

Astley Care Homes Limited

Brookfield House Care Home

Inspection report

Brookfield Park
Shrewbridge Road
Nantwich
Cheshire
CW5 7AD

Tel: 01270624951

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07 July 2018

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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

Brookfield House Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. This home is not registered to provide nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Originally a private house it has been renovated and extended to provide care for up to 51 adults who present with needs associated with old age, dementia and/or physical disability. It is a two-storey building and people live on both floors. Access between floors is via a passenger lift or the stairs. The home is set within well maintained gardens and located close to the centre of Nantwich.

This focused inspection of Brookfield House Care Home was undertaken following our receipt of a number of concerns by four people who told us they knew the home. We visited the home on Wednesday 4 and Saturday 7 July 2018. This inspection was unannounced.

This location requires a registered manager to be in post. 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. Although there was a registered manager in post at the time of our inspection they were not present throughout the time we visited.

At the last inspection which we carried out on the 8, 9 and 14 May 2018 we found that the service was safe and caring but not always effective, responsive or well led. We identified breaches of the regulations on Person-centred care, Safe care and treatment, and Good governance and awarded the home a rating of requires improvement overall.

This inspection focused on two key questions only safe and well led. We found that the service was not safe or well led and people were at risk of receiving unsafe and ineffective care. We identified breaches of the regulations in respect of Person Centred Care, Safe Care and Treatment, Safeguarding service users from abuse and improper treatment, and Good Governance.

The registered manager and the deputy manager had failed to protect people from the risk of abuse when allegations of abuse were made. The registered manager failed to notify the Commission of allegations of abuse and when we asked why they gave us false and misleading information.

We found that people did not always receive care that was centred on their needs. We identified institutionalised care practices, including day staff getting people ready for bed in the early evening purely as a measure to assist night staff and night staff dressing people in the early morning and putting them back to bed fully clothed purely to assist day staff.

Care was not being provided in a safe way. The registered person was not always assessing the hazards

presented to people or developing plans and effective arrangements for care to mitigate risk of harm.

Care plans were not always developed to ensure staff had guidance on meeting the person's needs and some were found to be inaccurate. We found one person's care plan outlined a care practice which was potentially dangerous and put the vulnerable person at risk.

In response to concerns we had raised with the local authority they asked an occupational therapist (OT) to check moving and handling procedures in the home. The OT visited the home and reported back that they had identified issues that required urgent action because moving and handling plans were inaccurate and staff seemed to be unsure about which bits of the plan to follow when.

We found that people had not always received their medicines as their doctor had prescribed them and a medicines trolley was left unattended near to where people were seated with a bottle of medicine on top.

We found that care records could not be relied upon. Care staff were not always making timely or accurate records of care provided and we witnessed staff falsifying records of food and fluids given to one person.

The provider had instigated systems to monitor the quality of care provided but these did not identify the concerns we identified during our inspection. The provider and registered manager had failed to take effective action to address the breaches in regulations at our last inspection, which meant people had remained at risk of receiving unsafe and infective care.

The home was clean and odour free throughout. Most of the people spoken with presented as relaxed and at ease in the home's environment. They all spoke well of the care provided and we could see they had good relationships with the staff. They told us that they were offered plenty of drinks and the food was good. Records showed that staff were monitoring people's weights but their calculations were not always correct giving a false impression of the person's wellbeing despite this issue being raised as a concern during our last inspection.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location from the providers registration.

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.

People were at risk of receiving poor and ineffective care and their needs not being met because risks were not always identified and mitigated and care planning was not always ineffective.

Managers and staff did not always seek advice of health care professionals when a person's needs changed so people remained at risk.

The registered manager failed to operate effective adult safeguarding procedures so vulnerable people remained at risk of harm and abuse.

Is the service well-led?

Inadequate ●

The service was not well led.

People were at risk of receiving unsafe and ineffective care because the management team failed to identify, assess and mitigate the risk of harm.

The management team failed to notify the Commission of allegations of abuse.

The registered manager lacked knowledge of their requirements and responsibilities under the regulations. The registered manager's actions and failure to safeguard vulnerable people showed that they lacked integrity and therefore did not have the required competencies and attributes necessary to manage the home.

