Methodist Homes

Brockworth House Care Centre

Inspection report

Mill Lane
Brockworth
Gloucester
Gloucestershire
GL3 4QG

Tel: 01452864066
Website: www.mha.org.uk/care-homes/dementia-nursing-care/brockworth-house

Date of inspection visit:
19 December 2022
20 December 2022

Date of publication:
14 February 2023

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Brockworth House Care Centre is a residential care home providing care to a maximum of 55 people. The service predominantly provides support to people who live with dementia. At the time of our inspection there were 46 people using the service.

People are accommodated in one purpose-built building across two floors; on two units upstairs and one-unit downstairs. The different units provide the opportunity for people to be supported at various stages of their journey in care. Providing the freedom for people who are more mobile and a quieter environment for people who are more physically and mentally frail.

Each unit has its own communal spaces comprising of a kitchenette, dining space and a selection of areas to sit and relax or take part in social activities. Each person has their own bedroom, toilet and washing facility and there are adapted bathrooms on each floor. A large enclosed garden supports people to safely enjoy the outside.

People's experience of using this service and what we found
The information held about people's medicines was not always sufficient to provide staff with clarity on the administration and use of some prescribed medicines, to ensure the risk of medicine errors occurring from this were fully mitigated. At the time of the inspection processes to ensure people's prescribed medicines were obtained in a timely manner ready for administration, still required improvement to avoid gaps in people's treatment.

Infection, prevention and control (IPC) practices and arrangements were not always supporting the prevention of infection spreading.

The provider's quality monitoring processes were not fully effective. They had not identified the shortfalls found at this inspection, in relation to medicines and IPC. This had not resulted in necessary improvement action being taken to address these shortfalls. Managers were not using enhanced monitoring processes to assure themselves that an outbreak of COVID-19 in the home was managed safely.

Improved scrutiny was needed to ensure the provider's quality monitoring and governance systems were effectively implemented to ensure the service remained compliant with necessary regulations and best practice.

The service experienced significant challenges during the pandemic and since and the provider had taken action to provide staff with leadership and enough staff to keep people safe.

Risks which otherwise may impact on people's physical and mental health were assessed and managed. These included those associated with the premises and environment, people's mood and behaviour, poor

mobility and falls, eating and drinking, potential choking and pressure ulcer development.

Arrangements were in place to protect people from abuse and to act if abuse was suspected. Processes were in place to ensure people, relatives and staff felt comfortable in reporting poor care or discrimination so this could be acted on. People were supported to live safely with dementia. Staff supported people's preferences in relation to their protected characteristics.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We observed interactions and actions taken by staff which demonstrated a dementia friendly and person-centred culture was in place. Joint working with social care and health care professionals, community and church leaders took place to support people's health and wellbeing needs.

Staff felt supported by senior staff and had access to training which suited their learning needs, and which helped them perform their roles safely.

Relatives were kept informed of their relative's health needs and informed of any accidents or incidents involving their relative.

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

Rating at last inspection
The last rating for this service was good (published 10 August 2018).

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service required medical assistance. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risks associated with swallowing problems and potential choking. This inspection examined those risks.

Action had subsequently been taken to ensure the person received the right care and treatment to meet their needs. Processes and practices had been reviewed to ensure the safe use of thickeners (sometimes used in people's drinks to help them swallow safely).

This focused inspection reviewed the key questions of safe and well-led only.

We have found evidence that the provider needs to make improvements. 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.

For those key questions not inspected, we used the ratings awarded at the last rated inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Brockworth House Care Centre on our website at www.cqc.org.uk

Enforcement
We have identified breaches in relation to the management of people's medicines and quality monitoring processes at this inspection.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Brockworth House Care Centre

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by one inspector, one (CQC) medicines specialist and an 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.

