Brentwood Homes Limited

Seven Arches Nursing Home

Inspection report

Lea Rigg, Cornsland
Brentwood
Essex
CM14 4JN

Tel: 01277263076
Website: www.brookvalehealthcare.co.uk

Date of inspection visit:
27 April 2018
04 May 2018

Date of publication:
04 July 2018

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

We carried out an unannounced comprehensive inspection in October 2017 at which time the service was rated good in all areas.

Following on from that inspection we received information of concern in relation to the safe care and treatment of people and poor management and oversight of the service. As a result we undertook a focused inspection on 27 April and 4 May 2018 to look into those concerns.

This report only covers our findings in relation to those topics at that time. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Seven Arches Nursing Home on our website at www.cqc.org.uk.

This inspection took place on 27 April and 4 May 2018 and was unannounced. During the inspection we found that the registered manager and provider had failed to consistently and reliably assess and mitigate risks to people and monitor and improve the quality and safety of the service. We therefore found the service in breach of Regulation 12, 13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

People were not protected from the risk of abuse as staff training in safeguarding was not always up to date. In addition, potential safeguarding concerns had not always been identified, investigated or reported appropriately.

Accidents and incidents were not reliably monitored and analysed which meant that appropriate preventative measures had not been put in place to minimise the risk of re-occurrence.

We found evidence of poor risk management relating to the use of bedrails, which when used appropriately can reduce the risk of a person from falling from bed. The registered manager demonstrated a lack of understanding of how to manage the risks associated with bedrails whilst at the same time protecting people's rights and freedom.

Poor planning and management of risk was found in relation to the lift being out of service and risks to people had not been considered or assessed which meant there was the potential for harm or injury of people and staff due to unsafe practices.

Written records did not always accurately reflect risks to people or how these were being managed. In addition, the monthly of the risks to people were hand-written and were sometimes illegible which posed a potential risk with regard to information sharing around risk .

The arrangements to ensure fire safety at the service were not robust. Not all staff had received the necessary training and the fire risk assessment had not been regularly reviewed. Recommendations made

by an independent fire safety risk assessor had not been always been followed.

We have made a recommendation that the provider seek advice from an independent source to ensure all necessary fire safety measures were in place for the safety of people and staff in the event of an emergency evacuation.

The registered manager had failed to notify us when the lift broke down. This meant they were not meeting the legal requirements of their registration. The registered manager also demonstrated an inconsistent and inaccurate approach to record-keeping. This meant they were not able to reliably oversee and monitor many aspects of the service such as staff training and supervision.

The registered manager and provider were unable to demonstrate robust oversight of the service. The quality assurance systems in place were ineffective as had failed to identify and address the issues we found during our inspection.

Improvements had been made in response to feedback from the local authority with regard to the safe administration of medicines whilst the lift was out of operation.

Checks had been made to ensure staff were suitable to work with vulnerable adults and there were sufficient staff employed to safely meet people's needs.

Infection control audits had been sporadic and staff training was not always up to date. However, the service was clean with no bad odours. Staff wore protective gloves and aprons to prevent the spread of infection and people had their own equipment to prevent cross contamination.

People felt safe and well cared for and were happy with the service they were receiving. People and relatives praised the staff and registered manager who they found approachable and knowledgeable.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks were not always well managed or communicated.

People were not reliably protected from the risk of abuse.

There were sufficient staff employed who had been subject to disclosure and barring checks.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The quality, safety and effectiveness of the service had not been sustained since our previous inspection.

The registered manager had not met their registration requirements as had failed to notify us of a significant event that happened at the service.

The quality assurance systems were not fit for purpose as had failed to pick up on the issues we found during our inspection.

Seven Arches Nursing Home

Detailed findings

Background to this inspection

Seven Arches Nursing Home was awarded a rating of 'Good' in all five key questions.

In response to information of concern we had received regarding the safe care and treatment of people and lack of oversight of the service, we carried out an unannounced focussed inspection of Seven Arches under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We inspected the service against two of the five questions we ask about services: Is the service safe? And, is the service well led?

The inspection was undertaken by two inspectors. Before our inspection we reviewed all the information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events, which the provider is required to send us by law. We also reviewed information we had received from the local authority's quality improvement and organisational safeguarding teams.

