TLC Care(UK) Limited

Briarcroft Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 1 August 2016. The inspection started at 06:20 am to allow us to meet with the night staff and observe activity at the home first thing in the morning.

Briarcroft Care Home was registered to provide care for up to 20 people. People living at the home were older people, the majority of whom were living with dementia.

The home did not have a registered manager. Although there was a manager in post, they had not yet completed their registration with the Care Quality Commission, and are therefore referred to as the manager throughout this report. 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.

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Briarcroft Care Home was last inspected on 8, 10, and 13 July 2015. The home was rated as good across all key questions at that time. This inspection on 1 August 2016 was bought forward because we had received information of concern about the home since the last inspection, including about cleanliness, people being got up early, general care of people and a recent safeguarding concern about a person with a pressure ulcer.

On this inspection of 1 August 2016 we identified a number of concerns about the home, including issues around cleanliness and infection control, management and leadership, care planning, systems for managing quality and risk and a lack of action with regard to protecting people's rights under the Mental Capacity Act 2005.

Risk assessments were not always in place or did not contain enough information to help keep people and others safe from risks associated with their care. This included concerns about the monitoring of people's food and fluid intake where they had been assessed as being at risk, and support to help people with distressed or risky behaviours.

The environment was not always safe for people. We identified risks from the furnishings, equipment, poor cleanliness, and poor infection control. Some areas of the home were not being cleaned regularly or thoroughly, and stained or torn cushions and chairs were evident both in communal areas and in people's rooms. Some areas were visibly dirty, and care and attention was not always being paid to quality issues such as making beds properly to help provide a comfortable environment for people to live in.

People's rights under the Mental Capacity Act 2005 were not always being respected and applications had not been made for Deprivation of Liberty Safeguards where needed. Best interest decisions had not always been recorded. However staff had a good understanding of capacity and consent issues in day to day practice. Staff understood how to report concerns about people's well being and welfare. Systems were in place for the management of complaints.

People were not always being protected from the risks associated with medicines, for example we found some prescriptions creams had been left out in people's bedrooms. Other areas of medicines practice was well managed, and people received the medicines they were prescribed appropriately. People had access to the community healthcare services they needed, including medical specialists and community nurses.

There were enough staff on duty to meet people's physical care needs on the day of the inspection, although staff told us that at times this was 'tight' dependent on people's changing behaviour or needs. Staff were able to respond to people's planned needs and care tasks, but people were left alone in the lounge and unobserved for periods, and there was a lack of dedicated time to support people socialise or engage with activities. The manager did not have a system to identify the number of staff needed based on the dependency level of the people at the home. We have made a recommendation about keeping staffing levels under review to ensure they meet people's needs.

A full staff recruitment process had been followed for two out of the three staff files we saw. The manager agreed to ensure the other file was completed retrospectively as the person had already started work at the home. We have made a recommendation that the registered person ensures safe recruitment practice is followed for each staff member.

Staff received training and had observations carried out of their practice. But where issues had been identified regarding staff performance we could not find evidence that this was followed up, so it was not possible to see what improvements had been made. We have made a recommendation about this.

Meals served to people were not always varied or well planned, although we did see people being offered choices. Where there were concerns over people's swallowing, advice and assessment had been sought from appropriate healthcare staff. But this information was not always easy to find in people's files and the home had not undertaken a choking risk assessment for people.

The building was not well adapted to meet the needs of people living with dementia. Information was not always provided to help people maintain their independence or orientate themselves to their environment. We have made a recommendation about this.

We saw evidence of some positive relationships in place, and caring interactions between staff and people living at the home. But we also saw instances where people's dignity was not always supported and staff did not always treat people with respect. For example people's dress and self-care needs were not always being followed.

Care planning information was not always clear and did not always contain information from people on their preferences regarding their care. There were no clear and consistent plans for activities to help with supporting people to remain active and reduce risks from social isolation. Care plans focussed on people's physical needs, and had little information about the impact of dementia on people's day to day lives. The home did not use specialist tools for assessing the needs of people with dementia, for example pain assessment tools to support people who had limited verbal communication.

