

London & West Investments Limited

Brooklands Nursing & Residential Home

Inspection report

Costessey Lane
Drayton
Norwich
Norfolk
NR8 6HB

Tel: 01603262666

Website: www.carebase.org.uk

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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

Brooklands Nursing and Residential Home is a care home which provides personal and nursing care to people aged 65 and over who may be living with dementia, a physical disability or sensory impairment. The service can support up to 70 people. At the time of this inspection there were 59 people receiving support.

The home is built over three floors with one floor being dedicated to people living with dementia. All bedrooms have a wash hand basin and many have toilet facilities. In addition, there are shared bathroom facilities and shared living areas on each floor. Within the grounds there is an enclosed and accessible garden.

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

Risk assessments did not always include all necessary information to mitigate risk of harm to people. Where change had occurred, accurate updates of risk assessments had not always been conducted.

The quality assurance processes and systems in place were not robust and did not drive change and improvement to the quality of the service. The audits had not identified shortfalls in medicines, monitoring charts or risk assessments.

The provider had identified the current electronic system was less effective in recording person centred information. The provider advised the inspector a new system had been identified which was due to be implemented in the service. Training had been planned for all staff and a process was in place to transition and review all records when moving these to the new system.

People were supported by a staff team which were familiar to them. People and relatives were complimentary about the staff who they felt were caring and kind. People told us they felt safe. People, their relatives and staff felt the manager would address any concerns they had.

Staff had received an induction and training which prepared them for their role. Staff were confident in reporting concerns internally and to external organisations. Staff felt supported by the registered manager, who they found to be approachable and visible in the service.

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 did not support this practice.

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 the service under the previous provider was good, published on [19 November 2017].

Why we inspected

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 COVID-19 and other infection outbreaks effectively.

We received concerns about the provider's governance systems and oversight of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Brooklands Nursing and Residential Home 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 monitor the service and will take further action if needed.

We have identified breaches in relation to care planning, risk assessing, and the quality assurance 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?

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 ●

Brooklands Nursing & Residential Home

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 two inspectors, a medicine inspector 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

Brooklands Nursing and Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement dependent on their registration with us. Brookland Nursing and Residential Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Notice of inspection

This inspection was unannounced.

Inspection activity started on 17 May 2022 and ended on 30 May 2022. We visited the service on 17 and 18 May 2022.

What we did before 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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with eight people who used the service and eight relatives about their experience of the care provided. We spoke with 10 members of staff including the registered manager, deputy manager, business manager, registered nurses, care staff and members of the catering department.

We reviewed a range of records. This included eight people's care records. We reviewed medicine administration and associated records for 17 people, observed medicines being given to people and we spoke with six members of staff about medicines. We looked at four staff files in relation to recruitment and staff supervision, and one agency staff record. A variety of records relating to the management of the service, including audits, staff training, policies and procedures were also reviewed.

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.

Assessing risk, safety monitoring and management; Using medicines safely

- Risk assessments for people had been completed. However, these had not all been reviewed and updated to contain accurate information to guide and direct staff to provide safe, appropriate care and support.
- For example, for one person who was at risk of pressure injury, their records had not been updated for several months to reflect changes which had occurred. This increased the risk of the person receiving inappropriate care and further deterioration of their condition. For another person who had been prescribed oxygen, the service had not considered the risks around its safe storage and administration at the service.
- Oral medicines were stored securely and at correct temperatures. However, medicines prescribed for external application such as creams and emollients were not being stored securely to ensure people could not access them and put themselves at risk of accidental harm. We also found that some medicines for external application had been opened and in use for longer than their expiry times.
- We looked at the electronic Medicine Administration Record (MAR) system and noted that people received their oral medicines as prescribed. However, records did not show the application of each individual medicine prescribed for external application. We found that a controlled drug (medicines requiring additional security) had not been properly registered into the home in line with national legislation. This was discussed with the registered manager at the time of the inspection who took action to address this.
- We found that information to administer people's medicines safely was sometimes not available or regularly reviewed. People's medication care plans were sometimes inconsistent and inaccurate. Known medicine sensitivities or allergies were not consistently recorded. When people were prescribed medicines on a 'when required basis' (PRN), there was sometimes a lack of written guidance available to help staff give them these medicines consistently and appropriately.
- When people were prescribed medicated skin patches there was sometimes a lack of additional records to show their application and the removal of previous patches for safety. For some, the records could not demonstrate the site of application of patches to the person's body had been adequately varied, with appropriate intervals before repeating use of the sites to avoid the potential for irritant skin reactions.

Systems to assess and manage risk and medicines were not robust enough to keep people safe. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had received training on medicine management and had been assessed as competent to give people their medicines. We observed that staff gave people their medicines by following safe procedures.
- Equipment and environment safety checks were regularly completed by the maintenance team. On the day of the inspection, flooring was being replaced in one room and further decoration had been planned to

take place in the service.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe. One person told us, "I couldn't possibly look after myself, having [staff] available all the time reassures me and makes me feel safe."
- One relative told us, "[Family member] is definitely safe. The [staff] keep me well informed and they go to [family member] straightaway if they request anything."
- Staff had received safeguarding training and were aware of their responsibility in recording and reporting potential signs of abuse internally, and to external organisations including the Care Quality Commission (CQC).

