that there were enough staff to provide the care and support people required.

People were protected against the risks associated with the appointment of new staff. There were appropriate recruitment practices in place, taking into account staff's previous experience and employment histories. Records showed that staff had the appropriate checks and references in place and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out criminal record and barring checks on individuals who intend to work with vulnerable adults, to help employers make safer recruitment decisions.

People were supported by staff that knew how to recognise when people were at risk of harm and knew what action they should take to keep people safe. One person said, "I have plenty of people around me now, that is what makes me feel safe. Staff will pop in and ask how are you? That makes me happy." Staff were able to tell us about signs they looked out for which may suggest somebody was at risk of harm and the action they would take. The provider had made referrals to the local safeguarding authority when required.

Requires Improvement

Is the service effective?

Our findings

People could not be assured that they would receive care and support from staff that had received the appropriate training to enable them to work effectively in their role. A number of staff that had worked in the home for several months had not received manual handling or first aid training. Several people living in the home required support to reposition and to transfer using a hoist. These staff were actively deployed within the home supporting people to manoeuvre in this way however, had not received the training that they needed to do this safely. There was a significant risk that staff would not have the skills and knowledge required to support people to move safely or provide safe support in an emergency. People were at risk of receiving support in a way that put their health and safety at risk. The registered manager was aware that staff training was overdue and had scheduled the training required. However, the training had not been provided to staff in a timely manner.

This constitutes a breach of regulation 12: Safe care and treatment of the HSCA 2008 (Regulated Activities) Regulations 2014.

Regular training was provided in other areas such as safeguarding, food hygiene, and communication. Staff had received an induction into their job role, which included reading key policies and procedures and shadowing experienced members of staff. Training provided as part of the induction; included introduction to dementia, catheter care and fire training.

People's needs were met by staff who were provided with regular support and supervision. Staff were able to access advice from the registered manager and deputy manager when necessary and regular supervision and appraisal meetings were available to all staff. The supervision meetings were used to assess staff performance and identify on-going support and training needs. One member of care staff said "I've had supervision with [Deputy Manager] recently, it was helpful and I was able to say what I wanted to".

Improvements were required to ensure that people's nutritional needs were adequately supported. People were weighed on a regular basis; however the guidance from the Malnutrition Universal Screening Tool (MUST) was not implemented. MUST assessments for people living in the home were viewed during the inspection and insufficient action had been taken in respect of people with a high risk of malnutrition. Action had been taken to monitor people's daily intake and fortify people's diets, however no action had been taken to gain medical advice or support. We raised this with the provider who immediately arranged for people with a high risk of malnutrition to be reviewed by their general practitioner.

Staff were aware of the action to take when people were acutely unwell. A general practitioner who visited the home regularly told us that they had confidence in the staff's knowledge and skills; staff contacted them promptly when needed and consistently followed the advice that they provided. Records showed that staff had promptly contacted health professionals in response to sudden deterioration in people's health. People were supported to access regular health checks, for example regular reviews were in place for people with long term conditions such as Parkinsons disease. During the inspection we saw that a chiropodist was visiting some of the people that lived in the home.

People told us that the food they received was of good quality and that they were able to choose an alternative if they did not like what was on the menu. One person said "The food is good, occasionally there is something I don't like then cook will come and ask me what I would like." Another person's relative said "The food is lovely; we often eat together, the roast dinner is better than mine, lovely tender meat." A menu was displayed on the day of inspection and we saw that this did not provide an alternative to the main meal. Staff explained that they were aware of people's likes and dislikes and provided an alternative if people did not like the main meal. However, on the day of inspection some people were not aware of the food on the menu and would not have had the opportunity to ask for an alternative. Where people required a special diet, we saw that this was provided. However, the provider needs to ensure that people on a pureed diet are provided with a choice of food that is presented in an appetising manner. Drinks and snacks were readily available to people living in the home and staff supported people with eating and drinking as needed.

People received care and support from staff who understood how to ensure that support provided was in people's best interest. 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 Act 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. People's care plans contained assessments of their capacity to make decisions for themselves and consent to their care. Care staff had received the training and guidance they needed in caring for people that may lack capacity to make some decisions for themselves. The registered manager and care staff were aware of, and understood their responsibilities under the Mental Capacity Act 2005 (MCA 2005) and in relation to Deprivation of Liberty Safeguards (DoLS) and applied that knowledge appropriately.