Leadership was poor and management had not been effective at identifying quality and safety concerns or addressing them. Where action plans had been drawn up in 2015 to make improvements, actions identified had not been completed or had not been effective in making the changes needed.

Records were not all well maintained. Care records did not always reflect people's needs or wishes consistently. Management records including audits were not completed and the manager could not locate

some we asked for. Policies and procedures had been marked as being updated in 2015, but referenced out of date legislation or other care homes. This told us they had not been updated thoroughly, and would not offer the most recent guidance for staff.

We identified a number of breaches of regulation on this inspection. 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 safe?

Requires Improvement

The service was not always safe.

The environment was not always safe for people. We identified risks from the furnishings including broken furniture, poor cleanliness, and poor infection control.

Risk assessments were not always in place or in sufficient detail to help keep people and others safe from risks associated with their care.

People were not always being protected from the risks associated with medicines.

There were sufficient staff on duty to meet people's physical care needs, but people were not always being monitored or supported with social interactions and stimulation. We have made a recommendation about keeping staffing levels under review to ensure they meet people's needs.

A full staff recruitment process had not been followed for every member of staff. We have made a recommendation about this.

Staff understood how to report any concerns about people's welfare.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not always being respected and applications had not been made for Deprivation of Liberty Safeguards where needed. Best interest decisions had not always been recorded. However staff had a good understanding of capacity and consent issues in day to day practice.

Meals served to people were not always varied or well planned.

Staff received training and had observations carried out of their practice. But where issues had been identified they were not always followed up, so it was not possible to see what improvements had been made. We have made a

recommendation about this.

People had access to community healthcare services they needed.

The building was not well adapted to meet the needs of people living with dementia. Information was not always provided to help people maintain their independence or orientate themselves to their environment. We have made a recommendation about this.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw evidence of positive relationships in place, and some caring interactions between staff and people living at the home.

People's dignity was not always supported and staff did not always treat people with respect in the interactions we heard. The living environment and some practices we saw did not support people's independence.

People's self-care needs were not always being met.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care planning information was not always clear and did not always contain information from people on their preferences regarding their care. We have made a recommendation about this.

There were no clear and consistent plans for activities to help with supporting people to remain active and reduce risks from social isolation.

Systems were in place for the management of complaints.

Is the service well-led?

Requires Improvement

The service was not well led.

Action plans identified to address concerns had not been completed or were not effective in making the changes needed.

Leadership was poor and management had not been effective at

identifying quality and safety concerns or addressing them.

Systems to manage risks to people's safety and welfare were not always in place or effective.

Records were not all well maintained.

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 was 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 the 1 August 2016 and was unannounced. The inspection started at 06.20 am to allow us to meet with the night staff and observe activity at the home first thing in the morning. The inspection was carried out by one adult social care inspector.

We looked at the information we held about the home before the inspection visit. We looked at information the provider had sent us, and information of concern, complaints and notifications that we had received since the last inspection. We contacted other agencies such as the local authority safeguarding team, quality improvement team and environmental health department to discuss the home.

We spent time observing the care and support people received, including staff supporting people with their moving and transferring. The majority of people living at the home were not able to share their views with us about their experience of care at Briarcroft. We spent several short periods of time carrying out a short observational framework for inspection SOFI observation. SOFI is a specific way of observing care to help us understand the experiences of people who could not communicate verbally with us in any detail about their care. On the inspection we spoke with or spent time with three of the 18 people who lived at the home, one visitor, the manager and five members of both day and night staff.

We looked at the care plans, records and daily notes for six people with a range of needs, and looked at other policies and procedures in relation to the operation of the home, such as the safeguarding and complaints policies. We looked at three staff files to check that the home was operating a full recruitment procedure, and also looked at their training and supervision records. We looked at the accommodation provided for people and risk assessments for the premises, as well as for individuals receiving care and staff providing it.