During the inspection we spoke with the registered manager, the maintenance man and two members of staff. We also spoke with four people and two relatives. We reviewed various documents including four people's care records, five staff files including supervision and training records and other documents central to people's well-being and the management of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in October 2017, the service was rated good in the domain of safe. In response to information of concern we received relating to safeguarding; risk management; emergency planning; fire safety; medicine management and staff recruitment we completed a focussed inspection looking at these aspects. At this inspection we found the service had deteriorated and the rating is now requires improvement with breaches of the regulations.

We looked at how well the service protected people from the risk of abuse. Feedback from the local authority reported that safeguarding alerts had not always been raised by the registered manager after people fell and sustained an injury. During our inspection we found that not all staff had up to date training in how to safeguard people from the risk of abuse and we found that safe practices in relation to safeguarding people were not always followed. For example, staff used a handover book to share information when they observed that people had unexplained bruising. However, this information was not followed up appropriately. Body maps had not been completed to show where the bruising was and there had been no investigations into how the bruising had occurred. When people experience bruising that cannot be explained, it may be appropriate to raise a safeguarding alert with the local authority. The lack of proper investigation of potential safeguarding concerns can leave people vulnerable to abuse.

We discussed our concerns with the registered manager who told us that because their focus had been on developing their end of life care service, the failure to investigate concerns and raise the necessary safeguarding alerts was an oversight on their part.

This was a breach of Regulation 13 of the Health and Social Care Act (2008) Regulations (2014).

The failure to follow through with appropriate actions was also observed in other areas of the service. We looked at the services' accident and incident records and saw that the service had failed to act after an incident where a person was injured. The person had fallen from their wheelchair and sustained bruising to their arm and face. This incident had been documented and staff had given an account of how the incident happened, however no risk assessment or management plan for this person's wheelchair use had been put in place. This meant there was a lack of guidance for staff to help prevent a re-occurrence of the incident.

Concerns were shared with us by the local authority with regard to the safe and appropriate use of bed rails. Bed rails are used to prevent people from falling from bed but come with their own risks, for example, the risk of people climbing over them or becoming entrapped. For this reason, risk assessments should be completed prior to the use of bed rails and should then be regularly reviewed.

We looked at the care records of four people who had bed rails in place. We found that risk assessments had been completed and where they were able, people had consented to their use. However, we found one example where the use of bed rails was not being applied safely. We saw that one person who had bed rails in place had been identified at risk of climbing over them which could result in injury. In response to this, a crash mat had been put in place to minimise the risk of injury and the person's bed had also been lowered.

However, the use of a crash mat and bed rails represents a contradiction as if people are at risk of climbing over bed rails then safety guidance dictates that they should be removed. We looked at the risk assessments and management plans to support this person to stay safe in bed and found they were inconsistent. There was no clear clinical rationale for the use of bed rails which demonstrated a lack of understanding by the registered manager with regard to risk management, legislation and best practice guidance. We also reviewed the person's daily notes and the falls log kept by the service which demonstrated that the bed rails were being used, not to keep the person from falling out of bed but rather to stop them walking around as they were at high risk of falling when mobilising. This is not the use that bed rails are intended for. This meant that the person's rights and freedom to walk around were being unduly restricted which could impact on their health and wellbeing. It could also have a negative impact on their independence as their level of physical function may decrease over time.

We discussed our concerns with the registered manager who advised us that they had since met with the local authority who had agreed with their management plan including the use of bedrails. However, we subsequently established that this had been a misunderstanding on the part of the registered manager and have received confirmation that the bed rails have now been removed.

We received information of concern regarding the services' poor planning and management of risks to people whilst the lift was out of service. The local authority reported that they had observed a person accessing the stairs using their zimmer frame with the support of their family members. During our inspection we reviewed the person's daily notes and found that this person had been accessing the stairs with the support of family members or staff members on several occasions. Consideration of the risks to the person had not been undertaken and there was no risk assessment in place for this action. We also found that a person living upstairs who had a hospital appointment to attend had been supported by staff to access downstairs using an 'ambuchair'. This is a means for supporting people to be carried up and down the stairs in the event of an emergency evacuation. A risk assessment to assess the safety of this action had not been completed and we later established that four out of five of the staff using this equipment had not had any training in how to use the equipment correctly. This posed a potential risk of injury not only to the person but also to the staff. The person's relative told us that their family member had found the experience of being carried in the chair very distressing.

