

Alliance Care (Trendlewood) Limited

Brockwell Court Care Home

Inspection report

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Date of inspection visit:
05 March 2019
07 March 2019

Date of publication:
02 April 2019

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service: Brockwell Court is a residential care home which provides people with nursing and personal care. The home can accommodate up to 75 people. At the time of our inspection there were 61 people using the service.

People's experience of using this service: Records held in the service to describe people's care needs and provide guidance to staff were not always accurate and up to date.

Information was provided to kitchen staff about people's dietary needs. This was not always accurate and information used by kitchen staff to serve people's meals in one area of the home contained errors.

Checks had been carried out to ensure people lived in a safe environment. There were however gaps, in some of these checks. Actions were agreed with the regional manager and the registered manager with the fire service to reduce potential risks in the home.

The service had failed to assure themselves agency staff who worked in the service had the necessary background to deliver people's care needs. Pre-employment checks were carried out on permanent staff to ensure they were suitable to work in the home. People told us they had experienced insufficient staff being on duty.

People who used the service were not always treated with dignity and respect. We made a recommendation about the provider finding ways to improve this area of practice.

People's personal risks were not identified or actions put in place to reduce the risks of harm to people. Where accidents and incidents had occurred, the registered manager had monitored them to see if they could have been prevented.

Staff had access to gloves and aprons to support them in their duties. Cleaning was ongoing in the home to reduce the risk of cross infection. However, there were areas of the home which required further cleaning.

The care provided fluctuated in different parts of the home. Whilst people and their relatives spoke positively about staff, people who lived in the Allensford area of the home lived in poor conditions. The fabric of their part of the home required attention. Following our site visits the registered manager told us the flooring problems had further deteriorated and the provider had taken the decision to close the unit.

Induction, training and supervision was provided to educate and support staff carry out their roles. Staff felt supported by the registered manager and were complimentary about their management skills.

People were supported with their health by staff who had regular contact with other healthcare professionals to discuss people's conditions and seek advice. Information from other professionals had not always been incorporated into people's care plans.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. People were given choices and their decisions were respected.

Staff spoke to people with kindness. People felt staff acted in a kind manner. There were examples of staff supporting people to be more independent.

People had the opportunity to give their views about the service and a complaints procedure was available. Complaints had been thoroughly investigated. Relatives were invited to meetings to give their views and hear news about the service.

Activities were provided in the service. An activities co-ordinator was supported by staff to engage people in meaningful activities during our inspection.

People's preferences for their end of life care had been discussed with them and their wishes were noted. Arrangements were in place for people who did not wish to be resuscitated.

More information is in the 'Detailed Findings' section below. For more details, please see the full report which is on the Care Quality Commission's (CQC) website at www.cqc.org.uk

Rating at last inspection: At our last inspection in January 2018 this service was rated as requires improvement. (Report published 13 March 2018)

Why we inspected: This was a scheduled inspection based on the previous rating.

Improvement Action: Please see the 'action we have told the provider to take' section towards the end of the report.

Follow up: We will continue to monitor the service through the information we receive and discussions with partner agencies. We will be speaking to the provider about their next steps to improve the service to an overall rating of Good. We have rated the well-led key question inadequate. This means we will inspect the service within the next six months.

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 effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring

Details are in our Caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Details are in our Responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our Well-Led findings below.

Inadequate ●

Brockwell Court Care 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

The inspection was carried out by two inspectors, an assistant inspector, a specialist advisor to the Commission in nursing 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. The expert by experience on this inspection had experience in caring for people living with dementia.

Service and service type:

Brockwell Court is a 'care home'. People in care homes receive accommodation and nursing or personal care, this home provides accommodation for up to 75 people.

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:

We did not give any notice of our intended inspection.

What we did:

We reviewed the information we held on the service. We also contacted professionals involved in caring for people who used the service; including local authority commissioners the local authority safeguarding team and the Infection Prevention and Control team.