Requires Improvement

Is the service safe?

Our findings

Risks at Briarcroft Care Home were not always being identified or managed well. We identified risks from the environment, cleanliness and infection control, and in relation to people's care.

People were not always being protected from risks posed by the environment. We found some unstable furniture that was not secured to the walls in the bedrooms of people living with dementia. This furniture would pose a risk to people if they were to fall against it, causing it to be pulled over. These had not been risk assessed. The manager told us this would be addressed without delay. Risk assessments had not been completed for bed rails in use. We saw broken furniture such as chests of drawers and rusty commodes in people's rooms that could not be cleaned properly. This could lead to people injuring themselves on broken furniture and having an increased risk of cross infection. The manager told us that they had a meeting planned with the providers to look at the replacement of furnishings.

People were not being protected from the risks associated with fire. A person who lived at the home was seen to be repeatedly propping open the fire door to their room throughout the inspection with a waste paper basket. The manager told us they were "always speaking" to the person about this. There was no automatic hold open device fitted to their door, which would have reduced the risk as the door would have closed automatically in the event of a fire. A fire exit at the foot of the back stairs was partially blocked by an unused medicines fridge and sack of potatoes. These were removed during the inspection, but would have presented risks to people in the case of a fire, as they would not have been able to use the back staircase as a fire escape. The Fire Precautions (Workplace) Risk Assessment for the home could not be located. The manager told us this was because it was being updated.

People were not always being protected against the risks from medicines. We found prescribed creams left in the bedrooms of people living with dementia. These were not kept securely in people's rooms so could have presented risks to people if they were accidentally ingested or misused by the person or another person who had entered their room. These did not always have an opening date to help staff assess if they were still safe or effective to use. One prescribed cream did not have a prescription label in place so it was not possible to tell who the cream had been prescribed for or what instructions had been given about its use.

People were not being protected from the risks of cross infection. We found an unlidded bin containing used continence products in the laundry room which was smelled strongly of urine. This room was next to the kitchen and the smell from the bin had permeated into this area through a door that was open but should have been closed. Bags of soiled continence pads were being stored outside but not in bins, as the manager told us the bins were not large enough to store all the pads waiting for collection. This meant there was an odour and potential pest control problem. The manager had identified this as a concern but had not taken action to resolve the risks. There was no recorded risk assessment of this.

The failure to identify and address risks to people is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe Care and Treatment).

Some areas of the home were not clean and had a strong odour of urine. Some chairs in the lounge were stained and some chairs and furnishings in people's rooms smelled of urine and were not clean. One bedroom had a bedside table with food residue on it from a previous meal. A number of pressure relieving cushions in communal rooms and in people's bedrooms had split or torn covers and smelled of urine. These could not be kept clean. A toilet frame in a communal toilet was found to be heavily soiled underneath the seat, and flooring in a bathroom and toilet was dirty. The windows were dirty. The manager told us these had not been cleaned for a while.

The failure to keep the premises clean was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Premises and equipment).

There were enough staff on duty to meet people's physical care needs on the day of the inspection, although staff told us that at times this left little flexibility if people's behaviour or needs changed suddenly. Staff were able to respond to people's planned needs and care tasks, but people were left alone in the lounge and unobserved for periods, and there was a lack of dedicated time to support people socialise or engage with activities. The manager did not have a system to identify the number of staff needed based on the dependency level of the people at the home. They told us they thought the home would benefit from an additional staff member being on duty at the evening mealtime and more cleaning hours, but we did not see that any action had been taken on this. The manager said they planned to discuss this with the providers on their next visit.

We recommend the registered persons ensure that staffing levels are kept under close review to meet the needs of people accommodated at the home.

