Care Quality Commission

Blue Ocean Brookwood Limited

Brookwood Manor

Inspection report

Holbrook Hall Park
Little Waldingfield
Sudbury
Suffolk
CO10 0TH

Tel: 01787736372
Website: www.qualitas-healthcare.com

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Brookwood Manor is a country manor which has been adapted into a residential care home. It provides personal care for up to 28 people, aged 65 and over and many of whom live with dementia. At the time of inspection, 22 people were living in the home.

People's experience of using this service and what we found
We found continued shortfalls in the oversight and governance of the service. The leadership and culture of the home failed to identify significant shortfalls in the management of the service. These failings placed people using the service at risk of harm, and significant exposure to the risk of harm.

The provider continued not to have a registered manager in place. On day one of our visit we found the chair of the company that owned the service had stepped in three days previously as manager. A manager from an agency came for seven days and then was replaced by another manager on a short-term contract.

There was a lack of consistent managerial oversight at the service, which led to risks to people not being identified, acted on or reduced adequately. The provider's risk management remained ineffective, and did not identify where there were serious risk issues. Therefore, incidents continued to occur and place people at risk of harm.

We were not assured the provider was doing all that was practical to ensure people were protected from the risks of acquiring infections, including COVID-19. The service was not consistently following Government guidance about how to operate safely during the COVID-19 pandemic, this included the wearing of personal protective equipment [PPE], cleaning regimes, social distancing and ensuring staff were provided with designated areas for putting on and taking off their PPE. On both days of our visit we found discarded PPE and used lateral flow tests. Some PPE was readily available to staff, but not masks nor face shields/goggles when required.

Risks to people's health, welfare and safety continued not to be identified with action taken to reduce the risk of harm. Audits did not identify the shortfalls we found as part of this inspection, and there continued to be a lack of effective quality and safety monitoring in place to drive improvements needed. This included the risks to people in the event of a fire, acquiring infections, legionella risks, risks to people of scalding from exposure to hot water pipes and unguarded radiators, risks of falls and of losing weight.

People had to endure times when the heating had failed or been ineffective since our last visit in December 2020. On day one of our visit most parts of the home were warm. However, exposed radiators and pipes posed a significant scald risk to vulnerable elderly people living with dementia. Even after we fed back these issues, they remained on day two.

The provider did not follow their own policy in the management of people's medicines when needing to be administered covertly.

Rating at last inspection
The last rating for this service was Inadequate. (Published 12 February 2021).

At our previous inspection in December 2020, we found shortfalls in the management of risk to people's safety and welfare, staff and governance of the service. The service was rated inadequate and placed in special measures.

We have been monitoring closely and liaising with partner agencies.

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in response to concerns received about management of the service, and infection control risks. A decision was made for us to inspect and examine those risks.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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 coronavirus and other infection outbreaks effectively.

We found evidence during this inspection that people were at risk of harm from these concerns. Please see the safe and well led section of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Brookwood Manor 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 continued breaches in relation to safe care and treatment, governance, staffing and safe recruitment. Immediately after the inspection we wrote to the provider and requested they provide us with urgent information telling us what they were going to do regarding safe care, the management of risks, infection control and ineffective governance arrangements.

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 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.

Special Measures
The overall rating for this service remains 'Inadequate' and the service remains 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 act 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? Further information is in the detailed findings below.	**Inspected but not rated**
Is the service well-led? Further information is in the detailed findings below.	**Inspected but not rated**

Care Quality Commission

Brookwood Manor

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the provider was keeping people safe. We will assess all the key questions at the next comprehensive inspection of the service.

Inspection team
This inspection was undertaken by two inspectors.

Service and service type
Brookwood Manor 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 did not have a manager registered with the Care Quality Commission. This position had been vacant since 2019. This means that only the provider is 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.

What we did before the inspection
Prior to our inspection we reviewed information we held about the service. This included any safeguarding referrals and statutory notification that had been sent to us. A notification is information about important events which the service is required to send us by law.

The provider had not completed a provider information return (PIR) as we had not requested one. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of planning we sought feedback from other agencies such as the Local Authority and we used this information to plan our inspection.

During the inspection
We spoke with six members of staff, a contract person working at the service, the chair of the company and the nominated individual who was visiting on day one. We observed staff and people's interactions to help us understand the experience of people who could not talk with us. We examined care records for four people, medication records, incident and accident records, three staff files and records associated with the running of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We also requested documents be sent to us but needed to repeat the request as these were not forthcoming.

Inspected but not rated

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 Inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to explore the specific concerns we had about Brookwood Manor. We will assess all of the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had not been enough improvement at this inspection and the provider remained in breach of regulation 12.

• At our last inspection there was not sufficient oversight of accidents and incidents to protect people from harm. At this inspection we found this was an ongoing concern. One person had suffered a severe injury to their lower limb, whilst this had been attended to at the time, no learning or investigation about how it had happened or if it could be prevented from happening had taken place.
• People at risk of losing weight had not been adequately monitored. One person had lost significant weight in one month with no referral being made to health professionals who could offer specialist advice. An audit of people's weight on 7 March 2021 found concerns and despite our raising this with the manager no action had been taken on our second day of inspection.
• At this inspection we found a continued lack of systems and processes for assessing and managing the risks to people's safety. Risk assessments when in place were brief in detail, contained conflicting information and did not clearly determine the level of risk. Risk management guidance for staff did not always reference for example, measures to prevent or minimise the risk of falls and access to stairs, the risk of scalding from the exposed radiators and hot water pipes we found in bedrooms and bathrooms.
• We found a lack of action taken to address deficiencies identified by Suffolk Fire Service who visited in December 2020. There was no effective evacuation plan in place that staff were trained in. This meant people continued to be at risk in the event of a fire.
• In addition, people continued to be placed at risk in the event of a fire as people's bedrooms had yale type locks that staff needed a key to enter. Fire doors were found to have large gaps around the edges which would not resist the passage of fire and smoke. This put people at ongoing risk of harm .
• A Legionella report dated 11 January 2021 identified four defects that had required immediate attention. We found action had not been taken to mitigate the risk of harm to people.
• On day two of our inspection the shaft lift stopped working. This was a known issue for several months and had been reported to CQC previously. A lift engineer report dated 22 February 2021 found serious concerns which identified a risk of people becoming trapped if they used the lift. Prompt action to remedy this