During inspection:

We spoke with 13 people who used the service and eight relatives. We also spoke with 16 staff including the regional manager, the registered manager, a visiting registered manager, nursing staff, senior care staff, care

staff, kitchen staff, domestic staff, administrator and the activities coordinator.

We reviewed seven people's care documents and gathered information from other records held by the provider. These included records about medicines, complaints, audits and accidents and incidents.

After inspection:

We reviewed the evidence provided to us during the inspection and asked the registered manager for further information. We plan to attend a meeting arranged by the local authority which involved the provider and multi-agency professionals to review the service.

Is the service safe?

Our findings

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

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; Systems and processes to safeguard people from the risk of abuse: Using medicines safely: Preventing and controlling infection.

- People's care plans did not always contain risk assessments.
- People living in the Allensford area of the home had been moved upstairs during the day due to flooring issues which was uneven in some parts of the corridors. The registered manager told us a risk assessment was not required when facilitating a change in environment for people. Staff told us people were distressed by the environment and had asked to go 'back home' meaning downstairs. One staff member said, "It is distressing for residents to keep moving." The potential distress to people who used the service had not been risk assessed.
- People were living in an area of the home with flooring issues and were walking on dirty, damp carpets. Actions had been taken to trace the source of the problem. The bathroom in the area had flooring which did not meet the walls for easy cleaning. The bath seat was rusty. One person told us, "My toilet has been broken for ages; its stained I've mentioned it but nothing has happened."
- Nurse call buttons in two areas of the home were found on the floor and not always accessible to people. Radiator covers and high furniture were not always secured.
- Peoples medicines were not always safely managed. Records for 'as and when' required medicines, the application of pain patches and topical medicines failed to demonstrate safe administration.
- Throughout the home we found areas and equipment such as microwaves which were not clean. One fridge in a clinic room contained a body fluid sample dated January 2019.
- There were gaps in the safety checks on the building.

Risks relating to the health, safety and welfare of people were not always assessed. People were not receiving their medicines safely. People were potentially at risk of harm. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our site visits, Allensford area of the home was closed and people provided with alternative accommodation.
- The ordering and disposal of people's medicines were safely carried out.
- Staff had access to gloves and aprons to reduce the risks of cross infection.
- Accidents and incidents were monitored by the registered manager for trends.
- Staff had identified safeguarding concerns and made alerts to the local safeguarding team.
- People told us they felt safe. People said, "No, I don't lock my door on a night time as I feel very safe" and "I'm safe here, I just press my buzzer and they come as soon as they can."

Staffing and recruitment.

- Agency nurses were employed. The regional manager was unable to provide us with evidence that they had assured themselves agency staff had the necessary backgrounds including knowledge, skills and experience to meet the needs of people using the service.

Relevant checks had not been made to ensure fit and proper staff were providing care and treatment potentially putting people at risk. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Pre-employment checks were carried out on permanent staff to check if they were suitable to work in the service.

- The provider calculated staffing levels. This was reflected in the rotas. People and their relatives told us staff did not have the time to talk to them. One person said, "I get my medication on time-but no way is there enough staff especially on a night time." Staff confirmed, sickness levels, particularly on a weekend made staffing levels poor. At lunch time, in one area of the home there were seven people requiring full assistance to eat in their rooms. Hot food was dispensed by kitchen staff and two care staff were available to support them. A third member of staff was required to attend to another person elsewhere in the home.

The provider had failed to deploy sufficient numbers of staff to meet people's needs. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong.

- Following the last inspection, the provider submitted to us an action plan to address the breaches of regulations. We continued to find the same issues during this inspection.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.

- Before people moved into the home staff carried out an assessment of their needs.
- People who moved in from hospital. Staff received limited information over the telephone before they arrived. Staff carried out additional assessments to discover people's needs and choices.

Staff support: induction, training, skills and experience.

- Staff confirmed they received supervision and training to support their roles. The staff training matrix showed some staff required moving and handling training. This was being addressed through a training course for staff to teach others about the topic.
- There were induction records on staff files.
- Nurses and seniors have had medicines competencies carried out within the last 12 months.

