TLC Care(UK) Limited

Briarcroft Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Briarcroft is a care home which provides accommodation for up to 20 older people who may be living with dementia.

This focused inspection took place on 13 January 2017 and was unannounced. The inspection was undertaken to review the progress the provider had made with meeting the requirements of the warning notice issued following the comprehensive inspection of the home in August 2016. At that inspection we rated the home as requiring improvement in all five of the key questions. We identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the quality and safety of the services provided.

The home was obliged to have a registered manager in post as this was a condition of the provider's registration with us. The provider had appointed a new manager following the previous inspection. They confirmed they were in the process of applying to register with us. Following the inspection, the provider confirmed the manager had submitted their application to registered with us. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Following the inspection in August 2016 we met with the provider who gave assurances of their commitment to improving the quality and safety of the care and support provided to people. At this inspection in January 2017 we some found improvements had been made. The provider had taken action to commence a programme of improvements within the home and had been visiting each week. The manager had been working with the local authority's quality and improvement team and had developed a service improvement plan. However, we found there were other areas that required improvement and some of the decisions made by the manager did not promote safety or protect people's rights.

Broken and unsuitable furniture had been replaced and equipment had been serviced. A programme of refurbishment and redecoration was underway. The manager confirmed the laundry room would be redecorated as the paint was peeling from the walls which made this room difficult to keep clean. The manager said this room had been identified by the provider as requiring redecoration and this would be undertaken shortly: it had been identified as requiring repainting in the refurbishment plan.

We found equipment in use that placed people's freedom of movement and their safety at risk. A gate had been placed across part of the hallway on the first floor which restricted access to two people's bedrooms. This use of the gate had not been properly assessed or authorised and as such its use was an unauthorised restriction of people's liberty. We also found a portable ramp was being used to bridge the gap between two sets of steps. The use of the ramp had not been assessed as safe to use. The manager removed the gate and the ramp immediately.

At the previous inspection we identified that care planning records were insufficiently detailed to identify people's care needs and how they should be supported. Since then the home had introduced a computerised care planning system. Each person had a newly competed care plan. However some improvements were still required. For example, people's preferences in how they wished to be supported were not recorded. In September 2016 the manager had sent questionnaires to people to gain their views about the quality of the care and support in the home: we saw the results of these were favourable about the care being provided. A thank you letter from a relative was received by the home on the day of the inspection.

We made a recommendation for improvement and identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The home did not have a registered manager in post.

Systems in use by the provider for monitoring of the quality and safety of the service were not robust in identifying unsafe and restrictive practices.

The provider had not identified that legislation to protect people from improper restrictions had not been adhered to. Some people's freedom of movement was restricted without assessment or authorisation.

Systems to assess risk to people's safety were not in place when considering using equipment that may increase, rather than decrease, risk.

Care planning did not identify people's preferences with how they wished to be cared for.

Audits allowed for review of care practices within the home. Actions had been identified and taken to improve the service.

Briarcroft Care 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 ass 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.

One adult social care inspector undertook this unannounced inspection on 13 January 2017. The inspection was undertaken to review the progress the provider had made in relation to the warning notice issued following the previous inspection in August 2016. There were 20 people living at the home on the day of the inspection. We spoke to the manager, made a tour of the home and reviewed a number of documents relating to the safety of the home and the care people were receiving.

Requires Improvement

Is the service well-led?

Our findings

At the inspection in August 2016 we identified a number of areas that required improvement in relation to how the home was managed. Quality assurance systems were not robust which had led to ineffective care planning, failure to ensure equipment was serviced and maintenance in a safe working order, and other safety aspects of the home not being monitored to ensure people's safety. We issued a warning notice to the provider to make improvements. Following the inspection the provider appointed a new manager. We met with them and the provider who gave assurances of their commitment to improving the quality and safety of the care and support provided to people.

At this inspection in January 2017 we some found improvements had been made. The provider had taken action to commence a programme of improvements within the home and the manager had been working with the local authority's quality and improvement team. They had developed a service improvement plan and we were provided with a copy which detailed the actions the provider and manager were taking and timescales for completion. However, we found some of the decisions made by the manager did not promote safety or protect people's rights.