People's files contained copies of risk assessments for pressure area relief and falls. We saw evidence of good practice regarding moving and positioning of people. Plans, guidance for staff and risk assessments were in place in each person's file. Pressure area care and treatment was under the direction of the district nursing team. The manager told us that following a recent safeguarding concern the district nursing team were going to deliver some training to staff in pressure ulcer prevention.

People were not all able to share their experience about whether they felt safe at the home. One person told us they felt the home was "alright" and we saw people approaching staff for contact, comfort or support. Staff had received safeguarding training and knew who to report any concerns to and there were policies and procedures to support this available.

A recruitment process was in place that was designed to identify concerns or risks when employing new staff including disclosure and barring (police) checks. We sampled three staff files, and identified a full recruitment process had been followed for two of these. One other file only contained one reference, despite it being the home's policy to have two, and did not have a full employment history for the person. The manager agreed to follow this up. We recommend the registered person ensures people are protected by an effective and safe recruitment process followed for each staff member.

We looked at the medicines systems in use with a staff member who was responsible for administering medicines on the day of the inspection. They had received training on the system in use. Medicines kept centrally in the medicines cupboard were being stored safely, and taken around the home in a lockable trolley. We observed the staff member giving medicines to people throughout the day. This was done well with people being given time to take their medicines and an explanation of what they were for. Controlled medicines were being stored safely and the records maintained balanced with the stocks held. The manager told us they had recently changed pharmacists and training had been provided to all staff who administered

medicines. Staff were signing to confirm the administration of medicines, but records were not always being completed for the administration of creams in people's rooms.

During our inspection the Environmental Health Officer visited the home to look at Food safety issues. They did not identify concerns. The manager told us they had followed the advice of the infection control team in regards to the laundry, and had made changes to ensure a separation of clean and dirty laundry the preceding year.

Contracts were in place to manage the servicing of some equipment such as hoists. The manager told us that a recent fire check had been carried out and a new fire plan was being prepared. Personal evacuation plans were in place.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) 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.

We checked whether the home was working within the principles of the MCA. We found the home was not taking appropriate actions to protect people's rights. Staff were aware of people's right to refuse support. We saw people being offered choices and being asked for their consent throughout the inspection. However, records did not reflect a good understanding of the MCA in practice. We did not find that discussions had always been held or best interest decisions made or recorded regarding areas where people lacked capacity to consent. This included for example with regard to taking medicines, delivering elements of personal care or the use of bed rails. One person had been identified as needing a best interests decision regarding them remaining in bed for their safety, but this had not taken place. The manager confirmed they knew this was an area they needed to work on.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications had not been made for authorisations to deprive people of their liberty at Briarcroft in all situations where this was needed. The manager told us that one application had been made and authorised and another was being processed. CQC had not been notified that the application had been granted as is required by law. The manager told us they understood they would need to make applications for other people at the home but told us they had not done so yet. This meant people's rights were not being protected.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Need for consent).

One person had the involvement of an Independent mental capacity advocate (IMCA) to support their decision making, and other people who had no relatives or other supporters had their finances managed by the Court of Protection.

The premises did not always reflect good practice in design for people with dementia, and not all areas had been well maintained. Briarcroft Care Home is a converted period villa with accommodation for people over three floors. The environment did not support people's independence. There was little signage to support people orientate themselves. For example, there were no visual clues to support people with accessing drinks or finding their way to toilets independently. Some rooms needed attention to décor or furnishings to provide an appropriate and pleasant environment for people living with dementia. For example, the dining room was poorly lit. The manager had bought some patterned cutlery to help people with eating independently. However there were checked tablecloths and patterned china which could have led to visual

confusion for people living with dementia. The manager told us about plans that were being made for internal redecoration and improvements, including the purchasing of new furnishings.

We recommend the provider consults with a reputable source on the adaptation of the environment to support people living with dementia.

Staff received a variety of training which was relevant to their role. Staff told us they had 'plenty' of training and several had come from previous care settings with qualifications. Five staff were working through the Care Certificate which is a set of national standards that social care and health workers should follow as a part of their induction training. Other training that had recently been provided was for moving and handling practice. Staff did not receive regular supervisions or supportive professional development, but told us they could go to the manager if they needed advice or guidance at any time.