We discussed our findings with the registered manager who advised us that individual risk assessments for people relating to the lift breakdown had now been completed. The registered manager told us that they had not been at the service on the day in question and would not have allowed the person to have been transferred using the ambuchair. We were later provided with evidence that twelve of the staff had since had training in how to use the ambuchair and that training was booked for the remainder of the staff team.

We found that people's care plans and risk assessments did not always accurately record the level of care and support people required or were receiving. For example, two people who had lost weight had their nutrition care plans reviewed by a nurse. The review stated that the plan was to weigh both people weekly and refer to the dietician. This plan was in accordance with the services policy on managing weight loss. However, we were unable to find any evidence of referrals being made to the dietician for either person. In addition, written documents showed that both people were being weighed monthly rather than weekly.

We discussed our concerns with the registered manager who told us that despite the policy stating that people identified at risk should be weighed weekly, in reality people were only ever weighed monthly. The manager provided us with an explanation regarding why referrals had not been made to the dietician in both cases. However, the decision-making had not been recorded in the care plans which meant the monthly review of the two people's care that had been completed by the nurse did not represent an

accurate reflection of what was happening in practice.

Throughout our inspection we experienced significant difficulties in understanding the monthly reviews of people's care plans and risk assessments. The entries were handwritten and many were illegible. Care plans and risk assessments contain essential information for those receiving and giving care. Illegible notes can result in care staff not knowing how to safely support people and mitigate any potential risks to people's health and wellbeing.

These failings represent a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulations) 2014.

Concerns were raised by the local authority about the management of fire safety within the service. There was a fire risk assessment in place but this had not been reviewed since 2016. Fire risk assessments should be reviewed annually or sooner if something changes. We reviewed the fire risk assessment document and saw that not all of the recommendations made by the company that provided the assessment had been implemented. We also found that not all staff had received up to date training in the event of a fire or emergency evacuation. At the time of inspection, we were unable to locate any evidence of checks of the fire alarm system and emergency lighting, however this was later provided to us. We did find that consideration had been given to how to evacuate people in the event of a fire or other emergency as there was an evacuation plan which was held centrally in one folder. This document had been updated so that the newest admission to the service had been added. However, there were no individual personal evacuation plans (PEEPs) held in people's care records. The purpose of PEEPs is to provide sufficient guidance to staff on the level of support people require in the event of an emergency evacuation.

We discussed these concerns with the registered manager. They told us that the fire risk assessment had not been reviewed as there had been no changes to the building since 2016. We were also informed that not all recommendations had been followed as they had not considered them necessary. We were advised that a programme of retraining for fire safety and evacuation had been booked for staff. In addition, there were plans in place to ensure individual PEEPs were kept in each person's care plan.

We recommend that the provider seek advice from an independent source to ensure robust systems and processes are in place that protect the safety of people and staff in the event of a fire or other emergency evacuation.

Concerns had been highlighted by the local authority that because the lift was out of action and the medication trolley was stored upstairs, medicines were being transported downstairs in pots to several people at a time. This practice put people at risk of receiving the incorrect medication. . However, during our inspection we found that the issue had been addressed and people were receiving their medicines on an individual basis to ensure safe practice was adhered to.

We received information regarding the unsafe recruitment of staff. Concerns were raised regarding a lack of Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We looked staff recruitment files and found that DBS checks had been completed.

Written records showed that health and safety checks looking at infection control were sporadic. However, we found that the home was clean, fresh and well decorated. People's rooms we visited were very clean, well arranged and personalised to people's individual preferences. We observed staff using protective equipment such as plastic gloves and aprons at appropriate times to prevent the spread of infection. People also had their own equipment for when they were moved or repositioned to prevent cross infection. This

was confirmed by a person who told us, "I have my own personal sling and slide sheet."

People, relatives and staff all confirmed that there were sufficient staff employed to meet people's needs. One person told us, "I use my buzzer and they [staff] look after me well." Another said, "Yes there is enough staff, always popping in" As a member of staff walked in they added, "Here is my lovely lady who does my laundry."

The feedback we received from people and relatives during our inspection was very positive and people told us they felt safe and well cared for. One visiting relative told us, "I am not aware of any shortages of staff here, they monitor [family member] very well, and keep us up to date with their weight and health."