Service and service type
Brockworth House Care Centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Brockworth House Care Centre is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
The inspection was limited to 2 of the care home's 3 units as one unit had an outbreak of COVID-19 infection. We sought feedback from infection, prevention and control professionals who had previously visited the service. We spoke with 1 person who used the service and their relative to gain their view of the care provided to them. We observed interactions and activity between staff and 6 other people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the operations manager, registered manager, deputy manager, a registered nurse, 2 care staff, head chef, head housekeeper, activities co-ordinator and training co-ordinator.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- People's medicine records did not always provide clear information and guidance on why people were prescribed medicines and how their medicines were to be administered. This included when people's medicines had been reviewed and altered by a health care professional.
- This was seen for people who had medicines prescribed for constipation and for the treatment of seizures. People did not have clear guidance for the administration of medicines prescribed to be given 'as required' and covertly (hidden in food or drink).
- There were unresolved problems in obtaining medicines, in a timely manner, so they could be administered as prescribed. One person had not received a prescribed medicine for 10 days because of this. At the time of the inspection there had been no impact on this person's health from this.

People were at risk of not receiving safe care and treatment in relation to their medicines. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Action was taken immediately during the inspection to rectify and improve people's records and to further follow up the missing medicine.

- The impact of people's medicines was monitored and reviewed by staff who liaised closely with the person's GP or other specialist health care professionals about these.

Preventing and controlling infection

- We were not assured that the provider was making sure infection outbreaks were effectively prevented or managed. People who had tested positive to COVID-19 had not been sufficiently isolated or cohorted from those who were not infected. Following further spread of the infection on one unit, steps had been taken to improve segregation of those who were COVID-19 positive from those who were not. This had helped to reduce further spread of the infection on the unit.
- We were not assured that the provider was ensuring PPE was used in accordance with national guidance during an outbreak of infection. The registered manager told us staff were not wearing visors when supporting people on the unit with a COVID-19 outbreak. They told us they were unaware of the national guidance to do this. This was despite guidance also being provided by the local authority's infection, prevention and control team who had recently visited the care home.
- Practices observed on the units not infected with COVID-19 did not always support good infection prevention and control as used continence products and personal, protective equipment (PPE) was not always disposed of safely in line with provider policies.

● Clean PPE was stored on the same trolley used to gather items for laundry, placing the unused PPE at risk of contamination.

Arrangements were not fully in place to protect people from the spread of infection. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection. For example, people were supported to wipe their hands clean before eating.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. For example, preventative measures were in place to ensure infection from the 1 unit was not spread to the other 2 units.
● We were assured that the provider's infection prevention and control policy was up to date.
● There were no restrictions on visiting to the care home, but guidance related to this was taken from the health protection team during the COVID-19 outbreak.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risks of abuse because staff received training on the subject; how to identify and report safeguarding concerns.
● Senior staff adhered to the local authority's multi-agency safeguarding protocol and ensured relevant concerns were shared with the local authority, including agencies who also had safeguarding responsibilities such as the police and CQC.

Assessing risk, safety monitoring and management
● Risks associated with the environment and people's health were assessed and action taken to reduce these. These included risks associated with fire, water supply, care equipment, falls, pressure ulcer development and behaviour which could cause distress or harm to others.
● At the time of the inspection staff were aware of the risks associated with people's eating and drinking, which included any swallowing problems and potential choking or aspiration (the sucking into the lungs of food or drink) risks. A review had been completed to ensure all staff were competent in the use of thickeners (sometimes added to people's drinks to make them easier for people to swallow safely).
● Kitchen staff were aware of who required textured altered foods to meet their needs. Instructions from a speech and language therapist and guidance in accordance with the International Dysphagia Diet Standardisation Initiative (IDDSI) were followed.

Learning lessons when things go wrong
● Learning had been taken from the incident which had resulted in one person requiring urgent medical assistance. This had included a review of how decisions were made, by nurses who worked in the care home, which necessitated a change in a person's agreed treatment. These must now be discussed first with the registered manager or on call manager or GP before changes are implemented.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were met.

Staffing and recruitment

● The provider had experienced significant challenges with retaining and recruiting suitable staff, particularly nurses. This had resulted in a heavy reliance on agency nurses and staff to maintain safe working numbers. However, subsequent staff recruitment had started to improve this situation.

● We observed there to be enough staff available to meet people's needs. We also observed care staff making time to support people's emotional needs. An activities co-ordinator was employed to support people's social and wellbeing needs. Where people required one to one care, additional staff were organised to provide this.

● New staff had been recruited safely. Checks through the Disclosure and Barring Service (DBS) had been completed, providing information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions. Previous employment, including gaps in employment, had been followed up and references sought and received before employment.