We saw people being offered choices with their food, and heard different options being selected. We saw two staff members supporting people to eat. We saw this was done well, with the staff member helping the person to engage with the task. People who were prescribed supplements received these. A member of staff who was cooking told us how they had fortified the meals with cream to help increase people's calorie intake. They also told us about how they incorporated a dietary supplement into other menu choices to help one person enjoy the taste better.

Staff demonstrated that they knew who had what type of textured food and thickened liquids. We saw people were given their breakfast and drinks when they got up rather than having to wait for set meal times which was good practice. Some people chose to eat their meals in their rooms or the lounge which was respected.

People received the healthcare support they needed. We saw evidence in people's files of support from opticians, podiatry services, specialist support services such as community mental health teams and GPs. Prior to the inspection we had received information from the district nursing team that they had no current concerns about the home. District nurses were attending the home to manage pressure ulcers. The manager told us they had a good working relationship with the community nursing teams and gave us examples of where they had worked together well to meet people's needs quickly.

Requires Improvement

Is the service caring?

Our findings

During the inspection we spent several small periods of time observing staff delivering care and support to people. We saw staff supporting people to eat, to move and orientate themselves. We also looked at the environment of the home. We saw evidence of both good and poor practice.

Staff did not always sensitively support people's independence or confidence in a caring manner. We heard a member of staff telling a person they had yesterday's food down the front of their clothing. They did not offer to clean their clothes with them or help them change. They said "That's why you can't be left to dress yourself". This did not support the person's wellbeing.

People's personal care was not always maintained to a high standard. Some people's fingernails were dirty and clothing did not look well ironed, cared for or co-ordinated. We saw that attention had not always been paid to tidying people's rooms or to respect people's belongings. For example beds were poorly made. Sheets had not been tucked in or covers smoothed. This left people's rooms looking uninviting and not well cared for. Some people's rooms had been left dirty. For example three rooms had flooring that needed cleaning. This did not demonstrate respect for people or the environment they lived in.

We observed instances where staff spoke about people's needs in front of other people or carried out conversations between themselves while supporting people.

At the time of the inspection the cook had left and the home manager was interviewing for a new cook the following day. Care staff were filling in to cook meals. We found this had led to a lack of planning over meal choices or thought into providing people with a varied and interesting diet. People's main meal choice on the day of the inspection was a beef burger in gravy, mashed potato and baked beans with mousse and chocolate swiss roll for dessert. One person was vegetarian, and they had vegetarian sausages in place of the burger. However, in the evening staff were again preparing baked beans and bread for people's evening meal until we pointed out that people had already had baked beans for lunch. Staff then said they would prepare spaghetti hoops. There were no pictorial menu supports or visual clues to support people with dementia make choices about their food. This did not demonstrate a thoughtful or caring approach to supporting people to enjoy a positive mealtime experience.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Dignity and respect).

We also saw some good practice from staff in supporting people's wellbeing. Staff were mainly respectful in their speech and tone when supporting people. People sought out staff for support, comfort and information. One person joked with staff about their experiences at lunchtime, and they laughed together. We saw one person being supported to eat by a staff member. The person was in bed. The staff member sat with them and put the rugby on so that the person could see it. They said the person being supported to eat enjoyed rugby and so did they. This became a shared experience and was more pleasurable as a result. We saw this was reflected in the person's care plan. Staff made sure they adjusted the person's position so that

it was easier for them to eat their meal.

Another person was being supported to follow a programme for managing their smoking. We saw staff carried out the plan exactly, which helped manage the person's anxiety. We heard staff complementing one person on how nice their aftershave was, and how lovely they smelled.

