

# A.G.E. Nursing Homes Limited

# Brockfield House

## Inspection report

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11 August 2020

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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

Brockfield House is a residential care home providing personal and nursing care to up to 45 people aged 65 and over. At the time of our inspection there were 35 people using the service.

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

Medicines were not always safely managed. People were at increased risk due to a lack of understanding around the management of their known health conditions.

Risks to people were not always safely managed. People were left at increased risk due to inconsistent information around personal emergency evacuation plans (PEEPs). People were also at increased risk of legionella and scalding due to a lack of maintenance in these areas.

The provider had quality control systems in place, however they were not effective as records were not correct and audits had not always identified errors in records. The provider did not always learn lessons when things went wrong; where audits had identified errors, action plans had not resulted in improvements.

There were enough skilled and experienced staff to meet people's needs. Staff were adequately trained and had regular competency checks. Staff told us that they felt supported by the management team.

Care records were person-centred and contained sufficient information about people's preferences, specific routines, their life history and interests.

People and their representatives were involved in the planning of their care and given opportunities to feedback on the service they received. People's views were acted upon.

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.

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

### Why we inspected

The inspection was prompted in part due to concerns received about moving and handling practices and unexplained injuries. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 have found evidence that the provider needs to make improvement. 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 Brockfield House on our website at [www.cqc.org.uk](http://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 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 two breaches in relation to the management of medicines and the accuracy and oversight of records at this inspection. We also found that when the provider identified that improvements were needed, action plans were created but improvements were not always made as a result.

### 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## 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** ●

# Brockfield House

## 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.

#### Inspection team

The inspection was carried out by two inspectors who visited the service on 10 August 2020. One of the inspectors then contacted the relatives of people who use the service via telephone on 11 August 2020.

#### Service and service type

Brockfield House 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 had a manager registered with the Care Quality Commission. 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.

#### Notice of inspection

The inspection was unannounced; however we spoke to the registered manager on the telephone before entering the service. This supported the home and us to manage any potential risks associated with Covid - 19.

#### What we did before the inspection

We reviewed information we had received about the service since the last inspection and sought feedback from the local authority. 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 consideration 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 four relatives of people who use the service about their experience of the care provided. We spoke with four members of staff including the registered manager, the clinical lead and two care workers.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed, including policies and procedures.

#### After the inspection

We continued to seek clarification from the provider to validate evidence found and reviewed further evidence that the provider submitted, including updated care plans and corrected PEEP information.

# 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.

### Using medicines safely

- Improvements were required to medicines management. Staff were not completing stock count checks for controlled drugs and homely remedies as often as they should in line with the provider's policy. We saw that, for one person, staff had recorded the stock count of a controlled drug as ten doses, whereas when we counted, we found there were nine doses in stock.
- Diabetes management was not always safe. Monitoring of people's conditions was not always effective. Staff did not always look at all areas of people's condition to monitor their diabetes appropriately. We saw that two people did not have guidance in place to support staff to manage their diabetes safely.
- When people were unable to consent to taking their medicines, they received their medicine covertly. This means they were disguised, usually in food. However, the appropriate guidance was not always in place for staff to follow. For example, we saw that pharmacy advice available to staff did not match prescriptions. This meant that people were at risk of not having their medicines administered in line with the prescriber's guidelines.

The failure to manage medicines safely is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We observed staff administering medicines in a safe way and staff treated people with dignity and respect. We observed a staff member attempt to administer medicines to a person who was sleeping in the lounge. The staff member made attempts to gently wake the person but was unable to do so. The staff member returned the medicines to the medicines room, labelled them appropriately and administered them later.

### Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Personal Emergency Evacuation Plan (PEEP) information was not consistent. We saw that the PEEPs in four people's care plans showed different risk levels to the information displayed on their bedroom doors and to the PEEP list available to staff. This meant people were at risk of not being appropriately supported to evacuate the premises in response to an emergency such as a fire. Following the inspection we received further information from the registered manager to show that PEEP information had been corrected.
- The risk of legionella was not managed effectively. We saw no evidence of regular boiler temperature checks to minimise the risk of legionella. Empty room flushing was not being completed and there did not appear to be a schedule in place for this task. This placed people at risk of developing Legionnaire's disease.
- The risk of scalding was not managed effectively. Thermostatic mixing valves (TMVs) reduce the temperature of stored hot water to an appropriate level by blending it with cold water before it reaches the tap. The annual service check and maintenance of TMVs had not been completed as required. This placed

people at risk of scalding.

- Reviews and investigations following incidents of medicine errors were not always sufficiently thorough and necessary improvements were not always made. This meant that lessons were not always learnt when things went wrong.

The failure to mitigate risk is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We observed good moving and handling practices. One person who used the service was supported by two staff members to transfer from a wheelchair to a chair using a hoist. The person was re-assured throughout the process and asked about their comfort whilst being hoisted. The person was appropriately sat in the chair and was asked if they were comfortable or needed repositioning.

