Blue Ocean Brookwood Limited

Brookwood Manor

Inspection report

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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

About the service
Brookwood Manor is a residential care home providing personal care to 27 people aged 65 and over at the time of the inspection, in an adapted country manor. The service can support up to 28 people, many of whom live with dementia.

People's experience of using this service and what we found
The service had no registered manager and no manager in post. There was a lack of managerial oversight at the service, which lead to risks to people not being acted on or reduced adequately. The provider's monitoring system did not look effectively at processes throughout the service and did not identify where there were issues. Therefore, incidents continued to occur and place people at risk.

Safeguarding referrals were not made to the local authority safeguarding team and the deputy manager did not recognise when this was required. Risks to people were not managed safely. People were at risk of suffering harm from aggressive behaviour from other people living at the service. This risk was increased because staff did not have guidance about managing behaviour that challenged. Incidents of aggression were not reported to the appropriate authorities and this led to continued harm. Fire evacuation practices were not safe; fire doors were propped open, not enough staff had received up to date training and there were not enough staff to safely evacuate people at night. There were not enough staff available to make sure people were safe from harm. There was low staff morale and not enough staff to take adequate actions to reduce risks.

Infection prevention and control practices did not ensure the service was clean and hygienic. Lessons were not learned about accidents and incidents. Actions and other solutions to reduce these had not been identified.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The service met the characteristics of Inadequate in two areas; more information is in the full report.

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 4 February 2020).

Why we inspected
We received concerns in relation to environmental risks, reduced staffing levels, unhygienic flooring, lack of infection control measures to reduce risk of transmission of infection, and a lack of a manager. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 improvement. Please see the safe and well-led sections of this full report.

We asked the provider how they intended to improve following our visit to the service. They provided enough information to assure us they would take action in response to our most urgent concerns.

We reviewed the information we held about the service. 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 inadequate. This is based on the findings at this inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to keeping people safe from harm, managing risks, safe staffing levels and provider oversight of the service at this inspection. We also identified a breach of the need to notify CQC of events.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Brookwood Manor

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 undertaken by four inspectors.

Service and service type
Brookwood Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. We contacted the service a few minutes before the inspection visit. This was because we needed to know the Covid-19 status in the home and discuss the infection, prevention and control measures in place.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, which included notifications. A notification is information about events that the registered persons are required, by law, to tell us about. 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 three staff members, including the deputy manager, the head of care and a member of care staff. We spent time observing interactions between people and staff, and how people spent their time. We looked at medicines information too.

After the inspection
We spoke with three relatives and a further three staff members of care staff by telephone.

We continued to seek clarification from the provider to validate evidence found. We reviewed a range of records. This included five people's care records. We looked at information about three staff files in relation to recruitment. We also looked at a variety of information relating to the management of the service, including analysis of records.

Inadequate

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 deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- The provider did not ensure people were safeguarded from possible harm. Staff recorded incidents of harm, including physical aggression between people, although these were not reported to the local authority safeguarding team. Staff told us they had been advised not to make safeguarding referrals unless there had been an injury. This had resulted in continued harm to people and on one occasion a serious injury, which had also not been reported. No action was taken
- Not all staff had received safeguarding training or knew whether they should report incidents between people. One staff member said they did not know the different types of abuse that could occur. Another staff member told us senior staff did not always take any action when they were advised about injuries. Information showed that only one staff member out of 20 had completed training in keeping people safe from harm.

People were placed at risk of continued harm with inadequate action taken to safeguard them. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people were not adequately assessed and actions to reduce these risks were not adequately identified to ensure people were safe. People displayed behaviour that challenged during our visit to the service, which included verbal and physical aggression towards others. Staff were not always available to redirect people or to prevent situations from escalating. Where they were present, there were only one or two staff in the room, and they were often occupied with other people or in tasks, such as giving out hot drinks.
- One staff member told us information about people's behaviour that challenged was recorded in care records but two other staff said they did not have access to where these were kept. This was because they were locked away in another room. One staff member said, "I have got to know people's personalities so that is how I manage." While another staff member told us that not all staff knew how to complete records correctly and information was passed on verbally about how to care for people. This staff member also told us that staff often said they did not want to go near some people for fear of being hit.
- Accident and incident records identified numerous incidents of aggression between people, ranging between verbal assaults and physical attacks where people were held down and hit or pushed. These frequently resulted in minor injuries such as cuts and bruises, and on one occasion a serious injury that required hospitalisation. Assessments of these risks had not always been completed for each person who displayed behaviour that challenged others. Where information had been completed, staff had a description of the person's behaviour but did not have any guidance about how to reduce risks to others. We had such

significant concerns about the number of aggressive incidents between people that we considered taking immediate action to reduce risks to people. We made referrals to the local authority safeguarding team following our visit to the service. We then told the provider we had these concerns and asked them how they intended to safeguard people.