Staff were thoughtful about how they could improve people's well-being. We heard them talking in the handover about how much one person had improved since spending time in the lounge in the afternoons. They shared suggestions for further engaging this person in activities outside of their room. The manager had purchased a toy animal for one person as they had often spoken about this animal. They were given the toy and began to cuddle it, which gave them comfort.

We saw that staff tried sensitively to encourage another person throughout the day to have a shave and change their clothes to help protect their dignity. The person was very resistive and became agitated when they were asked. We saw that staff withdrew and attempted to persuade the person later on several occasions.

Care was delivered in private and staff were discreet about offering people opportunities to go to the toilet. A screen was available for the double bedrooms to help ensure people's privacy.

At the time of the inspection one person was receiving end of life care. Pain relieving medicines had been obtained in advance of the person needing them, so that they could be given quickly if needed to relieve pain or troubling symptoms. The manager told us that the local hospice were coming to deliver training to staff in the month following the inspection on good practice in end of life care. Treatment escalation plans were in people's files where the clinician responsible for their medical care had made a decision with the person or their representatives regarding their resuscitation status.

Requires Improvement

Is the service responsive?

Our findings

Each person at the home had a care plan. We looked at the care plans and records for six people. We identified that people's records were held across a number of files and in different locations and were not always well organised. This meant that it was not easy to track any changes or follow clear plans about how people's care was to be delivered. For example we saw information on a professionals visit sheet in one person's file. This indicated action was to be taken to refer the person for an assessment by a specialist team. There was no further entry on this record to show what had happened. However in another area of the file we found that the specialist had visited and sent a report with recommendations which was filed underneath another report. The manager told us they had done a lot of work on the care plans since they had been in post but acknowledged that this was "work in progress" and they were not yet satisfied the plans were working well.

Plans were not signed by the person or their supporters to confirm their agreement and involvement with the drawing up of the plan and there were some gaps in the care plans where they had not been fully completed. Some information was contradictory, and some assessments had not been dated, so it was not possible to know which was the most recent or current.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance).

Plans covered people's physical needs, but did not contain much information about people's known preferences and choices about their care or their emotional wellbeing. The manager told us this was an area the home was particularly working on. Staff we spoke with had a reasonable understanding of people's histories, likes and dislikes. For example a staff member told us about one person's personality and how this related to their past history and work. They understood how to support the person when they became angry or frustrated. However the detail of their knowledge was not recorded in the care plan so might not have been available to other staff. We saw them supporting this person and defusing a potential confrontation well.

Care routines were not always personalised. Staff told us that there was an expectation that a number of people were assisted to get out of bed by the night staff before the day staff came on duty. The manager told us this was only if the person was awake and ready to get up. We did not find that people were up when we arrived at the home at 06.20am, and some people were still in bed at 12.45pm through choice. However people's preferences regarding times to get out of bed not always recorded in their care plans. We have asked the manager to clarify this with staff.

Where people's files indicated they had swallowing difficulties their files did not contain risks assessments with regard to choking. We saw that referrals had been made to the local speech and language therapy service and advice had been given by them regarding appropriate textures of food for people to reduce the risk of them choking. However this was not always clearly reflected in people's care planning. Some of the risk assessments and care planning information in people's files was inconsistent, for example one person's

file said that the person was at a high risk of falls, but was also said to be "immobile".

There were no clear strategies for staff to support them in reducing risks from or to people. One person's care plan indicated they could have risky or distressed behaviours at times, associated with them living with dementia. This included potential harm to others. The person had been involved in a recent incident of assault on a staff member who was protecting another person. This had been recorded in the daily notes and on behaviour chart, but no further analysis or action had been taken other than requesting a test of the person's urine to check to see if they had an infection. There was no clear plan to help reduce risks to the person or others from this behaviour being repeated, or help staff support this person with their distressed or risky behaviours. Following discussion, the manager said they would to refer the person to the older person's mental health team for advice.

