Kentbrim Limited

Brownlands Nursing Home

Inspection report

34 London Road
Daventry
Northamptonshire
NN11 4BZ

Tel: 01327876985

Date of inspection visit:
10 November 2016

Date of publication:
03 January 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on the 10 November 2016.

Brownlands Nursing Home is registered to provide residential care for up to 31 older people, including people with dementia care needs. At the time of this inspection there were 27 people living in the home.

A registered manager was not in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Although CQC has taken enforcement action in relation to the lack of a registered manager it is a significant concern that an application for a registered manager has yet to be submitted.

There were insufficient systems in place to monitor the quality and safety of the service. Audits failed to identify risks associated with the management of medicines, record keeping and accidents and incidents. People were not always protected as environmental risks were not identified.

People did not always have care plans that reflected identified risks. This had been identified by the lead nurse and new care plans were being implemented. People had prompt access to healthcare services when needed and we found that their nutritional needs were being appropriately met and monitored.

People could be assured that sufficient numbers of staff would be working within the home to provide their care and support in the way in which they wished to receive it. Staffing levels had been calculated to reflect the dependency levels of people living in the home and the number of staff deployed reflected this. People participated in a range of activities and received the support they needed to help them do this. People were able to choose where they spent their time and what they did.

People felt safe in the home and relatives said they had no concerns about people's safety. Staff had been safely recruited and understood the need to protect people from harm and abuse and knew what action they should take if they had any concerns. Staff received training in areas that enabled them to understand and meet the care needs of each person.

Staff had good relationships with the people that lived in the home and knew people well. Staff supported people to be as independent as possible, provided appropriate support to people to enable them to make choices and treated people with respect and dignity. Staff listened to people and their relatives and responded to complaints promptly and in line with the provider's policy.
Where possible people were involved in making decisions about their care and support needs. There were formal systems in place to assess people's capacity for decision making under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

At this inspection we found the service to be in breach of two regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The actions we have taken are detailed at the end of this report.

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 always safe.

People were not always protected from environmental and personal risks as measures in place to identify and reduce these risks were not always sufficient.

Safe recruitment practices were in place; however there was no process in place to review criminal records checks.

There were systems in place to manage medicines in a safe way, however these systems did not always ensure that people received their medicines as prescribed.

Staffing levels ensured that people's care and support needs were met.

People were protected by staff that were clear on their roles and responsibilities to safeguard them.

Is the service effective?

Good

The service was effective.

People were supported to access appropriate health and social care professionals to ensure they received the care, support and treatment that they needed.

Staff received training to ensure they had the skills and knowledge to support people appropriately.

People were actively involved in decisions about their care and support needs and how they spent their day. Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People received the support they required to ensure that their nutritional needs were met.

Is the service caring?

Good

The service was caring.

Staff had a good understanding of people's needs and preferences and worked with people to enable them to communicate these.

People were encouraged to make decisions about how their care was provided and their privacy and dignity were protected and promoted.

There were positive interactions between people living at the home and staff.

Is the service responsive?

Good

This service was responsive.

People were involved in their care planning. Their views were acknowledged and acted upon and care and support was delivered in the way that people chose and preferred.

People were supported to complete activities of their choice that reflected their personal preferences and interests.

People using the service and their relatives knew how to raise a concern or make a complaint and a system for managing complaints was in place.

Is the service well-led?

Requires Improvement

This service was not always well-led.

There had been no registered manager in post for some time and the provider had not taken action to begin registering a manager for the service.

There was a lack of provider oversight of the quality and safety of the service.

The systems in place to monitor the quality and safety of the service had not identified potential risks to people's safety.

Where shortfalls in the quality and safety of the service had been identified, action was not taken in a timely manner to rectify these shortfalls.

Brownlands Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10 November 2016. The inspection was unannounced and was undertaken by two inspectors.

We reviewed the information we held about the service, including safeguarding information and we looked to see whether we had received any notifications from the provider. A notification is information about important events which the provider is required to send us by law. We also spoke to local commissioners about the service.