Good

Is the service caring?

Our findings

Staff supported people in a kind and caring way and had built positive relationships with people and their families. One person said "Staff are always cheerful; happy to help and listen and we have a laugh." Another person said "I wouldn't want to be anywhere else, it's lovely. The friendliness and the good care we get, everything is really good." One person's relative said "The most important thing is that the staff are approachable and very caring."

People said that they enjoyed the time that staff spent with them. One person said "The night staff are especially good, when they come to check on me they always crack some jokes because they know I like dry humour. Sometimes I go and join them for a cuppa."

Family and friends were welcome to visit anytime and we spoke to people's relatives who told us they were pleased with the care and support provided for their family members, one person's relative said "All I can say about the staff working with [Name] is that they are kind and tender, they talk to them, try to engage and interact."

We observed staff having meaningful conversations with people and it was clear that staff knew people well. People's individuality was respected by staff and we observed staff gently encouraging people to make choices and do things for themselves. One person told us they were happy with the way staff supported them; they said "I help to tidy my room, they let me potter around in my wheelchair and I like to keep busy and active." One member of staff said "We encourage people to do what they can for themselves. For example, sometimes [Name] can manage their meals independently and other times they need more help. We monitor how they are getting on and offer more help if needed."

There was information in people's care plans about their preferences and choices regarding how they wanted to be supported by staff; these had been produced with the person or their representative, if they were unable to do this. One person's relative said "We had the opportunity to design the care plan together, which was very comforting." Staff understood the importance of respecting people's choices and supporting them to make informed choices.

Staff were mindful and considerate of people's wishes when asking if they could enter their rooms. One person said "I feel very well respected; they knock and say who they are." We also observed staff knocked on people's bedroom doors and waiting to be invited in before entering the room.

Staff understood the need to respect people's confidentiality and understood not to discuss issues in public or disclose information without people's consent. People's dignity and right to privacy was protected by staff.

The provider supported people to speak up for themselves and were aware that if people did not feel able to or had no family to support them that they would support them to find an advocate. At the time of the inspection no one needed the support of an advocate.

Good

Is the service responsive?

Our findings

People's care and support needs were assessed before they came to live at Brackley Fields Country House Retirement Home, to determine if the service could meet their needs. One person's relative said "Before we moved [Name], the manager came to see us at home to see if they would be able to support them. I found that very important, the manager was very open and honest and from that moment we had them as the first point of contact for everything." The assessment considered people's past and current needs and the information from the assessment was shared with staff. Initial care plans were produced and these were monitored and updated as necessary.

Staff knew people well and people received person centred care and support according to their preferences and needs. One person's relative said "[Name's] needs changed a lot but the work the staff do to make them comfortable is like they are looking after their own relative."

Some documentation gave good descriptions of how people should be supported and was clear in instructing staff how they should respond to people in particular situations. For example where people required support with personal care, their care plans provided staff with clear guidance on how to do this. Where people were at risk of pressure ulcers, their care plans recorded the equipment and support they required to help prevent them.

The assessment and care planning process considered people's hobbies and past interests as well as their current support needs. Staff supported people to do the activities that they chose and were knowledgeable about people's preferences and choices. One person said "[Activity] staff have given me a plan so I know what's happening, I like Uno and dominoes. There's a music quiz this afternoon that I might go to". Activities on offer included; quizzes, card games, carpet bowls and outside entertainers. One person told us that they had been supported to make knitted items to sell for the local hospice. They were proud to show us the letter of thanks they had received from the hospice for the money they had raised.

People chose how and where to spend their time. Meals were served in either people's own rooms or in the lounge and dining area. Some people liked to spend time in their bedrooms; others spent time in the communal areas. One person said "If there are activities I may join in; sometimes I feel like it, sometimes I don't. I might read or talk to staff, or just watch, sometimes that helps as well to pass the time. There is always something to do, but I am someone who likes the peace and quiet of my room." We observed that people were able to move freely around the home.

There was a complaints policy and procedure in place and a suggestion and complaints book in the reception area. The registered manager told us that they had not received any formal complaints. People and their relatives told us that they knew who to speak to if they were unhappy with any aspect of the service. One person said "I know there is a way to address things I don't like, but I've never really thought about it as I'm quite happy here." Another person's relative said "I've never had any problems, so I've had no reason to raise any concerns or complaints, but I know I received a form to complete if there were any problems." Staff were knowledgeable about how to respond to complaints, one member of staff said "I

would speak to the deputy manager or manager."