Where information was available about people's interests and experiences, we did not see this knowledge always being used to help people remain socially active or engaged. There were no organised activities or one to one opportunities for activity for people on the day of the inspection. People were not engaged by staff. One person's care plan indicated that their religion was very important to them. We saw that the person was regularly visited by friends from their church who said prayers with the person. The manager told us that the home had previously been supported by an external person to deliver activities but they 'hadn't been recently'. Some people would only be able to engage in activity on a one to one basis, but there were no clear plans for this to happen. The manager told us some people enjoyed playing dominoes or playing with a beach ball or taking part in a simple quiz, but there were no formal activities taking place regularly.

The home were not using any specialist assessments with regard to supporting people with dementia. For example tools for assessing pain in people who had difficulty communicating verbally because of their dementia were not in use. This was despite there being people at the home who had impaired verbal communication, and could mean people in pain may not have this identified. There was little in the care plans about the impact of living with their dementia on each individual person.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Plans had been updated regularly. The manager told us when they had started working at the home there had not been a lot of information available to help construct the care plans. They told us they had been working on putting in a structure and detail to make them more 'person centred' and individual. For example they showed us they had sent out to relatives some forms to provide a social and personal history about the person where this was possible. This is important where people are living with dementia as it helps staff understand people's behaviours in the context of the life they have lived.

The home had a complaints process, but this included referring complaints to the CQC rather than other more appropriate agencies for investigation and resolution. This was different to the policy on display in the home's entrance hallway. The manager told us that they had not received formal written complaints about the service but had managed to deal with issues as they arose with people.

Requires Improvement

Is the service well-led?

Our findings

Systems for identifying quality and risk issues were not in place or were not effective. We identified multiple breaches of legislation that had not been identified, addressed or managed. The manager of the home had not completed their application for registration, which was a legal requirement.

Risks to people's health and wellbeing had not always been assessed or mitigated. Some risks had not been identified or actions put in place to address them, for example from unstable furniture or cleanliness in the environment. Where the manager had identified concerns there were not always plans in place to address them for example the management and storage of clinical waste awaiting collection. The manager told us that some new cleaning schedules had been provided but these had not yet been implemented and the manager could not tell us when this would happen.

There were not effective systems in place to check the safety or safe functioning of equipment in use or monitor risks within the environment. Wheelchairs were not being checked regularly to ensure they were safe to use. One wheelchair we saw was dirty with old food residue. Equipment in use to relieve pressure was not being effectively monitored. There was a system in place at the home to record on a regular basis that the equipment for relieving pressure was at the correctly identified setting, but this was not being operated effectively. On the inspection we found pressure relieving mattresses had been recorded as being set at the correct setting by staff 45 minutes before we identified they were incorrectly set for the person's weight. This told us the system for checking them was not effective. Where equipment had been provided for people's safety, such as water temperature regulation to taps at wash hand basins, no regular checks were being carried out to ensure regulation devices were still effective.

There was no system in place to analyse and escalate accidents and incidents to people or to identify patterns to enable staff to reduce risks. Falls and incidents were being recorded individually in people's files. It was not possible to identify patterns of falls because there was no system to collate falls and review them. Incidents of behaviours that presented risks to others were being recorded, but there was no analysis included of actions taken to reduce the risk of this happening again.

Quality assurance systems were not robust. We identified concerns over the management and leadership of the home. Briarcroft Care Home was operated by a limited company. The manager told us that directors of the company visited the home regularly – usually every week – but had not done so for several weeks due to illness. They were in regular telephone contact. The manager could not show us any reports or action plans completed with the provider to look at quality improvement issues at the home. The manager told us they had initially received some support from the quality improvement team from the local authority in setting up audit programmes and action plans to address concerns. However these systems had not been continued by the manager following the withdrawing of the quality team.

There was a lack of clear, targeted and well understood strategies for improvement or a sense of which areas were a priority for action. An action plan had been prepared with the quality team at the time of their involvement in 2015 but had not been completed, and did not have target dates for actions to be completed

by. Some of the concerns identified on the action plan were issues we identified on this inspection. This told us action had not been taken to address the concerns that had been identified in 2015. The manager told us they had been struggling to prioritise the actions they needed to take.