Audits of the care home had not identified the concerns we found during this inspection. This was because there was a continued lack of effective governance and oversight.

Brookfield House Care 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 checked 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.'

The inspection took place on Wednesday 4 and Saturday 7 July 2018 and was unannounced. The first unannounced visit commenced at 10.30 am and finished at 18.55 that day. The second unannounced visit commenced at 7.30 am and ended at 12.55 that day. The inspection team consisted of two adult social care inspectors.

Before our inspection we reviewed the information, we held about the service. This included notifications we had received from the registered provider about incidents that affected the health, safety and welfare of people who lived at the home, previous inspection reports and information provided by other agencies including the local safeguarding authority.

The inspection was prompted in part by our receipt of information from four people who knew the home. Three of these people gave us their names and contact details the fourth person remained anonymous. These people raised concerns about the safety and welfare of the people who lived at Brookfield House Care Home highlighting a number of alleged incidences. These incidences are subject to ongoing investigations by the local authority and the police. As a result of this our inspection did not examine the circumstances of the specific incidents. However, the information shared with CQC about the alleged incidents indicated potential concerns about the management the home, failure on the part of management to take effective action when there is evidence or allegation of abuse, the existence of institutionalised care practices, including force feeding, food and medication, neglect and vulnerable people being treated in an undignified manner. These issues indicated that vulnerable people may be at risk of receiving poor, ineffective and abusive care. This inspection examined those risks.

The methods used during this inspection included talking to people using the service, their relatives and friends or other visitors including three visiting health and social care professionals. We interviewed staff, undertook pathway tracking, observed care practice, read records including personal care records for majority of the people who used the service. We also looked at a range of other records associated with the management of the home.

We met 15 of the 34 people who were living at the home and had conversations about the quality of care provided with six of them. We spoke with eight members of staff including the area manager, the deputy manager, three senior care staff, two care staff, and spoke with the provider's representative on the telephone. We met with representatives of the local authority and the local clinical commission group both prior to and during the inspection and gathered information about the care provided at the home.

Is the service safe?

Our findings

When we carried out our last inspection of Brookfield House Care Home in May 2018 we found that the service was safe. The home had appropriate safeguarding policies and procedures in place and staff knew what action to take in the event of any abuse or allegation of abuse. The manager was clear on the requirements of the regulations and this gave us confidence that vulnerable people were being adequately safeguarded from abuse, unsafe care and inappropriate treatment.

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Subsequent to our receipt of allegations of abuse and poor and ineffective care we contacted the registered manager to ascertain that safeguards were put in place to ensure vulnerable people were safeguarded from abuse whilst investigations were ongoing. The registered manager told us that they were aware of these allegations and knew who had made them. They told us that they had shared them with the registered provider on the same day they had received them and had been asked to investigate them. We were concerned to hear that the manager had been aware of these allegations but had failed to report them to the local safeguarding authority or the Commission or to take any action to safeguard vulnerable people from abuse. We contacted the registered provider's representative and they told us that they had not been informed of these allegations until CQC had raised it with them and they had not asked the registered manager to investigate them. It was only then that the registered provider's representative took action to ensure vulnerable people were protected.

We could see by the nature of the allegations that it would have been inappropriate for the registered manager to carry out the investigation, and they should have known that. The registered manager failed to respond effectively to allegations of abuse. The registered provider acted on this in the best interest of vulnerable people and the registered manager was suspended pending further investigation.

When we visited the home, we found that the deputy manager was aware of allegations of abuse but they too had not taken any action to inform the registered provider or the registered provider's representative. The deputy manager was fully aware of the home's safeguarding procedures including the whistle blowing procedure but had failed to put them into practice and had therefore left vulnerable people at risk of abuse. We spoke with a number of care staff who told us that they were aware of the homes safeguarding

procedures however some demonstrated a lack of understanding as to what action to taken in the event of abuse.

On the second day of the inspection we found a body map in a person's file that described and illustrated five bruises on their arm. The injuries described were unaccounted for and could have been as a result of unsafe or inappropriate moving and handling techniques or other forms of abuse. We asked a senior care worker what action had been taken in respect of these injuries. Whilst they told us they were aware of them, they had not taken any further action to establish how they might have been incurred.

