Inspection Report 2023-2024

Brookfield Nursing and Residential Home

Adult Care Home

18 August 2023

Isle of Man Government

DHSC

Under the Regulation of Care Act 2013 and Regulation of Care (Care Services) Regulations 2013

SECTION A Overall Summary

We carried out this inspection under Part 4 of the Regulation of Care Act 2013 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements, regulations and standards associated with the Act. We looked at the overall quality of the service.

We carried out this unannounced inspection on 18 August 2023.

The inspection was carried out as part of a series of focussed inspections on services where we identified a number of unwitnessed falls or serious injuries over the last year.

The aim is to confirm if this is due to an increase in appropriate notification and/or an indication that actions need to be taken to improve the service in the area of falls.

In the cohort of older people the presence of multiple risk factors increases the likelihood of a fall or fracture. Research tell us that older people in care homes are three times more likely to fall than people of a similar age in the community, often these incidents are preventable. There are a number of approaches that can prevent some falls and fractures.

https://doi.org/10.1136/bmj-2021-066991

https://evidence.nihr.ac.uk/alert/falls-prevention-programme-effective-care-homes/

The inspection was led by a member of the Registration and Inspection team.

Service and service type
Brookfield Nursing and Residential Home is a care home based in Ramsey. People in care homes receive support and accommodation as a single package under a contractual agreement. At the time of the inspection there were fifty-six people using the service.

People's experience of using this service and what we found
To get to the heart of people's experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our key findings
There was evidence of the home involving individuals or significant others in the review and risk assessment process. Family members were informed when an incident / accident had taken place.

Care plans and risk assessments were being regularly reviewed, including mobility assessments.

Brookfield provides a warm and welcoming environment. Staff knew the people in the home and their needs well.

Assistive technology, such as sensor mats, were being used to support better outcomes for people.

Care records evidenced that the home was seeking to continuously learn and improve following any fall.

SECTION B The Inspection

About the service
Brookfield Nursing and Residential Home is registered as an adult care home.

Registered manager status
The service has a registered manager. 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
This unannounced inspection was undertaken as part of a number of themed inspections where there were a concerning number of incidents notified to the Registration and Inspection team. The focus of this report was to review specific residents care files against the inspection framework.

We carried out this unannounced inspection on the 18 August 2023.

What we did before the inspection
We reviewed statutory notification of events forms from April 2022. We specifically concentrated on those notifications detailing unwitnessed falls or serious injuries during that period. Where there was a significant number of incidents, we analysed these in terms of frequency of falls for the same resident, actions taken by the home following the incident and any learning identified.

During the inspection
We examined the following evidence on inspection;

- A sample of electronic resident daily records
- Assessments and care plans relating to specific individuals
- Risk assessments relating to specific individuals
- Professional and other agency involvement

We also undertook a general walk around the home as part of the inspection.

After the inspection we discussed our findings with the senior nurse.

SECTION C Inspection Findings

C1 Is the service safe?

Our findings:
Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. The service does require an improvements in this area.

This service was found to be safe.

Initial assessments, care plans and risk assessments outlined people's choices and levels of independence.

The inspector was assured that people were being kept safe from avoidable harm due to care plans and risk assessments containing up to date, accurate information in the small sample examined.

There was evidence of the home involving individuals or significant others in the review and risk assessment process. Family members were informed when an incident / accident had taken place.

The home had a falls prevention policy which had been reviewed in May 2023. Staff were completing observations post fall and this was documented on individual's daily notes and on accident / incident observation forms. The senior nurse said that falls management formed part of staff moving and handling training.

On the day of the inspection the premises appeared to be clean and hygienic with communal areas uncluttered and free from hazards.

The senior nurse said that the home was sufficiently staffed to meet people's needs. The home did not currently have any staff vacancies.

There was a system for evaluating the dependency levels of each resident.

Medication reviews were taking place.

One person, who was prescribed PRN as and when medication did not have a protocol in place in order for staff to be consistent when administering medication.

Action we require the provider to take

Key areas for improvement:

- PRN protocols must be written where required.
  This improvement is required in line with Regulation 13 of the Care Services Regulations 2013 – Service recipients plan.

Inspection Findings

C2 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 service does not require any improvements in this area.

This service was found to be effective.

Pre-admission assessments were completed in detail. Information was then carried through into care plans and risk assessments. People's level of independence was identified and recorded.

People's mobility needs were clearly recorded. Equipment to aid mobility, such as walking aids had been provided.

Care plans and risk assessments were being regularly reviewed. These included mobility assessments. When falls had taken place, new risk factors were being identified as well as what actions were to be taken.

Cognitive problems, dementia or a person's ability to manage their own safety were being considered. These factors were then carried forward into people's care plans / risk assessments.

There was evidence of timely involvement from and proactive referrals to other professionals and agencies.

The inspector was informed that when there was a change in a person's circumstances, these were conveyed to staff via the home's in-house message system and on handover.

Inspection Findings

C3 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. The service does not require any improvements in this area.

This service was found to be caring.

Brookfield provided a warm and welcoming environment. Respectful interactions between people and members of staff were observed. Staff were seen spending quality time with residents.

Staff knew the people in the home and their needs well.

Records evidenced that residents, where possible, were involved / consulted following any fall with staff interventions discussed. The inspector spoke to one resident who confirmed that staff were always reminding him to use his walking frame rather than the handrails in the communal hallway.

Inspection Findings

C4 Is the service responsive?

Our findings:
Responsive – this means we looked for evidence that the service met people's needs. The service does require an improvement in this area.

This service was found to be responsive.

Initial assessments and care plans reflected what was important to people and, where possible, how they were to be involved in their care.

The inspector was assured that the home was delivering care that was responsive to people's needs. Falls triggered a review of need and interventions, such as observations, blood pressure checks and GP's informed. Care records evidenced involvement from other professionals and agencies in response to a change of needs.

Assistive technology, such as sensor mats, were being used to support better outcomes for people.

The inspector compared one person's accident / incident report against the statutory notification of events form submitted to Registration and Inspection for the same fall. The description of the event did not match.

Action we require the provider to take

Key areas for improvement

- Accident / incident reporting must contain clear and consistent information.
  This improvement is required in line with Regulation 14 of the Care Services Regulations 2013 – Records.

Inspection Findings

C5 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. The service does require an improvement in this area.

This service was found to be well-led.

The senior nurse, in the absence of the manager, was very welcoming and open to the unannounced inspection visit.

Information was disseminated to the staff team through various means, including handovers and internal emails.

Care records evidenced that the home was seeking to continuously learn and improve following any fall.

Generally the service had notified the regulator of all notifiable events within the specified timeframe. One fall had not been reported to the Registration and Inspection team and a discussion was had with the senior nurse about this. He confirmed that a new system had been implemented so that other Registered Nurses could complete notifications.

Action we require the provider to take

Key areas for improvement

- Notifications must be submitted following any event that affects the well-being of a resident.
  This improvement is required in line with Regulation 10 of the Care Services Regulations 2013 – Notifications.

If areas of improvement have been identified the provider will be required to produce an action plan detailing how the areas of improvement will be rectified within the timescales identified. The R&I team will follow up and monitor any actions undertaken.