Requires Improvement

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. This related to how the service was quality monitored and actions for improvement were identified and completed.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider's quality monitoring processes had not been established effectively to ensure compliance with regulatory requirements. Shortfalls in medicines process and practice, identified during this inspection, had not been identified through the provider's own monitoring systems despite medicine and care plan audits having been completed as required by the provider. These systems did not ensure information and guidance for staff was updated in a timely way when changes to people's medicines were made.
- The provider's systems to monitor the safety of infection, prevention and control (IPC) measures in the home had not been operated effectively to ensure IPC risks to people were managed. IPC audits had not been carried out in line with the provider's requirements and IPC shortfalls we found during the inspection had not been identified by the registered manager or provider.

Systems had not been established and operated effectively to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager audited accident and incidents records regularly to ensure these were completed and appropriate action was taken in response to an accident or incident. They monitored these for trends and patterns which may indicate that current support strategies were no longer effective and needed changing.
- A daily meeting was held between the registered manager, or in their absence, the next senior person on duty and heads of departments, to discuss the management of high-risk areas or new emerging risks.
- The registered manager and operations manager understood their responsibility to notify CQC of certain events involving people, such as serious injuries or deaths.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The registered manager promoted a person-centred and team approach to people's care which we observed during the inspection. The chef and training co-ordinator each interacted with people when they visited the units, clearly knowing some people well.
- People were understood as individuals, respected and included. We observed interactions and actions between people and staff which clearly demonstrated a dementia friendly culture. Staff provided orientation, dignity and choice in what they said to people such as "It's lunchtime. Would you like an apron

to protect your clothes" and "I'll just put your music back on (person's name)."
● Relatives were supported to remain included in their loved one's life and care as far as they wished to be. One relative liked to support their loved one to eat, also providing them with time with their loved one.
● The training co-ordinator said, "I love training and supporting the carers [staff]. It's my passion." This member of staff worked alongside staff when they were newly employed to ensure they felt included and people received the right care.

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; Continuous learning and improving care
● The registered manager understood their responsibilities in relation to duty of candour and to be open and honest with people or their relatives when things went wrong.
● Staff were also aware of the need to be honest and report near misses or things which had not gone to plan.
● Following the incident which resulted in one person requiring urgent medical support, an investigation had been completed by the registered manager and actions for learning and improvement identified and implemented.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People's relatives were recognised as being integral to achieving good outcomes for people. People's care plans, including activity and social plans, were compiled by involving the person and their relative, who could provide information which helped to engage and involve the person. Information about people's preferences, views and what motivated them was recorded.
● Staff recognised that people's relatives often needed a lot of support to navigate their way through their loved one's journey with dementia and the care and health system. A relative said, "If I want anything, I just ask the care staff and they'll try and help me. If ever I have got queries or questions, one of them [the office team] will try to help me."
● Staff had opportunities to feedback suggestions. One member of staff said, "[Name of registered manager] is approachable, you can make suggestions which are listened to."
● The training co-ordinator said, "I love training and supporting the carers. It's my passion." They worked alongside staff when they were new or when they needed additional support. They provided different ways of learning to meet staffs' learning needs, which included experiential learning. This had been used when training staff to use thickeners in people's drinks.

Working in partnership with others
● Staff worked with commissioners and other professionals to support people's access to the service for short and long-term care as required.
● This joint working continued when people lived in the care home to support their ongoing health and wellbeing. Staff had worked with an NHS behaviour support team to achieve one person's wish; to be part of and to use the wider community (outside the care home). This was now a regular part of this person's support plan which had made a positive impact on this person's wellbeing.
● People's spiritual needs were supported by visits by a chaplain who provided a weekly church service and monthly communion. They also provided pastoral support to people, their relatives and the staff. One relative said, "I had a very helpful conversation with the chaplain." Partnership working with leaders of other faiths and communities was also sought, as needed, to support people's diverse needs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not protected against potential medicine errors caused by a lack of or conflicting information and guidance about people's medicines. Medicines were not always obtained in a timely manner resulting in them not being administered as prescribed. People were not sufficiently protected from the risk of infection spreading. Regulation 12 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been fully and effectively implemented to assess, monitor and improve the quality and safety of services provided to people. Regulation 17(2)