The above comprises a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13. The registered person failed to establish and operate effectively systems and processes to prevent abuse of service users. Vulnerable people remained at risk of abuse because the registered manager and staff failed to take action as soon as they were alerted to alleged abuse.

We found that care was not being provided in a safe way. At the start of the inspection at 10.30 am on Wednesday the 4 July the deputy manager told us that all the people resident in the home were up and dressed. However, at lunch time we found one person still in bed, their bedding had ridden up so it appeared there was no bottom sheet on the bed and there was no indication the person had received any personal care that morning; their feet were dirty and their hair matted. We could see that their toe nails were overgrown and they had not been cut for a number of months.

This person responded to us and gave us permission to look at their bathroom and records. Whilst were with them a staff member came in to provide personal care and we waited outside. We had noted that there were no toiletries in this person's room other than toothpaste.

A senior care worker told us that the person had ran out of toiletries on the 28 June but staff had not taken adequate steps to ensure they were replaced. The staff member showed us a supply of communal toiletries used for a number of people. This is poor practice, it is institutional and something which should have been eradicated. We checked to see if the person had funds in their account and found they did so could see no reason why this person had not been supplied with toiletries to meet their basic care needs. Records showed that this person had not had their feet attended to since October 2017. There was no record of them refusing chiropody, but records showed they had paid for chiropody on three occasions since October 2017 including most recently 14 June 2018 and the funds had been taken from their balance of money held in the safe. The area manager who was present in the home on the day was unable to account for this person being charged for chiropody when we could see that they had not received it.

The person we had found in bed in a state of neglect was extremely anxious and afraid that they would be injured; they lay in their bed curled up in the foetal position. However, they engaged with a female inspector who was soon able to develop a rapport with this person listening to their fears and offering reassurance. This had a positive effect on the person who demonstrated sufficient confidence to get up and out of bed. Later in the day this person sought out the female inspector and sat with her again seeking reassurance. It was quite clear to us that this person was receptive to support and benefited from speaking about their anxiety. We observed staff attempting to engage with this person but they did not seem to have success. They were unable to develop a rapport and did not present with concept of a plan to engender confidence and give reassurance.

We looked at this person's care plans that addressed mental health and found it to be inadequate and requiring further development to ensure staff had appropriate guidance on how best to provide care and support at times of high anxiety.

The deputy manager told us that this person's behaviour displayed on the day of the inspection was out of character, yet did not seek the advice of a Community Mental Health Nurse (CMHN) who was in the home on the morning of the inspection. The deputy manager told us that the CMHN would not give advice on the care of any other person other than those they had come to see. We believe this to be misguided and incorrect and highlighted a lack of understanding. The above person was known to the mental health team and the nurse who had been in the home that morning told us, that whilst the home provided good care, staff on occasion had not sought the advice of the mental health team soon enough.

The risks of this person's mental health deteriorating were not being assessed or mitigated and the deputy manager had not responded to what they described as out of character behaviour.

On the first day of the inspection we found care provided was not safe because care records were inaccurate and could not be relied upon. We found indications that a number of people had not received personal care as was detailed in their records. Records showed that they had received personal care but their soap and tooth brushes were dry and encrusted with bone dry paste. A person's dentures were dirty, their records showed that they had refused to wear them on that morning which would indicate they were presented to the person in a dirty condition.

On the second day of our inspection we found a care worker writing up care notes at 07:45 retrospectively. There were numerous omissions, errors and contradictions in the records which showed us that the records could not be relied upon. Records showed that three people who required two staff were washed and dressed however when we checked at 08:00 we found that all these people were in bed and asleep. We asked the night staff senior carer as to why these people were in bed fully dressed. They told us that they had always done it that way, if they needed to change someone at night they would dress them in their day clothes and put them back to bed. All three people found in bed fully clothed required two staff to assist them with their mobility. The records showed that one person had been washed and dressed at 07:00, another 07:04 and another at 07:05. It was simply not feasible that the four staff on duty could have attend to 3 people within the space of five minutes. This was further evidence of institutional care practices which also showed us that personal care records could not be relied upon.

We observed the care provided to one person very closely because they had been the subject of an allegation of force feeding: food, liquids and medication. We were concerned that whilst staff were unable to rouse this person at any point during the morning from 08:20 to 12:55, they persisted in attempting to put food, and fluids in their mouth without any prospect of the person being able to swallow successfully because they were totally unresponsive.