The provider had engaged a management company to undertake a review of the home's policies and procedures to ensure the appropriate policies were in place to support the management of the home. They also visited the home every week to support the manager with the running of the home. However, the monitoring systems used by the provider were not robust in ensuring people were protected from avoidable risk and were not unduly restricted.

Broken and unsuitable furniture had been replaced and the manager confirmed the refurbishment and redecoration of the home was underway. We saw a number of rooms had been decorated and had new flooring fitted. We found the environment to be clean and tidy. However, the laundry room was found to have paint peeling from the walls which meant the room was not easy to clean. The manager said this room had been identified by the provider as requiring redecoration and this would be undertaken shortly. They showed us a copy of a refurbishment plan which included improvements to the communal areas, bedrooms and the laundry room. Equipment had also been serviced or replaced as necessary. For example, the hoists and the lift had been serviced and some commodes had been replaced.

However, we found sufficient consideration had not been given to the appropriateness and safety of using some equipment. We found equipment in use that placed people's freedom of movement and safety at risk. A gate had been placed across part of the hallway on the first floor which the manager said was to reduce the risk of one person coming to harm if they left their room unnoticed by staff. They said the person was at risk if they used the stairs without staff supervision. However, due to the position of the gate a second person's access to their bedroom was also restricted. The two people whose access to their rooms was restricted had not consented to the use of the gate. The use of the gate had not been assessed as safe or appropriate to use and as such was an illegal restriction to these people. The manager immediately removed the gate: they said staff would more closely monitor this person to ensure their safety. Barriers preventing people's movements around the home should only be considered as last resort when other less

restrictive options, such as increasing the number of staff on duty, have not been effective in keeping people safe. Restrictions must be agreed by others involved in people's care, such as family members and social workers, to be in the person's best interests. Applications to restrict people's liberty must also be made to the safeguarding authorities for legally authorisation.

Failure to properly assess the need for and request authorisation to restrict people's freedom of movement is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A portable ramp was in use over the gap between the top of one small flight of steps to another. The manager explained that this was to allow one person wheelchair access to and from their bedroom and the lift. The ramp was not securely fitted and due to one flight of steps being at a higher level than the other, staff had to push the wheelchair up or down a slope. When the ramp was not in use we saw it had been lifted onto its side but remained in place across the stairwell. This could potentially have caused a trip hazard to people and staff using the stairs. The ramp had not been assessed as safe to use and the manager immediately removed it. They said the person for whom the ramp had been put in place could use the few steps involved in accessing the lift but the ramp had made it easier for them.

Failure to properly assess and establish that equipment reduced risk and was safe to use is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection we found the care plans were insufficiently detailed to guide staff in meeting people's needs. Since then the home had introduced a computerised care planning system. The manager said they and the staff were familiarising themselves with the system. Each person had a newly completed care plan that described their needs and guided staff on how to meet those needs; however people's preferences about how they wished to be supported was not recorded. This meant that people's preferences may not be known and understood by staff. The system allowed staff to record the care they had provided, how people had spent their day and how well they had been eating and drinking. The system also included risk assessments such as those relating to falls and skin care. The manager said that as staff became more familiar with the system, they were confident the care plans would provide a full account of people's needs and how these should be met.

We recommend the home ensures people's preferences in how they are cared for be identified and recorded.

Internal audits had been introduced to monitor the care and support people were receiving as well as reviewing health and safety issues. For example, in December 2016 the manager had undertaken a number of audits. These included hot water temperature to ensure it was maintained at a safe temperature; medicine records to ensure these had been fully completed and people had received their medicines as prescribed; whether there had been any accidents; staffing levels and whether records in relation to people's food and fluid intake were fully completed. The manager confirmed a specialist agency had undertaken a risk assessment in relation to the prevention of Legionnaires Disease in October 2016 and found the control measures in place were sufficient.

Following the inspection in August 2016 the manager had sought the views of people and their relatives. Questionnaires had been sent to people in September 2016 and we saw the results of these were favourable about the care being provided. A thank you letter from a relative was received by the home on the day of the inspection.

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 The provider had not assured equipment in use had been properly assessed as safe to use. Regulation 12(1)(2)(a)(b)(d)(e)

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 People's freedom of movement around the home was restricted without proper assessment or authorisation. Regulation 13(1)(2)(4)(b)(5)