● We received concerns before this inspection in relation to environmental risks, such as equipment breaking down and the use of portable heaters. The deputy manager confirmed that the lift had been repaired prior to our visit. During our visit we saw freestanding heaters and a wall mounted television with a power cable running loosely to the wall socket. We also saw two people move furniture around the home. The risks to people from picking these heaters up while being in use, tripping over the power cable or of pulling on the television power cable had not been assessed.

● People were not protected from the risk in the event of a fire. We saw fire doors propped open with objects that did not provide an automatic closure if the fire alarm was activated. Training information showed that only two staff had successfully completed fire safety theory training and none had completed practical fire safety training in the last 12 months. We had concerns that three staff on night duty would not be able to provide adequate support to people in the event of a fire. Following our visit, we contacted Suffolk Fire and Rescue who carried out an audit and found deficiencies in relation to the fire risk assessment, the emergency plan, staffing at night, fire doors and the use of hold open devices and staff training.

● Only two staff working at the service had completed first aid training. However, when these staff were not available, other staff assessed possible injuries to people following incidents of physical aggression. Decisions were made by these staff regarding whether the person had sustained any injuries. Not all people suffering injuries were referred to a health care professional, which meant staff without adequate knowledge and skills were making decisions about appropriate action to be taken.

Preventing and controlling infection

● We were not assured that the provider was taking all the action they could to prevent the transmission of infection into and around the service. Staff had enough personal protective equipment (PPE) and wore this correctly. However, they did not have suitable changing facilities to ensure clothes could be changed before starting and after finishing work. There was not always enough information to prevent visitors from spreading infections. There was no information at entrances to the service about how to put on or take off PPE safely.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. There was a very strong offensive smell in the ground floor communal areas that continued throughout our visit. We were told housekeeping staff cleaned frequently touched surfaces, although we found surfaces such as radiator covers and handrails were visibly stained and tacky to touch. One staff member told us housekeeping staff had started to clean three times a day but this had reduced to once a day.

● People found it difficult to meet social distancing rules due to living with dementia, however other systems to reduce the risk of transmission of infection were not in place. One staff member told us, "Staff go wherever needed." They confirmed this had also happened when a person had been admitted to the home from hospital. The provider had not employed cohorting or zoning measures to restrict movement around the home for people or staff.

Learning lessons when things go wrong

● Lessons were not learnt when incidents occurred. The provider did not take action to review and make changes following accidents and incidents. We found records in the manager's office dating back to the beginning of October 2020 that detailed physical aggression between people. These had not been reviewed and no action had been taken to identify how to reduce incidents occurring. Two staff told us they were not aware of any learning from incidents.

Risks to people were not adequately assessed or action identified to reduce those risks. These were all breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were not always enough staff available to meet the needs of people in a safe way. We received information before this inspection that the provider had reduced staffing levels and the provider was not assessing staffing numbers properly. Staff told us there were five staff working each day, although staffing numbers had been higher early in the year and had reduced in March 2020. This number of staff did not allow them to monitor people adequately. They said that they were not able to spend time with people one to one and it, "Feels like firefighting all of the time."

● While completing tasks, such as giving out drinks, staff were continually interrupted by people or were having to divert people's attention to reduce aggression. We saw incidents of behaviour that challenged, and staff were able to redirect people so those that occurred in communal areas were resolved before escalating. However, we saw that there were not enough staff to keep people occupied and prevent incidents from occurring. There were also not enough staff to monitor people who were on other floors. We witnessed one incident of shouting and door slamming that occurred on the first floor. Records also showed that incidents away from communal areas resulted in people being pushed over and suffering other physical harm when no staff were present.

● Staff told us there were three staff working on night duty, and only two staff if there was sudden sick leave. This was to care for people living on all three floors of the home, including six people who needed two staff to reposition them. Accident and incident records showed that incidents of behaviour that challenged occurred from as late as half past midnight and as early as 6.30am, in all areas of the home. Three staff at night did not ensure there were enough staff to adequately monitor people's whereabouts.

● The provider told us they used a staffing tool to determine adequate staff numbers. However, they also told us that the staffing tool had not been completed correctly and did not accurately reflect people's care needs.

Inadequate staffing levels put people at risk of harm. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Staff said they had received training and they completed competency checks to safely give medicines. However, information did not show when staff had last received this training and only three staff at the time of our visit to the service had their competency to administer medicines assessed.