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 being met.
- Staff understood the need to seek people's consent and permission before providing care and treatment.
- Mental capacity assessments had been completed for people and were decision specific. However, the records did not provide clear information about how people had been supported to understand the decision being discussed and be fully involved in this process. The registered manager told us they were reviewing practice to ensure they provided clear guidance for staff to follow about involving people in the decision-making process with a person-centred approach.

Staffing and recruitment

- People told us they were supported by a familiar staff team who they felt comfortable with. One person told us, "[Staff] do not rush me with anything. I can't go fast, and they know that." Another person said, "There are not as many [staff] as there were when I came here. They do what they can with grace."
- Relatives felt that staffing was consistent although did comment the staff were always busy. One relative told us, "At weekends it appears there has not always been enough staff at times, but there is not a high turnover and there seem to be more staff now."
- The registered manager told us a recruitment drive had been positive and several new staff were joining the team. This would reduce the use of agency and bank staff which had been used to support when unexpected absence had occurred.
- A recruitment process was in place to ensure staff were safe to support people. This included completion of identity checks and Disclosure and Barring Service (DBS) checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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 meeting shielding and social distancing rules.
- 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 were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

- The visiting policy had been reviewed and was inline with current government guidance. People were able to see visitors in the service. Visitors were requested to complete a rapid COVID-19 test prior to their visit and receive a negative result. Face masks were required to be worn by all visitors whilst at the service.

Learning lessons when things go wrong

- The provider had identified the current care planning system was less effective in enabling the recording of person centred information. The registered manager advised the inspector a new electronic system which worked well in other homes, was due to be introduced in the service.
- Staff told us daily briefings with team leaders took place. These provided opportunity for updates relating to people to be shared. In addition, staff told us regular staff meetings took place where they felt able to discuss openly and confidentially incidents which had occurred and actions to follow to make improvements.

Is the service well-led?

Our findings

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. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The quality assurance process in place was not effective in identifying where quality and standards were compromised, or actions which had been taken to make improvements. Some of the information we reviewed including care plans, risk assessments and repositioning charts were incorrect or incomplete.
- We found that whilst there had been medicine checks, these had not been carried out frequently enough or were not sufficiently robust to identify the issues we raised about medicines during the inspection.
- Repositioning charts, where required, were in place. However, these had not been completed accurately and there were large gaps in their completion. For example, the record for one person who was to be repositioned every four hours only showed two entries made by staff in a 24-hour period. This was discussed with the registered manager who felt this was a recording error and no new pressure injury had been identified at the time of inspection. The registered manager told us the importance of recording consistently would be discussed with staff at the daily meeting.

The provider's governance systems were not effectively used to ensure the quality and the safety of the care people received was monitored and improved. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People we spoke with felt the staff provided care which met their needs. One person told us, "The [staff] are so good here. I now feel like I can do things for myself. I am going to be returning to my own home with care support." Another person told us they had been encouraged to participate in carpet bowls and had enjoyed refereeing as they had not felt well enough to play.
- Relatives we spoke with told us the service had maintained contact with them throughout the pandemic via emails, video calls and telephone calls. One relative said, "The communication is good. If I want anything I can email or phone and there's always a quick reply."
- Staff told us the registered manager was very supportive, approachable and visible in the service. Regular staff meetings provided staff the opportunity to make suggestions and comments. Staff told us they felt valued by the registered manager.
- People and their relatives were encouraged to give feedback on their experience of care and support. This

was done formally through surveys, meetings, compliments and complaints and the findings used to support making improvements. As a result of a survey conducted by the provider, it was highlighted further work was required to ensure people's religious and spiritual needs were met. The provider took action to address this and a regular visit by local religious leaders took place. One person told us, "The priest visits once a week, that means a lot to me."

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

- People, their relatives and staff told us they found the registered manager to be approachable. One person said, "The [registered manager] is a wonderful person who does a lot of unseen things. I would not hesitate to approach [registered manager] and [registered manager] would address my concerns. If I had worries, I would go straight to her."
- The registered manager was aware of their responsibility to notify CQC of reportable events when required. Following recent concerns raised by the CQC regarding late submission of reportable events, a review of incidents had taken place within the service and there were no outstanding events which required reporting.

Working in partnership with others; Continuous learning and improving care

- Records reviewed demonstrated the provider had maintained links with the local authority, community nurses and other health care teams to support the provision of appropriate care.
- The service had engaged with a local dental surgery and were participating in a pilot scheme to improve people's oral hygiene. The dentist had visited the service recently and provided a dental check to those who had given consent.
- Further work was being conducted by the provider, who was working with the University of East Anglia to analyse trends in falls and explore methods to reduce falls in the service. This included provision of additional training for staff.

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
Treatment of disease, disorder or injury	Risk assessments did not always contain adequate information to enable staff to support people safely. The provider had failed to ensure the safe storage of prescribed cream. Care plans relating to the storage and administration of oxygen were not in place. Medication care plans did not always contain information to support the safe administration of 'when required' medicines. The provider had failed to ensure information to administer people's medicine was adequate and up to date. Processes to record the receipt of controlled drugs in the service were not always followed. Regulation 12 (1) (2) (a) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to ensure that their governance systems identified and resolved issues in the service. Regulation 17 (1) (2) (b) (c)