During this inspection we visited the home and spoke with eight people who lived there and s two of their relatives. We also looked at care records relating to five people. We spoke with the manager, clinical lead and five members of staff, including nursing staff, senior care staff and care staff. We looked at five records in relation to staff recruitment, as well as records related to staff training and the quality monitoring of the service.

We made observations about the service and the way that care was provided. We also used the Short Observational Framework Inspection (SOFI); SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People were not always assured that they were kept safe. There were elements of the management of the environment and a lack of adherence to some procedures that required improvement.

People could not be assured that the environment they lived in was always safe. On the day of inspection we found that people who were living with dementia had access to rooms used for storing chemicals and the boiler room and lift mechanism room were accessible to anyone. Some of these areas had doors that had no means of locking. We brought this to the attention of the manager who arranged for locks to be fitted to the relevant doors immediately. There were environmental risk assessments in place; however these had not identified the risks associated with the chemicals and equipment. The provider requires a more robust system of maintaining a safe environment.

People could not always be assured that their care needs would be met in a safe way following an accident or fall. There was a procedure in place to monitor people after an accident but the procedure was not robust enough to identify an injury in the hours following an accident. Nursing staff had not carried out all the necessary clinical observations at the time of an accident or continued with regular observations in the following hours. This left people at risk from not having their injuries identified at the time of, or after an accident. Although people's accidents had been recorded and timely medical intervention had been sought where necessary, the provider needs to have a procedure embedded to help protect people from the risks associated with accidents.

People were assessed for potential risks such as moving and handling, skin integrity and poor nutrition. However, the information on how to mitigate the identified risks was not always consistent. For example one person's care plan identified they were at risk of anxiety and had psychological and emotional needs; but the care plans did not provide staff with clear guidance on how to support the person. The provider had recently introduced a new care planning system and staff were in the process of updating all people's risk assessments and care plans; this had resulted in inconsistencies in some information. Staff knew people well and demonstrated an understanding of risk assessment and the need to adapt the level of support they provided depending on the person's support needs and identified risks. For example one member of staff described how they supported people who were at risk of pressure sores, saying; "We reposition people who are at risk of pressure ulcers and we monitor the condition of their skin; we look out for any marks or changes to skin colour and report any changes to the nurse".

The provider had a policy in place to guide staff in the receipt, storage, administration, recording and disposal of medicines. We observed nursing staff adhering to the policy when administering people's prescribed medicines. However, we found that in the two weeks prior to our inspection two people had not always received their blood thinning medicines as prescribed. We brought this to the attention of the manager and advised them to seek medical advice for the people that had not received their medicines. The nursing staff immediately reviewed their processes for administering and recording blood thinning medicines and the manager reviewed their audit procedure to include these specific medicines. The provider needs to ensure that their procedures are embedded and the monitoring is effective.

These concerns constitute a breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

People were protected against the risks associated with the appointment of new staff. There were appropriate recruitment practices in place, taking into account staff's previous experience and employment histories. Records showed that staff had the appropriate checks and references in place and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out criminal record and barring checks on individuals who intend to work with vulnerable adults, to help employers make safer recruitment decisions. However, the provider had not assured themselves of the on-going suitability of staff, as they had not carried out a risk assessment to determine whether criminal records checks should be updated at regular intervals for staff who had worked in the home for a number of years.

Contingency plans were in place in case the home needed to be evacuated and each person had a Personal Emergency Evacuation Plan (PEEP) in place to provide information to emergency services in the event of an evacuation. There was a fire procedure in place and regular fire drills took place to ensure that staff knew how to respond in a fire.

There were enough staff to keep people safe and to meet their needs. People told us that the staff were attentive and responded when they called them. One person said, "I use my buzzer to call the staff, they come quickly, it's always the same, night or day, they always come quickly". Staff told us that there were enough staff available to meet people's needs and provide on-going support throughout the day. The manager confirmed that they used a dependency tool to calculate the required staffing levels to ensure they had enough staff to meet people's needs. On the day of our inspection we observed that there were enough staff to provide the care and support people required.