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in October 2017, the service was rated good in well led. In response to information of concern we received relating to the management and oversight of the quality and safety of the service, we completed a focussed inspection looking at the areas of concern highlighted. At this inspection we found the service had deteriorated and the rating is now requires improvement with breaches of the regulations.

There was a registered manager in post who was not meeting the requirements of their registration as they had failed to notify us of a significant event when the lift broke down. Notifications enable us to check that appropriate action has been taken to ensure people's safety and wellbeing.

This failing represents a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

We found that the service was not well prepared when the lift broke down although we did observe that all efforts were made to secure the repair of the lift as soon as possible. In the interim period whilst the lift was out of action, planning arrangements were poor as the registered manager did not have a contingency plan in place. There was no risk assessment or analysis of the effect on the service completed. This demonstrated a lack of consideration with regard to how the service would cope with the disruption and continue to support people safely.

Throughout our inspection we found that the registered manager and registered provider had failed to sustain an acceptable level of monitoring and oversight of the service to ensure the registration requirements were being met. Audits were not always up to date demonstrating a lack of drive for improvement, for example, the cleanliness and hygiene of the home environment was not regularly monitored as audits of infection control were sporadic. The quality assurance mechanisms in place were limited and had not identified the areas for improvement highlighted as part of this inspection. This demonstrated that the registered manager and provider were not taking all possible steps to assess, monitor and mitigate the risks to people's safety and wellbeing.

At our previous inspection in October 2017 we found that the provider completed their own internal audits of the service to ensure robust oversight of the service at provider level but this level of monitoring had now lapsed. We were advised that the provider did meet with the registered manager for informal discussions regarding the service but no formal checks were completed and action plans for improvement had not been identified or followed through. Therefore, the provider had failed to pick up on any of the issues we found throughout our inspection.

Safety-related information and concerns were not always considered, monitored, investigated or followed up appropriately. This showed us the registered manager and provider did not recognise the importance of reflective practice to ensure continuous learning and service improvement.

We also found that the registered manager had an inconsistent approach to record keeping and the systems for monitoring and ensuring the training and supervision of staff were not fit for purpose. The registered manager kept a matrix identifying when staff required training and supervision but these records did not accurately reflect the level of training and supervision staff had received. This meant that the registered manager would not be able to accurately identify when staff's skills and knowledge required updating.

Information shared with us by the local authority highlighted concerns regarding the registered manager and provider's ability to ensure the sustainability of the safety and quality of the service. Quality audits completed by the local authority which took place in between CQC inspections showed a pattern of non-compliance. This was confirmed by our findings throughout this inspection which evidenced that the standards of practice had dropped since our last inspection in October 2017.

We discussed our concerns regarding sustainability of good practice with the registered manager. They acknowledged that they had let things lapse due to focussing on obtaining the gold standard for practice around end of life care. However, this standard had not been achieved, and had instead impacted negatively on the quality and safety of the service as a whole.

At the last inspection we made several recommendations to improve the service. At this inspection we found that not all of these recommendations had been actioned. For example, we recommended that the quality of clinical training for nurses be improved to support their professional development. We found that this issue had not been addressed. Training for nurses was still provided via E-Learning and was not always kept up to date. One nurse who had started work in January 2018 had received no training from the service since their employment commenced. The registered manager told us that the nurse brought with them training from their previous employer but they had not seen copies of their training certificates to verify this. In addition, the registered manager had not completed their own observations or spot checks of the nurse to assess their knowledge and skills so could not be assured that they were competent to provide safe and effective support.

The failure to consistently assess and mitigate the risks to people and monitor and improve the quality and safety of the service represents a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Despite the failings highlighted above, feedback from people and their relatives was positive about the registered manager, staff and service they received. Comments from people included, "I love it here, I love the people. I am quite happy here." And," I am very happy with the care here." Relatives told us, "They [staff] are amazing, perfect, they are very caring and fully include every member of the family with their care." And, "The registered manager will answer all our questions and is very knowledgeable." Staff also told us they enjoyed working at the service and felt well supported by the registered manager.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had failed to notify us of significant events in accordance with the requirements of their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks had not always been identified, assessed and managed to ensure people's safety and wellbeing.

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 Safeguarding concerns were not always identified, investigated or reported appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of supervision and oversight of the service including the staff team at manager and provider level. This had resulted in a failure to assess and mitigate risks to people and monitor and improve the quality and safety of the service.