We later found that a staff member had recorded that the person had drank 300 mls of tea and 200 mls of orange cordial and had eaten ½ of their breakfast. We knew this to be false and we asked the person who made the record where they got the information from. They told us that they had been told by the person assisting the person with their food that they had consumed this amount of food and drink. When we asked the other person, they gave a different account. It was clear that both these staff were prepared to give a false account of what the person had eaten and drank.

At no point during the morning did these staff attempt to inform the senior care worker or the deputy manager that that this person was unresponsive. It was not until we intervened that the person's doctor was informed of their deteriorating condition.

We were concerned to find that the risk of this person being fed when they were otherwise asleep had not been highlighted by the manager or other senior staff, it was not assessed and was not mitigated. We looked

at this person's care plan on eating and drinking and found it provided unsafe and inappropriate guidance, which put the person at risk. It stated that the "(person) can become sleepy while eating. When sleepy (person) needs staff to gently brush the spoon along her lower lip. This prompts (person) to open their mouth to continue eating." This is an extremely dangerous practice which could result in the person choking or aspirating. Their care plan also instructed staff to inform the senior care worker if the person did not eat or drink. It was clear to see that staff did not follow this guidance.

On the first and second day of the inspection we saw that a person's bedroom door which was a fire door was wedged open with a chair. This would compromise the home's fire integrity in the event of a fire.

The above comprises a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe care and treatment. Care was not being provided in a safe way. The registered persons were not assessing the hazards presented to people or developing plans and effective arrangements for care to mitigate risk of harm. The provider was not always actively working with other health care professionals to make sure that care and treatment remains safe for people using services.

We found that people had not always received their medicines as their doctor had prescribed them. Records showed that people were not always receiving their topical medicines such as creams and soap substitutes. Staff were not routinely recording the application of creams or the use of soap substitutes and had not dated when they had opened a product and started to use it. We checked the medicines for one person and found that there were eight tablets in the bottle when the medication administration record indicated that there should only be four.

The above comprises a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe care and treatment. Staff were not following policies and procedures about the administration, recording and management of medicines,

We found that people did not always receive care that was centred on their needs. We identified institutionalised care practices, including day staff getting people ready for bed in the early evening purely as a measure to assist night staff and night staff dressing people in the early morning and putting them back to bed fully clothed purely to assist day staff.

Care was not being provided in a safe way. The registered person was not always assessing the hazards presented to people or developing plans and effective arrangements for care to mitigate risk of harm.

Care plans were not always developed to ensure staff had guidance on meeting the person's needs and some were found to be inaccurate. We found one person's care plan outlined a care practice which was potentially dangerous and put the vulnerable person at risk.

In response to concerns we had raised with the local authority they asked an occupational therapist (OT) to check moving and handling procedures in the home. The OT visited the home and reported back that they had identified issues that required urgent action because moving and handling plans were inaccurate and staff seemed to be unsure about which bits of the plan to follow when.

We noted from one person's records that they had a document that recorded their "preferred place of care". This indicated that the person did not wish to be resuscitated however there was no purple "Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decision" form. The purple form is a nationally established form which is immediately recognisable to all health care practitioners including paramedics, doctors and nurses.

Where a person is deemed assessed by their doctor and deemed unlikely to benefit from resuscitation due to their pre-disposing conditions the purple form is used to prevent health care professionals attempting invasive Cardio Pulmonary Resuscitation (CPR) which could lead to them experiencing unnecessary pain, increased anxiety and ultimately an undignified death. The deputy manager told us that they had been informed that a DNACPR form was not required because the person had a preferred place of care form. This is contrary to established practice and put vulnerable people at risk of receiving intrusive, unsuccessful and unnecessary CPR at the point of their death.

The area manager who was present at the time rightly corrected the deputy manager and informed her that should a paramedic attend a person who has collapsed they would be required to attempt CPR if a DNACPR form was not in place.

The above comprises a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9, person centred care. The registered provider failed to do everything reasonably practicable to make sure that people who used the service received person-centred care and treatment that was appropriate, met their needs and reflected their personal preferences.