Staff understood their roles and responsibilities in relation to keeping people safe. Records showed that all the staff had undertaken training in safeguarding and that this was regularly refreshed. The provider's policy was readily accessible to staff and provided them with the contact details of the local safeguarding team. Staff told us that if they had any concerns they would speak to the clinical lead or lead nurse on duty and if they were not satisfied with their response, they would report the incident to the safeguarding team directly. One member of staff told us "If someone reported something to me I would listen to the person and report it to the nurse on duty, if they didn't act I would take it higher; I would go to CQC or the council". The manager had made safeguarding referrals as necessary and worked with the safeguarding authority to investigate concerns as required.

Good

Is the service effective?

Our findings

New staff received an induction which included practical training in areas such as manual handling and shadowing experienced members of the staff team. Staff did not work with people on their own until they had completed the provider's mandatory training and they felt confident to undertake the role. Newly recruited staff were required to complete a booklet with the support of senior staff; this covered areas such as safeguarding, principles of care and manual handling, and was designed to ensure that staff had appropriate knowledge and skills to meet people's needs. The induction for nursing staff covered additional areas such as care planning and medicines and we saw that additional training needs were met; for example training in wound dressing.

People were supported by staff who had received training that was relevant to their role. Training was provided mainly by senior staff and records showed that staff had accessed training in key areas such as health and safety, nutrition and food hygiene on a regular basis. Additional training, relevant to people's needs included dementia awareness and mental capacity. One member of staff said "The mental capacity training was good, we talked about different scenarios based on real life and that helped my understanding".

People's needs were met by staff that were effectively supported and supervised. Staff were able to gain support and advice from senior staff when necessary and regular supervision meetings were available to all staff. One member of staff said "On a day to day basis, I feel very supported by the nurses, there is good teamwork and communication". Supervision meetings were used to assess staff performance and identify on-going support and training needs. One member of care staff said "Supervision helps to improve people's confidence; we talk about any areas where we need to improve and how we will do that."

People received care and support from staff who understood how to ensure that support provided was in people's best interest. Staff were aware of their responsibilities under the Mental Capacity Act 2005 (MCA 2005) and applied this knowledge appropriately. The MCA 2005 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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager and staff were aware of their responsibilities under the MCA and DoLS codes of practice. Care plans contained assessments of people's capacity to make decisions and recorded when 'best interest' decisions had been made. One member of care staff told us "We use MCA assessments to understand whether people are able to make their own choices". The provider had followed the legal process when applying for DoLS authorisations to place restrictions on people's freedom. Appropriate plans of care were in place to ensure that people's care and support needs were met in the least restrictive way and we observed that staff asked for people's consent before providing care.

People had access to their GP on a weekly basis. Staff were prompt to call the GP for acute health problems when needed. One person's relative said ""They get the doctor out quickly if [name] is not very well; they're working with the doctor at the moment to monitor [name's] medication". We saw evidence that people had regular support from a range of healthcare professionals such as psychiatric services, diabetic nurse and podiatrist.

Staff assessed people's risks of not eating and drinking enough by using a Malnutrition Universal Screening Tool (MUST). Staff referred people to their GP and dietitian when they had been assessed as being at risk. Staff followed guidance from health professionals to ensure that people
were able to have adequate food and drink safely, for example where people had difficulty in swallowing, staff followed the health professionals advice to provide food that had been pureed. We observed that people were provided with food that was suitable for their needs, for example thickened fluids or soft foods. People's care plans contained detailed instructions about people's individual dietary needs, including managing diabetes and food allergies.

People received the support that they needed to eat and drink enough to help maintain their health and well-being. Staff were knowledgeable about people's food preferences. We observed lunch being served; people were provided with a choice of meal and an alternative if they did not like what was on the menu. People said that they enjoyed the food; one person said "The food is really good, anything you don't like you tell the kitchen and they don't give it to you, you get a choice of about three different things every day". Staff serving lunch engaged with people in a positive way; asking if people had had enough to eat and drink, and checking that they had enjoyed their meal.

Good

Is the service caring?