Requires Improvement

Is the service well-led?

Our findings

During our inspection in June 2016 and December 2016, we found that improvements were required to the quality monitoring of the home.

During this inspection we found that the provider still did not have a clear picture of the issues affecting the quality of the service. Procedures to review the quality of the service were insufficient and required significant improvement. Where audits had been completed, they had failed to identify the issues we identified during this inspection.

During our inspection in December 2016 we found that medicines audits had not been effective at ensuring the accurate recording of medicines at the home. During this inspection we found that monthly medicines audits had been carried out. However, these had not identified that some people had not received their medicines as prescribed or inconsistencies on people's medicine administration (MAR) charts. We found that there was no system in place to ensure that the details on handwritten MAR charts were correct, as there was no checking process in place. People were at risk of not receiving their prescribed medicines as staff did not always follow the procedures designed to keep people safe.

During our inspection in December 2016 we found that people's falls were logged and informally monitored; however, no formal audit or analysis had been completed since the last inspection in June 2016. During this inspection we found that, although the provider had implemented a falls management strategy, this had not been consistently followed. The procedures in place were not effective at ensuring people who were at high risk of falls were identified and appropriate action taken. We viewed the records of three people who were at high risk of falls; insufficient action had been taken to mitigate the risks to their safety.

Quality assurance systems had failed to effectively monitor and improve the environment. Environmental audits had not highlighted the lack of action taken in response to recommendations by the fire authority. During the inspection we found several fire doors manually wedged open; there was no facility to ensure that these doors closed in the event of a fire.

Quality assurance systems had not identified that the Malnutrition Universal Screening Tool (MUST) guidelines were not being followed. MUST assessments for people living in the home were viewed during the inspection and insufficient action had been taken in respect of people with a high risk of malnutrition. The lack of auditing systems in use to identify these areas of concern meant that this had not been addressed in a timely way.

There was a lack of oversight of staff training; new staff had not been provided with training in key areas such as manual handling and first aid. The provider had not ensured that all staff were provided with appropriate, timely training.

These concerns constitute a breach of Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

During the inspection in June 2016 we found that staff felt supported by the management team but there was a lack of clarity regarding the management and leadership of the home. During this inspection we found that staff were unsure when they should report concerns to the registered manager. Staff said that they had reported some concerns to the deputy manager and were unsure whether these concerns should have been reported to the registered manager. A number of staff told us that when they had raised concerns, they were not confident that these had been addressed. We discussed these concerns with the registered manager who understood the need to clarify the lines of management and leadership in the service and provide assurance to staff that their concerns would be addressed. However, although this had been previously identified as an area that should be addressed by the management team in June 2016; we found that appropriate action had still not been taken.

The management team were active and visible in the home. People and their relatives knew who the registered manager was and said that they were accessible and approachable. One person said "I know who the registered manager is and they have a lovely assistant, one of them always comes and asks how I am."

The ethos of the service was based around providing personalised care in a homely environment. Staff understood the culture of the service and worked with people at their pace and listened to what they wanted to do.

The provider had a process in place to gather feedback from people, their relatives and staff through regular surveys and meetings. We saw minutes of a recent residents and relatives meeting. Discussions had taken place about the future plans for the home and the results of the most recent satisfaction surveys. During staff meetings, staff had the opportunity to make suggestions for improvements to the service. We saw meeting minutes which recorded discussions about health and safety, completion of care records and risk assessments.

Some policies and procedures were in place and had been updated when required. We spoke with staff that were able to demonstrate a good understanding of policies such as safeguarding. The registered manager had a good understanding of what notifications the Care Quality Commission required and sent these promptly when necessary. The provider had displayed their current inspection rating prominently within the home and on their web site.

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 provider had failed to take sufficient action to mitigate the risk of falls to people. Fire safety measures were not sufficient to protect people from the risk of fire. People's medicines had not been administered as prescribed. Staff had not received adequate training to enable them to provide safe support to people living in the home. Regulation 12 Safe Care and Treatment (1) (2) (a) (b) (c) (d) (g)

The enforcement action we took:

Impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have sufficient arrangements in place to monitor and improve the quality and safety of the care and support provided in the home. 17 (1) (2) (a) (b) (c)

The enforcement action we took:

Impose conditions on the provider's registration.