Supporting people to eat and drink enough to maintain a balanced diet.

- Kitchen staff served people's meals on Derwentside. They used a laminated sheet to prompt them about people's dietary needs. The sheet was not accurate when compared with the dietary information given to kitchen staff. The information on some people's diet notifications did not match people's care records.
- Staff had fluid balance charts in place people. These were not always totalled for staff to judge if people were had drank enough.

Systems and processes had failed to identify the risks associated with poor record keeping. Accurate and complete records were not maintained for people. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told people on both our site visits their sandwich choice e.g. cheese was not available.
- People told us, "The meals are nice but there is not enough variety, I like chilli and pasta" and "The choice is poor-but they do the best that they can, however the meat is always underdone". One person said, "The meat is awful. I often say is this `elephant or rhino` today. The meat is truly awful-only the breakfasts are okay, beans, egg and toast". A relative said, "The menu is poor, [person] prefers ice cream to milk pudding which looks and tastes disgusting. [Person] does get plenty to drink though but there is never any fruit to my knowledge.
- A drinks machine was available. One person said, "We get lots of water but in plastic containers and I can't grip them properly they spill. I would like a cup-is that asking too much?"
- There was a four-weekly cycle of menus with menu choices. Kitchen staff followed food hygiene guidance.

Staff working with other agencies to provide consistent, effective, timely care.

- The service had made referrals to a variety of professionals including the district nurse, the community matron, GP's and the Speech and Language Therapy team (SALT). Their advice had not always been included in people's care plans.
- The registered manager held 10am meetings to discuss people's needs. One professional valued the referrals made to them due to these meetings.

Adapting service, design, decoration to meet people's needs.

- A relative told us the building could do with a "lick of paint". The registered manager explained they were waiting for the allocation of the provider's decorators before they would put a re-decoration plan together.
- One person said, "I wish they would put a handrail on my husband's bed so that he can get out easier and I wish they would get the lift repaired it's been out of order since last year." The registered manager told us a new lift had been installed and they were waiting for the emergency telephone to go in the lift.
- The fire service visited with us. The fire officer offered advice to the provider to reduce risks. The registered manager and the regional manager agreed to take action.
- Signs were available to assist people orientate themselves around the home.

Supporting people to live healthier lives, access healthcare services and support.

- People spoke about seeing visiting healthcare practitioners. One person said, "I do see doctors fairly regularly and the nurse takes my blood and the chiropodist comes."
- Records showed staff supported people with their healthcare needs.

Ensuring consent to care and treatment in line with law and guidance.

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

- Applications had been made to the local authority by the staff to seek consent to deprive people of their liberty and keep them safe.
- Staff used MCA guidance to put in place capacity assessments and best interests' decisions involving family members.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity: Respecting and promoting people's privacy, dignity and independence.

- People were living in conditions in the Allensford area of the home which were unacceptable. Fittings and fixtures in bedrooms were in worn and in poor repair. One person's mattress was longer than their bed and they sat down on the edge of the bed and were at risk of falling.
- People were unable to call for help as nurse calls were not within reach or plugged in. One relative said, "Sometimes we come in and her buzzer is on the chair, so she can't reach it. How stupid is that?" They said their relative was often unclean and they had to ask staff to clean them.
- One person living with dementia had been left alone in their room, they were leaning forward in their wheelchair and chattering. We had a conversation with them. A member of staff then pushed their wheelchair up and down the corridor without face to face conversation.
- Staff supported people to the lounge area and then failed to turn a TV up so a group of people could watch a film.
- There were inconsistent levels of care provided across the home. One person's dignity and privacy was compromised when a member of staff said to a person in the corridor, "Come here and I will change you." A relative told us, "I came in recently and Mum had had an accident but the mess for want of a better word was still on her tummy from the previous day. More caring is needed."

We recommend the provider considers ways to enhance people's dignity.