Systems to manage staffing concerns had not always been effectively operated. We saw records that showed us that observations were made of staff practice to review if they had put their training and subsequent learning into practice. We saw where observations had been robust in challenging poor practice, these had not always been followed up with individual staff members or re-assessed, so it was not possible to see if there had been any improvement.

Questionnaires had been sent to relatives and staff in September 2015 to gather their views about the service and what could be improved. However responses received had not been collated or a plan drawn up to address any issues raised.

The manager could not show us any audits they were completing to assess the quality or safety of the service for example to assess the systems for infection control, medicines management or the environment. When we toured the premises the manager had not been aware of some of the cleanliness issues, or where they were aware had not taken action. For example to remove the torn and unhygienic pressure relieving cushions on chair seats.

Records were not all well maintained. Some records relating to people's care needs had not been completed in sufficient detail or were inconsistent. Policies and procedures were not all accurate or up to date, for example records referenced other homes by name or referred to out of date regulations. The policies had been 'signed off' as being updated and accurate in 2015. This meant staff did not have access to up to date policies and procedures to guide and support good practice.

Records for the administration of creams were not being completed by staff, either on the medicines administration record chart (MAR) or on topical medicine administration forms kept in people's care plans.

Some people were having their food and fluid intake recorded, as risk assessments of their nutritional status indicated they were at risk of poor health outcomes. However staff did not always record the amount of the meal taken, for example entries just listed the meal served such as "cottage pie and vegetables". There was no total kept of the total amounts of fluids taken by people during a 24 hour period and no record of what amount of fluid individual people needed to maintain their health. No-one had oversight of the day to day amounts of food or fluids people had. This meant it was not easy to identify whether people had taken enough food or fluids, which could place the person at risk of dehydration or malnutrition.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance).

We did not find that there was always effective leadership in place to plan changes and improvements needed. Staff expressed their frustration with the quality of the environment to us, and told us improvements were slow in coming. However some staff members were supportive of the manager. They felt that recent changes in the staff team had been positive and that the service could now move forward, as some previous staff had been 'resistive to change'. One staff member told us "It's getting better". Another was being designated as the "infection control champion" to help assess and manage improvements.

There was a clear staffing structure with a manager, deputy manager, team leaders, care workers, and cleaning staff. Staff had job descriptions. The manager told us there had been a large turnover of staff and

'things were 'a bit chaotic' at the home. They told us they felt daily care issues were being managed better as the deputy manager was now working alongside care staff supporting people and leading the team.

The registered persons had not informed us of incidents they needed to do by law. The manager took immediate action with regard to this.

It is a legal requirement that provider's share their ratings publically, including from their website. We checked the internet and found a number of websites in relation to Briarcroft but could not identify one that referenced the current provider or the last rating from 2015.

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 9 HSCA RA Regulations 2014 Person-centred care Care and treatment of people was not always person centred. Regulation 9 (1) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Person Centred Care).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always being treated with respect or dignity. Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Dignity and respect).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The home was not protecting people's rights in accordance with the Mental Capacity Act 2005. Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Need for consent).

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 12 HSCA RA Regulations 2014 Safe

personal care	care and treatment People were not being protected from the risks associated with medicines. Risk assessments were not always comprehensive or reflective of risks to people from their care and treatment. Risks from the environment and equipment had not been assessed or managed Nutritional needs were not being met. Risks from poor infection control were not being identified or addressed Regulation 12 (1) (2) (a) (b) (d) (f) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The home was not clean or free from odours. Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Premises and equipment).

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 17 HSCA RA Regulations 2014 Good governance Effective systems had not been operated to assess, monitor and improve the quality and safety of the services provided. Records were not well maintained Regulation 17 (1) (2) (a) (b) (c) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance).

The enforcement action we took:

We have issued the registered provider with a warning notice for this breach.