SSL Healthcare Ltd

Brookfield Care Home

Inspection report

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Tel: 01642286507

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10 November 2020

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Brookfield Care Home is a residential care home providing accommodation and personal care to older people and people living with dementia. It can support up to 30 people across a single, purpose-built site. There were 21 people using the service when we visited.

People's experience of using this service and what we found
We found people were not always protected from the risk of harm. Infection control procedures needed to be improved. People were receiving medicines as prescribed but some medicines records were not accurate or up to date. We observed people being supported by a sufficient number of staff. People's relatives were happy that their loved ones were safe. One relative told us, "I sleep better at home knowing she is safe in there."

Staff did not feel well supported by the management team. Quality monitoring systems failed to identify areas where improvements needed to be made. When areas for improvement had been pointed out by external professionals immediate action was not taken to address these.

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 13 March 2020).

Why we inspected
We undertook this targeted inspection as part of CQC's response to care homes with outbreaks of coronavirus. 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 inspected and found there was a concern with infection prevention and control measures, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

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 safe care and treatment and good governance at this inspection.

In particular, infection control practices, assessing and managing risk, accurate record keeping and management oversight.

Please see the action we have told the provider to take at the end of this report.

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 request an action plan for 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Brookfield 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. 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
The inspection was conducted by two inspectors. One visited the location and reviewed evidence and the other inspector made calls to staff and relatives.

Service and service type
Brookfield Care Home 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
We gave the service 24 hours' notice of the inspection.

What we did before the inspection
We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with the relatives of five people who used the service about their experience of the care provided. We made observations around the service. We spoke with ten members of staff including the nominated individual, registered manager, administrator and care staff. We also spoke with a visiting health professional.

We reviewed a range of records. This included four people's care records and three people's medicine records. We looked at recruitment records and a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested further information to be sent when the inspection process was extended from targeted to focused. We spoke with a health professional who had been supporting the service during the recent outbreak.

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 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.

Preventing and controlling infection

- The provider was not adequately encouraging social distancing. Where people were not able to isolate in their rooms they were all supported in one lounge area. The seating was not arranged in a way that allowed for a safe distance to be maintained and other communal seating areas were not being used. Some changes were made following our visit to improve the safety of communal areas.
- Cohorting of staff and zoning of the service had not been fully adopted to minimise the risk of infection travelling between different areas of the service.
- The provider failed to follow government guidance regarding isolation of staff who had tested positive and had not adequately manage the risks of staff who had tested positive working in the home. Five of the staff we spoke with told us they or their colleagues had been asked to come in to work whilst displaying COVID-19 symptoms or after a positive test result. One member of staff said, "The day the Covid started we came in one morning and there were a few girls (care staff) outside. They had tested positive and had been told to come into work."
- Not all staff had been trained in the correct use of personal protective equipment (PPE). PPE was not stored appropriately around the service, which compromised its effectiveness. There was insufficient provision to allow PPE to be disposed of safely.
- Cleaning was not always taking place in line with the provider's COVID-19 risk assessment.

These findings evidence a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks were not being effectively managed. Individual risk assessments were not being updated in line with the provider's policy. Risk assessments put in place in response to the COVID pandemic were generic and did not address the individual needs of people using the service or staff.
- People's weight was not being effectively monitored. Weekly weight records showed only the weight from that day. Staff were not calculating any variation to identify weight loss and risk of malnutrition.
- Several health and safety checks were completed around the service. However, we found that regular water flushes were not being done in areas that were not regularly in use to reduce the risk of legionella.

These findings evidence a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● Staff had received safeguarding training and told us they knew the procedure for raising concerns. However, not all staff were confident in the action that would be taken. One staff member told us. "I'm happy with the processes to raise any concerns. I would like to say a definite yes to concerns being followed up, but I'm not assured that would be the case."
● Accidents and incidents were recorded but no analysis was done to look for patterns or trends. Following feedback, a new approach was being adopted by the registered manager to include this analysis.

Staffing and recruitment
● Safe recruitment practices were followed in line with the provider's policy.
● Staffing levels were appropriate and had remained safe during the recent outbreak. Where agency use had been necessary to cover staff absence the provider used one agency and ensured staff were only working at one service to minimise infection control risk.

Using medicines safely
● Records showed people were receiving their medicines regularly and as prescribed.
● Some medicines records were not up to date or accurate. Guidance for medicines to be given 'as required' were not always in place and those that were in place were not always reviewed on a regular basis. Anticoagulant records were completed incorrectly but medicine administration records indicate the correct doses were being given.

Requires Improvement

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Care records and medicines records were not always up to date or accurate. This increased the risk of harm for people.
- Quality assurance audits had not identified the issues we had found during this inspection.
- The registered manager had not taken action in a timely manner when issues had been highlighted. During the inspection process there were delays in information being provided.

These findings evidence a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 management team were aware of their regulatory responsibilities. Required notifications had been made to us in a timely manner.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others

- Staff did not feel supported by the registered manager and the management team. One member of staff told us, "Management isn't great. We don't feel we have been looked after during Covid."
- A staff survey had been conducted but the results of this had not been analysed and as a result there had been no issues identified or lessons learnt.
- Non-essential visiting had been suspended due to the pandemic. Some window visits had been arranged but video calls for those who were not able to access window visits had been difficult due to poor wi-fi connection at the service. At the time of our visit we were told a solution had been found but this was not yet in place. Systems to enable indoor visits to take place were due to be reviewed on 27 November 2020 in line with government guidance.
- The home had received infection control support and guidance from external health professionals, but their recommendations were not acted on in a timely manner.
- People's relatives were happy with the communication from the home. One relative told us, "I have spoken with [the registered manager] on numerous occasions. There is good communication."

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 17 HSCA RA Regulations 2014 Good governance Quality monitoring systems failed to identify areas where improvements needed to be made. 17(2)(a) When areas for improvement had been pointed out by external professionals immediate action was not taken to address these. 17(2)(b) Records were not always accurate or up to date. 17(2)(c)

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 Infections prevention and control procedures were not robust. 12(2)(h) Risks to the health and safety of service users had not always been adequately assessed or reviewed. 12(2)(a)(b)

The enforcement action we took:

A warning notice was issued to the provider on 24 November 2020 in respect of the breach of regulation 12.