Systems and processes to safeguard people from the risk of abuse

- Safeguarding alerts had been raised appropriately and clear records were maintained. When incidents occurred, clear actions were identified and implemented to minimise the risk of re-occurrence.
- Staff were trained in safeguarding and knew how to recognise the signs of abuse. The staff we spoke with said that they know how to report incidents and who to report them to.
- One relative told us, "I think that [name of person] is very safe where they are and that is very important to us as a family."

Staffing and recruitment

- Staff recruitment was suitable. Pre-employment checks were carried out when appointing a staff member to ensure that they were suitable to work with vulnerable people. For example, a criminal conviction check and previous employer references were obtained.
- There were enough staff with the right skills deployed to provide people with their care at regular planned times and to respond to people when they needed care. One relative told us, "There are always staff available if [name of person] needs anything. I've never had an issue with staffing levels." Another relative commented, "If I needed anything I would ring the call bell and a member of staff would attend to us quickly."

Preventing and controlling infection

- People were protected from the risks of infection as the staff supporting them had undergone training in infection prevention and undertook safe practices when providing care. Staff demonstrated good knowledge of infection prevention and control practices.
- We observed staff using personal protective equipment (PPE) appropriately when providing care for people. There was enough of the right kind of PPE available to staff throughout the home.
- All areas of the home were clean and staff completed thorough cleaning schedules appropriately. We saw a cleaning rota for 'Residents of the Day', whereby staff completed a one hour deep clean of three resident's bedrooms each day.

# 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 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-centred care.

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

- Oversight of documentation and records was not always effective. For example, we found one person's diabetic care plan was out of date and staff had not identified this during several audits. The care plan was updated on the day of inspection. We found one person's paraffin-based creams risk assessment had not been reviewed since March 2019 and staff had not identified this during audits. Following the inspection, we were advised that staff will now review this on a monthly basis.
- We found that four people's PEEPs information was not consistent, and staff had not identified this during audits. This meant that staff did not always have the correct information. Following the inspection, we received further information to show that PEEP information was now correct.
- Auditing systems and processes were not always effective in identifying all incorrect information or errors within documentation and did not drive continuous learning and improvement. For example, the registered manager had completed monthly audits which had identified some, but not all errors in the administration of medicines in terms of recording and regular checks. Audits identified the same issues and action plans were developed as a result. These were not effective as they did not result in improvements to staff recording information and performing regular checks.
- The registered manager did not have effective oversight of the maintenance records. For example, there was no evidence the registered manager was aware that the TMV maintenance, legionella checks and asbestos risk assessment had either not taken place or had not been reviewed as required. This posed a risk to the people using the service.

The provider had not ensured that all reasonably practicable steps were taken to mitigate risks to people and to follow good practice guidance to make sure the risk was as low as is reasonably possible to people. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager responded immediately during and after the inspection. They were open and transparent throughout the inspection and have advised us that they have commenced an action plan, with some issues already addressed.

- The registered manager understood their regulatory requirements to report incidents and events to CQC.

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

- Staff and relatives said the management team was approachable and they felt supported by them. One staff member told us, "The registered manager is an amazing manager to have. I can go to them with anything and they will do all they can to help." One relative told us, "I would be happy to approach the registered manager as they seem like an approachable person. The Managing Director has been to the relatives' meetings a few times and they seem approachable."
- Information within care plans was person-centred and included up to date, relevant information around people's needs, their likes and dislikes, their life history and family relationships.
- Staff were knowledgeable about people who used the service and demonstrated they took a person-centred approach to providing 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 registered manager was aware of their responsibilities under the duty of candour, which is a regulation all providers must adhere to. Under the duty of candour, providers must be open and transparent, and it sets out specific guidelines providers must follow if things go wrong with care and treatment.
- The provider had implemented safeguarding and whistle blowing policies and had made all staff aware of them. There were posters in the communal areas advising people of who to contact if they had concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The management team worked with people to identify what they wanted and, if needed, changed routines and practices to achieve this. For example, we saw that the provider had increased the amount of choice during mealtimes and had changed the types of activities being offered as a result of meetings with people using the service.
- Relatives told us they felt involved in decisions about Brockfield House. Relatives had regular meetings with the management team. One relative told us, "I have attended the meetings where we have been able to talk about [name of person's] care and they listen to my input and changes have been made. I have been involved with every decision about [name of person] and have been able to express my opinion and this is listened to and acted upon."

Working in partnership with others

- The management team had established and maintained good links with local partners that would be of benefit to people who use the service, such as GP practices, chiropodists, dentists, hairdressers and social work teams.
- The provider had worked closely with Public Health England throughout the Covid-19 pandemic to ensure they had access to best practice guidance and they were accessing staff and resident testing appropriately.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  Risks associated with people's care and support were not always managed safely. This placed people at risk of harm. People's medicines were not managed effectively.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance  Governance and management systems were not always effective. This had resulted in failure to identify and address issues with the health, safety and quality of the care provided.