- One person told us how staff had supported them to be independent and improve their mobility.
- People were complementary about the staff. One person said, "They are kind and caring, they make everything light and cheerful. They chat away when showering although they don't have time to pop in and just chat, they put my mind at rest as I sometimes feel a bother. The staff are exceptional and kind, well, they treat us like their own family and to be honest I think of them as my family, even the hairdresser is lovely."
- Staff spoke to people in kind tones.

Supporting people to express their views and be involved in making decisions about their care.

- Daily audits carried out by staff provided people with an opportunity to give their views to specific questions.
- The registered manager held meetings for residents and relatives. Relatives had been involved to support people make decisions about their care

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.

- People's care records needed updating. Some were inaccurate.
- Information and advice supplied by other healthcare professionals had not been incorporated into people's care records.
- Information on people's health conditions was not included in care plans and risk assessments. Guidance to staff was therefore missing on how to meet people's care needs.

Records relating to the care and treatment of people were not accurate or up to date meaning staff did not have appropriate records. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Two activities coordinators were employed in the service. They provided a range of activities for people and took people on outings.

Improving care quality in response to complaints or concerns.

- The provider had a complaints policy in place. Complaints made to the service had been documented and investigated with outcomes.
- One person said, "Other than being short staffed no one has anything to complain about. We do exercises, we go out if you want to, the laundry is very good as nothing ever goes missing. We do bingo and go to church."

End of life care and support.

- End of life care arrangements had been discussed with people and their relatives. People had discussed with staff and healthcare professionals their wishes.
- Emergency healthcare plans were held on file.

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.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

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

- Audits were not effective as learning had not been transferred across the service.
- Care plans, risk assessments, medicine records and diet information were not always accurate or up to date.

The lack of robust quality assurance meant people were still at risk of receiving poor quality care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's views of the dining experience had been gathered. Staff had been advised of what actions were required.
- Staff told us the management was good, approachable and supportive. One member of staff said "Management are good, new, but approachable and do listen."
- The provider had contingency plans in place in the event of an emergency.
- The registered manager had sent statutory notifications to CQC.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility.

- The registered manager was open and honest with us, particularly the difficulties they had experienced in managing a service where one area of the home was experiencing unusual flooring difficulties.
- Staff had undergone training in the provider's Dementia Care Framework to increase their knowledge of working with people living with dementia.
- The provider had a Quality of Life framework in place to inform their practice.

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

- Staff had involved people in raising funds for the charity Blood Bikes.
- The provider had an electronic system to routinely gather the views of people, their relatives and staff. Comments were analysed to identify common themes.
- People were involved in a daily audit and asked for their views.
- Key updates were provided to people relating to the premises, plans regarding gardening.
- The registered manager held meetings with staff to provide guidance and share information.

Continuous learning and improving care.

- The provider had considered actions which were necessary to carry out repairs in the home and had an action plan. However, people had lived in an area of the home for over a year where the flooring continued to put people at risk. The registered manager's ability to improve the home was compromised by issues with the building and length of time repairs were taking.

Working in partnership with others.

- Professionals told us they felt confident and could rely on the clinical information provided by staff to help them make decisions about people's care.
- The provider had secured a trainer to train staff to deliver moving and handling to 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
Diagnostic and screening procedures	The provider failed to do all that is reasonably practicable to mitigate risks. Regulation 12(2)(b)
Treatment of disease, disorder or injury	The provider failed to ensure the proper and safe management of medicines. Regulation 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	The provider failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users Regulation 17(2)(b)
Treatment of disease, disorder or injury	The provider failed to have accurate, complete and contemporaneous records in place in respect of each service user. Regulation 17(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Diagnostic and screening procedures	The provider failed to assure themselves that agency nurses employed in the service had the qualifications, competence, skills and experience which are necessary for the work to be performed by them regulation 19(1)(b)
Treatment of disease, disorder or injury	

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Diagnostic and screening procedures	The provider failed to have sufficient staff on duty. Regulation 18(1)
Treatment of disease, disorder or injury	