● There were instructions for giving medicines that needed to be taken in a specific way or as required. Medicine administration records were fully completed and showed when medicines had been given or the reason why they had not.

● Medicines were stored securely, and action taken to make sure they were kept in the correct conditions. Staff continued to make sure medicines were secure by only administering these to one person at a time. They did this in a safe and considerate way.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality 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

- The provider had not sent us notifications about all events and incidents that happened, such as possible harm and serious injuries, and what action they had taken to resolve or improve things. This is required by law and we had received no notifications of possible abuse for over 12 months. One of these incidents also resulted in a serious injury and we did not receive a notification for this either. Despite being made aware of these incidents the provider has still not notified the Commission of them.

The provider did not act on their duty of candour and this put people at greater risk of suffering harm. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

- The service had displayed their inspection rating on their website, although this was not in the required place on their website. This did not meet the requirements for rating display or display the information in an open and transparent way.

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

- We were concerned about the provider's lack of oversight of this service as there had been a change of management staff prior to this visit. The provider had not had a registered manager at this service since August 2020, although they had employed a deputy manager to run the service, who had applied to register with the Care Quality Commission (CQC). The deputy manager told us they only had experience as a deputy manager but had been left to run the service with little support. The deputy manager told us the area manager had only visited on one occasion in November 2020 and not at all in October 2020. They had looked at audits of the service's systems during their visit.
- We asked the provider's representative how they monitored risks to and the quality of the service. They told us they had systems in place to do this and that audits, "Are now being completed in a timely way." They did not send us copies of these audits, so we were not able to corroborate this.
- Information about the accidents and incidents that had occurred since March 2020 showed statistical details about the number of falls and incidents, and their location, injury, hospitalisation and time of day. However, these provided no other breakdown or outcome to show any trends or themes, such as whether one person was more likely to fall or cause or suffer from aggression. There had been an increase in two months (October and November 2020) of incidents, where one person was identified as being involved more

often than other people. This person was not the only person who had been involved multiple times but no analysis of where in the service or who had been involved had been carried out.
● The provider had not identified any of the concerns or issues we identified at this inspection. They had not taken the appropriate action to report or mitigate areas of risk or to provide enough staff to ensure people were safe.

Working in partnership with others
● Staff did not work in partnership with other organisations, such as the local authority. There had been contact with only one other organisation in relation to the number of incidents of physical aggression between people. This had been in regard to only one person and there had been no other contact with the local authority safeguarding or local teams to reduce risks to people.

The provider's systems were not effective in assessing, monitoring or reducing the risks to people. 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
● There was not a positive culture present at the service. The deputy manager was overwhelmed by the responsibilities placed on them and the lack of support from senior managers. One staff member told us when there was a change of organisational Directors at the beginning of the year, there was no management support. Another staff member said between the, "Lack of training and a lack of staff wanting to work there, there is not much support for the staff."
● Staff were unable to provide high-quality care and support. They understood their responsibilities to ensure people received the care they needed but did not have the guidance or staff numbers to provide this. One staff member told us, "Staff didn't get shadow shifts or training and some staff did not have experience in care. And some staff were quite frightened of going near residents who could hit them."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider's representative told us the most recent survey sent to relatives and staff was in June and October 2019. They provided no further information about the outcome of these surveys or whether any actions were required. They aimed to send further surveys to staff and relatives in February and March 2021 to give them some time to see changes that were being implemented.
● Staff told us they had not had a staff meeting for three months prior to our visit. This did not give them the opportunity to raise concerns or to receive support and guidance to carry out their roles, as a group. Two staff felt the management team would listen and act if they raised concerns, but one staff member said that they had been redirected to other staff or received no response when they had raised concerns as an individual.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not adequately assessed or action identified to reduce those risks. Regulation 12 (2)(a), (b), (c), (h)

The enforcement action we took:

We have place conditions on the provider's registration for this location to prevent the admission of people to the service and to ensure the provider adequately assesses and monitors risks to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were placed at risk of continued harm with inadequate action taken to safeguard them. Regulation 13 (1), (2), (3)

The enforcement action we took:

We have placed conditions on the provider's registration for this location to prevent the admission of people to the service and to ensure the provider adequately assesses and monitors risks to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems were not effective in assessing, monitoring or reducing the risks to people. Regulation 17 (2) (b)

The enforcement action we took:

We have placed conditions on the provider's registration for this location to prevent the admission of people to the service and to ensure the provider adequately assesses and monitors risks to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Inadequate staffing levels put people at risk of ongoing harm.

Regulation 18 (1)

The enforcement action we took:

We have placed conditions on the provider's registration for this location to prevent the admission of people to the service and to ensure the provider adequately assesses and monitors risks to the service.