Our findings

People had developed positive relationships with staff. Staff knew people well people were treated with respect and compassion. One person told us "All of the staff are marvellous and they all know me very well." Another said "I get on well with all the staff, they're all very nice and never say no to anything you ask". People were relaxed in the company of staff and had developed caring relationships.

People told us that their family could visit whenever they liked. We spoke with one person's relative who described how they joined their family member most days for lunch and staff told us "We have lots of visitors here and they are welcome to come whenever they want".

Staff were knowledgeable about people's life histories and things that were important to them; people's care plans contained detailed information about their previous lives. We observed staff encouraging people to talk about their families and it was clear that people gained enjoyment from this.

People were encouraged to express their views and to make choices. There was information in people's care plans about their preferences and choices regarding how they wanted to be supported by staff and we saw that this was respected. We observed staff at lunch time interacting with one person who was unable to communicate verbally; staff supported them to choose what they wanted to eat by showing them a number of choices and encouraged them to point at the option they wanted. One member of staff described how they supported another person to make choices by showing them pictures and words that they could point at to communicate what they wanted. We also observed staff asking people whether they required any help throughout the day and encouraging people to choose the activities they may like to take part in.

People were able to choose where they spent their time. Some people enjoyed spending time in the communal areas of the home and other people preferred to remain in their rooms. One person told us "I like to have breakfast in my room, I go downstairs for lunch and I also join in the activities I enjoy later on in the day". People who had chosen to spend time in their rooms told us that this was their choice and said the care staff respected their decision. People's bedrooms had been personalised with their own belongings, such as photographs, ornaments and mementos to help people create their own personal space.

Staff knew people well and understood the importance of supporting people to maintain their independence. One member of staff said "We encourage people to try and do as much as they can themselves, for example when I'm helping people with personal care, if someone is able, I would encourage them to wash their own hands and face".

People's dignity and privacy was supported by care staff; we observed that staff ensured that people's bedroom doors were closed when providing care, one member of staff told us "When I'm helping someone with personal care I always make sure that the doors and curtains are closed". Staff understood the need to maintain confidentiality, we saw that staff ensured conversations about people's care and support took place where others would not overhear.

Good

Is the service responsive?

Our findings

People's care and support needs were assessed before they came to live at Brownlands Nursing Home, to determine if the service could meet their needs. This assessment was carried out by the clinical lead who considered people's past and current medical needs. The information from the assessment was shared with staff. Initial risk assessments and care plans were produced and these were monitored and updated as necessary.

Staff provided people with person centred care and support in line with their preferences. Staff knew people well and people received care and support according to their preferences and needs. People had plans of care in place that were regularly reviewed and staff were currently updating all care plans and implementing a new care planning system to ensure that people's needs and choices were accurately reflected.

People were involved in planning their care as much as they were able and people or their representatives had signed their care plans to consent to care and support. Some documentation gave good descriptions of how people should be supported and was clear in instructing staff how they should respond to people in particular situations. For example where people were at risk of pressure ulcers, their care plans recorded the equipment and support they required to help prevent them. People's pressure relieving mattresses were set to the correct pressure for each person's weight and people were helped to change their position to relieve their pressure areas regularly as detailed in their care plans.

The assessment and care planning process considered people's hobbies and past interests as well as their current support needs. Staff supported people to do the activities that they chose and were knowledgeable about people's preferences and choices. One person said "There is something to do here every day; they have carpet bowls, bingo, skittles, all sorts of things". People living in the home were provided with a plan of organised activities and we saw that these activities took place and were enjoyed by many people living in the home. Activities on offer included; arts and crafts, reminiscence and seasonal celebrations which families were invited to. Individual activities were available to people at times, one person said "I go out for coffee with [Staff] sometimes, I really enjoy that".

People chose how and where to spend their time. Meals were served in either people's own rooms or in the lounge and dining area. Some people liked to spend time in their bedrooms; others spent time in the lounge or dining areas. We observed that people were able to move freely around the home.

