

Bricket Wood Care Limited

# Bricket Wood Care Limited

## Inspection report

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## 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

Bricket Wood Care Limited also known as Uplands is a residential care home providing personal and nursing care to five people at the time of the inspection. The service can support up to six people.

### People's experience of using this service and what we found

Staff had not received training when they started working at the service and they were inducted in their role by working with the registered manager or more experienced staff. This meant that there was a risk that staff were not delivering care and support for people safely and in line with current best practice. The recently employed manager arranged for staff to receive training.

Not all staff were knowledgeable about how to report their concerns to local safeguarding authorities or best practice guidance relevant to their roles. They told us they would report or ask support from their managers if they needed.

At the time of the inspection, staff's recruitment files had little evidence that all pre-employment checks were carried out. Following our visit, the newly employed manager carried out an audit and found that not all employees had two references on their file, an application form or if some staff's eligibility to work was checked.

People's care plans lacked personalization and risk assessments were not always in place for known risk like fire or Covid-19.

On the day of our visit we observed the registered manager signing the medicine administration record for people in the office after they administered the medication. This was not in line with current best practice and increased the risk of errors happening.

There were no quality assurance audits or systems used by the registered manager to ensure they were able to effectively assess the quality and safety of the service provided. The recently employed manager carried out a range of audits we requested to ensure they could prioritize actions needed to improve the service. They developed a service improvement plan to ensure a systematic and planned approach to improve people's experience of the care they received.

People told us they felt safe in the home. They told us current lockdown measures meant they spent more time in the home and at times they found this difficult.

We expect health and social care providers to guarantee people with autism and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or people with autism.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. Staff used labelling language for people who may have had behaviours that challenged others. Positive behaviour support plans were not developed, and staff could not tell us if the methods they used to manage people's behaviours was in line with best practice guidance. People were not supported to set and achieve goals.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

#### Rating at last inspection

The last rating for this service was good (published 26 July 2018).

#### Why we inspected

The inspection was prompted in part due to concerns received about lack of training for staff and employment procedures not being robust. A decision was made for us to inspect and examine those risks.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

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 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.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

**Requires Improvement** ●

# Bricket Wood Care Limited

## Detailed findings

### Background to this inspection

#### The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the 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 on 19 January 2021.

#### Service and service type

Bricket Wood Care Limited 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.

#### 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. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

#### During the inspection

We spoke with two people who used the service, the registered manager and the newly employed manager who was taking over the management of the home. We reviewed two people's care records for risk assessments.

After the inspection

We reviewed a range of records we asked the newly employed manager to send us. This included various audits and quality assurance documents. We also spoke with three members of staff.

We continued to seek clarification from the new manager to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

# 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 Good. At this inspection this key question has now deteriorated 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.

Systems and processes to safeguard people from the risk of abuse

- Staff told us they have not received training since the March 2019. One staff member told us they knew how and when to report safeguarding concerns internally and to external safeguarding authorities as the information was displayed in the home.
- Two staff members who were recruited in 2020 had not had any safeguarding training and they were not aware of reporting their concerns externally, only to the registered manager.
- People told us they felt safe at the home and felt empowered to raise concerns, however had little confidence that anything would change if they did. One person said, "I do feel safe and things improved slightly but even if I raise concerns change takes a long time or not happening."
- The newly employed manager told us they had identified the lack of training provided to staff and they had made arrangements to enrol staff to on-line training. They were also in the process of assessing staff's skills and competencies to ensure training was shaped to staff's needs.

Assessing risk, safety monitoring and management

- People told us they were aware of risk associated with Covid-19 and that they should wear a mask if going out, however they were not maintaining social distancing in the home. We observed two people sitting very close to each other in the sitting room.
- Risk assessments were not always in place for known risks like fire.
- We asked the new manager to conduct an audit of the care plans and they have identified that one person had no risk assessments in their care plan and all risk assessments had to be reviewed, developed and implemented for staff to have guidance in how to support people safely.

Staffing and recruitment

- We received concerns from members of the general public that some staff working at the home had not had all the pre-employment checks done to ensure it was safe for them to work with vulnerable people.
- We asked the new manager to check if the employment files had all the necessary checks and found that five staff had no references on file and two staff only had one reference. None of the employment files evidenced that staff's eligibility to work in England and their identity was checked.

Using medicines safely

- We have not counted or checked the stock of medicines held for people.
- We observed when we arrived at the home and were shown in the office by the registered manager that they were signing the medicine administration records (MAR) for people to indicate they administered their

medicines. This was not in line with best practice guidance. The MAR charts should be signed right after administering each person's medicines.

- The registered manager told us they were only signing for one person who got up later and they have administered their medicines but didn't get around to sign the MAR.

#### Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We observed that freshly washed linen was put over the radiators to dry all over communal areas. There was no evidence that the cleaning equipment like hoovers were regularly serviced and they were fitted with special filters suitable to use in case of an outbreak. We recommended to the new manager that they review the infection control policy and procedure to be in line with current best practice guidance as well as government guidance.

We have also signposted the provider to resources to develop their approach.



# 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-centered care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centered care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The registered manager was leaving the service in February 2021 and they were handing over the service to a new manager. There was a new manager employed from the beginning of January 2021 who was in the process of registering with CQC.
- The new manager identified some shortfalls in the quality and safety of the service; however, they were not long enough in the service to complete a thorough assessment.
- There was a lack of audits done by the registered manager in 2020, therefore we asked the new manager to complete several audits. These included, medicines, health and safety, infection control, staff employment files, care plans and others.
- These audits evidenced that improvements were needed in all these areas. For example, staff employed in 2020 had not received any training to ensure they were skilled and understood their responsibilities. Cleaning schedules were not in place, people's care plans were not personalised, risk assessments were not developed.
- Staff had no one to one supervision and their competency to carry out their roles safely was not assessed. Staff were not aware of current best practice and could not tell us if the way they supported people was safe. This meant that people were put at risk of receiving care and support
- The new manager developed a service improvement plan to detail what actions were needed to improve the quality and the safety of the care people received.
- The provider carried out an inspection of the service in November 2020 and they have identified most of the concerns we found during the inspection. They identified concerns in medicine management, staff induction and training as well as health and safety and care planning. There was no follow up visits or action plan developed to evidence improvement and the audits carried out by the new manager identified the same concerns.
- Due to the lack of effective monitoring carried out at the service there was no shared learning amongst staff. The registered manager was not monitoring accidents/incidents or complaints for trends and patterns. This meant that opportunities to improve the service may have been missed due to poor management.

The lack of robust governance and management oversight at the service and the provider's failure to take immediate actions to improve the service when they identified failings in the quality and safety of the care people received was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

#### Working in partnership with others

- The new manager sourced on-line training for staff and contacted an independent care provider association for support with employment and training for staff. They also liaised with Local funding authorities and commissioners to ensure the improvements they were planning were in line with current best practice.

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider and the registered manager failed to implement robust governance systems to ensure the quality and safety of the care provided met people's needs. The provider failed to ensure that improvement actions were taken when concerns and failings were identified in the care people received.</p>