We found that there was a suitable number of staff on duty to meet the needs of people resident in the home. Rotas showed that there was a minimum of seven care staff on duty between the hours of 8am and 8pm, in addition to management, administrative and ancillary staff to meet the needs of the 34 people who lived at the home. This provided care staff to service user ratio of better than 1:5, and we could see that there were times when additional staff were rostered on duty. At night there were four-night care assistance including one senior night care assistant.

People who lived at the home told us that they felt safe and well cared for. They told us that the staff responded to their needs and overall were very good. A visiting relative, who had seen our poster letting people know we were carrying out an inspection sought us out and praised the home. They told us that their relative and received excellent care and as result they were enjoying a better quality of life.

During our inspection we saw many positive interactions between staff and the people who lived at the home. We observed staff being kind and courteous and at times provided sensitive and compassionate care.

Is the service well-led?

Our findings

When we carried out our last inspection of Brookfield House Care Home in May 2018 we found that the service was not always well led because the provider's quality assurance procedures were not sufficiently robust to have identified the concerns noted during that inspection.

The registered manager had not notified the Commission of recent allegations of abuse made directly to them by a member of staff who was leaving the home to work elsewhere.

Following our intervention, the registered manager made a late notification to the Commission which confirmed the date they had been made aware of the alleged abuse. In this notification the registered manager omitted to answer the question as to the date they had informed the registered provider. We asked them to clarify this and subsequently they sent us another notification. This second notification indicated that the manager had notified the registered provider of the alleged abuse on the day the manager had received them. The registered provider's representative told us that this was not factual and confirmed that they had only been informed of the allegations of abuse three days after the fact when the Commission had intervened. The registered provider's appointed area manager confirmed this.

This is a failure to notify the Commission of abuse or allegations of abuse as required and is an offence under the Care Quality Commission (Registration) Regulations 2009: Regulation 18. This matter will be addressed separately to this report.

In the light of receiving allegation of abuse the registered manager chose to work contrary to locally agreed multiagency safeguarding procedures. This meant that vulnerable people were left exposed to the risk of abuse, poor, inadequate and undignified care. The registered manager chose not to make an accurate record of the alleged abuse in that their record did not name the alleged perpetrators. We could see that the registered manager had personal and vested interests in protecting the alleged perpetrators. Their failure to act in the best interests of vulnerable people and their failure to protect them from abuse showed that the manager lacked integrity and candour. In the light of this the registered provider suspended the registered manager pending investigation and made alternative arrangements to manage the home.

We found that the registered manager had carried out an audit of a person's care plans and risk assessments. The registered manager's audit failed to identify that the person's care plans and risk assessments were inaccurate and did not reflect the needs of the person. The person's care plans indicated that they needed 30-minute observations throughout the day to ensure they were safe and protect from falls. The person was assessed at high risk of falls, but other than 30-minute observations no other measures were put in place, such as assistive technology to ensure the person was adequately safeguarded. 30-minute observations would not offer sufficient protection alone, however when we checked we found that staff were not checking the person every 30 minutes but every two hours. This showed that the managers care plan audit was ineffective.

The area manager carried out a number of audits and checks but these did not highlight the many

deficiency in care and care practice we identified during our inspection. The area manager was not aware that staff had adopted institutional practices getting people ready for bed in the early evening and dressing them in the early morning and putting them back to bed purely for the convenience of staff. The area manager was unaware that a vulnerable person had been charged a total of £70 for chiropody that they had never received. The money had been taken from the person's account and a record was made of the charges simply stating chiropody. The area manager was not aware that moving and handling care plans and risk assessment were unclear and inadequate. The area manager was unaware that communal toiletries were being used instead of people having access to their own personal and person-centred supplies. This showed a marked lack of oversight which had meant poor ineffective and institutionalised care practices, which put people at risk, had gone unchallenged.

We found that the home's record systems could not be relied upon. We found staff writing up records retrospectively and not on the basis of fact. We had found similar poor practice at our inspection in 2016 and we could see that the provider had not learned from experience. We found that staff were prepared to falsify records and give a false account of what a person had eaten.

The above comprises a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17(1) Good Governance. The registered person failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity and failed to maintain an accurate and contemporaneous record of care provided each person.