There was a complaints policy and procedure in place and complaints were logged and investigated promptly and thoroughly by the manager. People and their relatives told us that they knew who to speak to if they were unhappy with any aspect of the service, one person's relative told us that they had made a complaint to the clinical lead and they were happy with how it had been resolved. Staff were knowledgeable about how to respond to complaints, one member of staff said "If someone made a complaint to me I would inform the nurse on duty or clinical lead".

Requires Improvement

Is the service well-led?

Our findings

A manager was in post however there had been a long delay in them submitting an application to register as manager with the Care Quality Commission (CQC) and the provider had recently been served with a fixed penalty notice regarding this matter. At the time of the inspection no further action had been taken by the provider to register a manager for the service.

This constitutes a breach of Section 33 of the Health and Social Care Act 2008: Failure to comply with conditions.

There was insufficient monitoring of the quality and safety of the service. The manager told us that the provider visited the service informally but did not complete any quality monitoring or audits of the service. As a result there was a lack of provider oversight of the manager and of the quality of the service experienced by people living in the home.

A range of audits had been completed; however, some of these audits were not effective at identifying or addressing shortfalls. The manager carried out an environmental audit in October 2016; but they had failed to identify the environmental safety concerns found during this inspection. This meant that people continued to be exposed to risks associated with chemicals or substances hazardous to health and health and safety issues such as access to dangerous equipment.

The arrangements in place to manage medicines had failed to identify the medicines errors that were found during inspection. People were at risk of harm as a result of the lack of management and oversight of medicines. There was a lack of systems in place to protect people from the risks associated with accidents and incidents. Staff had no effective guidelines to follow at the time of an accident or the hours following an accident. People were at risk of a delay in medical treatment due to unidentified injuries.

Where the manager had identified shortfalls in the service action was not taken quickly enough to address these. For example an audit of staff training had identified that there was insufficient oversight of the training required for all staff due to the way training information was recorded. No action had been taken to rectify this and there was no plan in place to ensure that staff training was updated periodically

There were insufficient systems in place to monitor people's health needs as guidelines were not effective in ensuring that people's physical observations were checked as required. Procedures in place stated that physical observations such as temperature and respirations should be checked by nursing staff on a monthly basis; however records showed that this did not consistently happen. Therefore potential risks to people's health and well being may not be attended to in a timely manner. The registered manager was aware of this and had recently implemented a new protocol for people's physical observations; however this practice was not yet embedded.

These concerns constitute a breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

Some policies and procedures to guide staff were in place and had been updated when required. However the employment policy did not detail the need to carry out risk assessments to determine whether criminal record checks were required to be updated regularly for staff. We spoke with staff that were able to demonstrate a good understanding of policies which underpinned their job role, such as safeguarding people and mental capacity. One member of staff said "We go through all of the policies and procedures as part of our training, to make sure we know what to do in different situations".

People were supported by a staff group that did not always have clear managerial guidance. The manager told us that they dealt with the operational needs of the service and the clinical lead was responsible for overseeing the care needs of people. This had resulted in some confusion, as staff told us that at times they were unclear who was ultimately responsible for decision making.

Care staff told us that they gained support and guidance in their job from the clinical lead and nursing staff and that the culture within the home focussed on providing person centred care in a homely environment. The staff we spoke to were committed to providing a high standard of personalised care and support. Staff were aware of the standards expected of them and focussed on the outcomes for the people who lived at the home. Staff told us that clear guidance from the clinical lead and nursing staff enabled them to carry out their job effectively and that they felt able to ask the nursing staff for support, advice and guidance about all aspects of their work.

The provider had a process in place to gather feedback from people, their relatives and staff as they carried out regular surveys. We saw that questionnaires had been completed by residents, relatives and staff. Staff meetings also took place and nursing staff described how they attended regular meetings, where discussions took place regarding the actions required to implement improvements.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Section 33 HSCA Failure to comply with a condition There had been no registered manager in post since September 2013. A fixed penalty notice was served on 7 august 2016.

The enforcement action we took:

We issued a fixed penalty notice to the provider on 7 August 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have sufficient oversight or arrangements in place to monitor the quality and safety of the care and support provided in the home. 17 (1) (2) (a) (b).

The enforcement action we took:

A warning notice has been issued to the provider.