ongoing risk had not been taken.
• Peoples health was at risk due to a lack of monitoring their oral healthcare. We were unable to find toothbrushes and toothpaste in most of the bedrooms. When staff were asked why they were unable to provide an explanation and confirmed a lack of monitoring to ensure people oral health was assessed and reviewed.

Using medicines safely
• Medicines overall were well managed. However, the over reliance on one person to order, monitor and administer medicines was a risk of errors in the management of people's medicines not being identified.
• One person had their medicines crushed and given covertly in food. No instruction from a medical professional was in place and no best interest decision process had been followed. The provider's medicines policy stated that crushing medicines could only happen if authorised by the prescriber and in consultation with a pharmacist. Current practice placed both the person and staff members at risk.
• The disposal of medicines described in the policy was not that seen in practice. Additional items were stored in the controlled drugs cabinet along with medicines contrary to the policy. Staff were not trained, and competency checked in line with the provider's policy and procedural guidance.
• Staff did not follow the provider's policy which states two staff as opposed to the one should complete handwritten changes in medicines prescribed.

Preventing and controlling infection
• At our last inspection we were not assured that infections could or would be prevented or controlled. At this inspection we found further work was needed to protect people from the risk of acquiring infections.
• A review of the infection control and prevention measures found significant shortfalls in steps taken to protect people from acquiring Covid-19.
• We were not assured that staff were using personal protective equipment [PPE] effectively and safely. We observed staff not always following NHS and Government guidance in the wearing of PPE. Staff wore masks around their necks whilst not observing socially distancing measures. Designated changing areas to enable staff to change and dispose of their PPE safely had not been provided with signage in place to guide staff as stated in the providers own policy. In response to our findings the provider designated a room for staff to change in and out of their PPE.
• We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. For example, hygiene guidance had not been implemented to guide staff in protecting people from the risk of cross contamination when emptying commodes and the disposing of urine and faeces. We found a lack of hand sanitiser throughout some bathrooms and bedrooms.
• We were not assured that the provider's infection prevention and control policy was robust and steps to protect people in place as described. The provider's policy stated an infection control lead person would have oversight of the service. The acting manager told us no one had been appointed to this role. The acting manager also told us there were no infection control audits carried out which would have identified the shortfalls we found at this inspection.
• Robust cleaning was not being completed in all areas of the premises, on both days of the visit the premises were not visually clean and equipment such as raised toilet seats still had brown and yellow stains from the previous week. The underside of bath chairs were brown, yellow with pinkish slime and lime scaled.
• We were not assured that the provider was preventing visitors from catching and spreading infections. Visitors were not always screened for symptoms of acute respiratory infection or provided with guidance as to any infection prevention control protocols. There was a lack of signage and instructions to explain to visitors what they should do to ensure safety and prevent the risk of cross infection when entering the service.

Risks to people continued not to be adequately assessed or action identified to reduce those risks. This

demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We were assured that the provider was accessing testing for people using the service and staff.

Staffing and recruitment
• Recruitment processes required by law were not followed. One staff member working at the service had no records available to inspect. Two staff had no references to vouch for their character. One of these staff member's application form had gaps in employment that were not followed up at interview. They stated they had a conviction, but no risk assessment had been undertaken to evidence the provider's decision making in choosing to employ them and confirm their suitability to work with vulnerable adults.

This demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure fit and proper persons were employed.

Inspected but not rated

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 inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question, we had specific concerns about.

The purpose of this inspection was to explore the specific concerns we had about Brookwood Manor. We will assess all of the key question at the next comprehensive inspection of the service

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

At our last inspection the provider had failed to ensure systems and oversight of the home were sufficient to keep people safe. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had not been enough improvement at this inspection and the provider remained in breach of regulation 17.

• There continued to be a lack of systems and processes established and embedded that ensured effective oversight and governance of the service. The lack of oversight meant people were put at risk from unsafe recruitment, untrained staff, and environmental risks in relation to, fire safety, infection control, shaft lift maintenance, water checks in prevention of Legionnaires' Disease and disrepair of equipment were known about but not acted upon in a timely way.
• There was a continued failure to implement systems to ensure analysis and review of people at risk of falls, risk of scalding and burns from uncovered hot surfaces, inadequate food intake and outbreak of infections. There was a failure to analyse themes and trends from accidents and incidents with action plans to reduce the risk of harm.
• There was a lack of audits which would have identified the shortfalls we found at this inspection. This did not ensure consistent delivery of quality and safe care.
• Policies and procedures were not effective in providing guidance for effective governance. For example, the medicines policy and procedure in place met all legal requirements but was an 'off the shelf' document that had not been adapted for Brookwood Manor. It spoke of nurses, but the service does not provide nursing care and did not employ staff in that capacity.
• Part of the regulation on Good governance is to seek and act on feedback. We requested information as to how this had been achieved to drive improvements at Brookwood Manor. Since registration of the service 1 September 2020 no feedback has been sought in order to evaluate and improve the service provided.

The lack of oversight and governance of the service demonstrated a continued breach of Regulation 17 of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.