BRIJ Care Limited

Forest Brow Care Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Forest Brow is a residential care home providing accommodation and personal care to up to 32 people. The service provides support to older people, some of whom were living with dementia. At the time of our inspection there were 24 people using the service.

The care home accommodates people in one adapted building over three floors.

People's experience of using this service and what we found
People's medicines were not being properly and safely managed. There was a lack of stock control and monitoring, lack of auditing and lack of training. Risks related to people's health and safety were not always safely managed, this included risks related to safe moving and handling of people and fire safety.

There were no incident reporting processes in place, which increased the risk of potential safeguarding not being identified.

The provider and the manager had taken actions to ensure that the environment was cleaner, however further work was needed to ensure good infection control processes were being followed in line with guidance.

People told us they were happy and felt well cared for by staff.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published 04 January 2023) and there were breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We undertook this targeted inspection to check whether the Warning Notices we previously served in relation to Regulation 12 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met in relation to specific concerns we had about people's safety, safeguarding, infection control and medicines management. We did not review whether the Warning Notice for Regulation 17 in relation to governance had been met as the provider and the manager still have further time to meet the requirements of this regulation. Regulation 17 will be reviewed at the next inspection. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted

inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Forest Brow Care Home on our website at www.cqc.org.uk.

Enforcement and recommendations
We have identified the provider failed to fully address the action we told them to following our last inspection. There were continued breaches in relation to safe care and treatment and safeguarding at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Forest Brow Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

This was a targeted inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 12 Safe care and treatment and Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was undertaken by 2 inspectors and 1 medicines inspector.

Service and service type
Forest Brow is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post

for one month and told us they intend to submit an application to register.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 24 January 2023 and ended on 3 February 2023. We visited the location's service on 24 January 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with 2 people, 5 staff, the manager and 1 visiting professionals. We reviewed 2 people's care records focusing on the assessment of risk. We reviewed records relating to medicines management and safeguarding. We made general observations of interactions between staff and people and reviewed the environment.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question inadequate. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to manage risks to people's health and safety. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw 2 people requiring the use of a stand aid. A stand aid is specifically designed to assist people who have difficulty rising from a seated position to standing. Staff we spoke with raised concerns about the equipment, comments included "we shouldn't be using the stand aid, handle has a life of its own, it's the only one in the building" and "the legs could splay when a person is in it."
● We observed an agency staff member employed by the service trying to stand a person using a technique which can pose a high risk of injury. The inspector intervened to stop this practice continuing. The manager was immediately made aware.
● There were not enough staff sufficiently trained in moving and handling. There were 15 staff who had not received their online training to support moving and handling and there were 18 staff whose practical training was overdue for renewal. 2 staff had not received any moving and handling training. This was not in line with the providers policy.
● Where the provider had identified a risk, there were not always appropriate measures in place to manage that risk. For example, individuals with long term conditions such as diabetes did not have person centred plans in place to support staff in mitigating risk and avoiding harm.
● The provider had made significant improvements to the fire safety within the home, such as new fire doors and a fire panel. However, the risk relating to the doors of the fire evacuation route on the upper floors were still not compliant with relevant regulations. They continued to pose a risk to people's safety in that they did not automatically unlock and could impede timely and safe evacuation of people in the event of a fire.
● Staff did not always receive all relevant training. There were 9 staff who had not received online fire training and 2 staff had not received any fire training. The manager confirmed that face to face fire training for all staff had been booked with an external company.
● The provider had failed to ensure risks to people in the event of a fire was safely managed. This included a failure to ensure staff had received fire drills. The manager informed us she was going to carry out drills after the face to face training. We asked how they assure themselves that staff were competent to safely manage an evacuation in the event of an emergency especially using the fire equipment. Before the end of the site visit the manager wrote a risk assessment to demonstrate how this risk would be managed in the interim.
● We found an oil filled radiator which was on at a high temperature in a bedroom and not covered, this put

people at risk of burns should they have sustained contact. This was raised in our last inspection and the providers action plan stated this had been addressed. We immediately spoke with the manager about this and the electric heater was removed to ensure the persons safety.

The provider had failed to manage risks to people's health and safety. This placed people at risk of harm. This was a continued breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the site visit the manager provided assurances that the automatic door releases were booked to be fitted and that all staff will be up to date with their training by 28 February 2023.
● Following the site visit and in response to our feedback the provider ordered a new standaid.

Using medicines safely
At our last inspection people's medicines were not being properly and safely managed. This placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people were prescribed 'as needed' (PRN) medicines, which require clear protocols for their use. Guidance in the form of protocols or care plans were not always in place or person centred. This meant the provider could not be assured PRN medicines were always administered consistently.
● We were not assured people consistently received their medicines as prescribed. This included, time sensitive medicines not always being administered at the time required. Where a person was prescribed the use of transdermal patch the area of the body the patch was applied too was not always being alternated. This could lead to an increase in adverse reactions or potential overdose of a medicine.
● There was evidence of the reporting and actioning of medicines incidents. However, there was not a robust process to ensure that all staff were included in the sharing of learning to prevent reoccurrence.
● We could not be assured that all staff administering medicines had an up to date competency assessment for the administration of medicines. Nor were we assured that there were medicines trained staff on duty at all time, which may put people using the service at risk of unsafe or delayed administration of medicines.
● Medicines audits were completed by the provider however, we were not assured that these audits were effective in identifying actions to be taken to make the improvements required. For example, an audit that was completed prior to inspection did not identify the issues we found upon inspection. A further audit was undertaken 3 days later and provided retrospectively however, there was no evidence of what was done to correct the issues that were identified during inspection.
● Information on how people like to have their medicines administered and any special administration methods were not available to staff whilst they were conducting the medicines round. This information is helpful to ensure residents get medicines in a person-centred way.
● From the records available, we could not be assured that the recording and stock control of controlled drugs was in line with regulations. This was because the manager was unable to locate the previous controlled drug registers.

People's medicines were not being properly and safely managed. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had been responsive to some improvements required in relation to medicines since the last inspection.

Preventing and controlling infection
At our last inspection the provider had failed to ensure that systems to prevent and control infection were implemented effectively. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were risks of cross-contamination. Staff were seen using the same stand aid sling for 2 people. People should have their own slings to prevent cross contamination. A tilt chair was being used for 2 people at alternate times of the day which was dirty and had visible rips to most of the seams.
● There were 20 staff, the providers policy stated staff should receive infection control training. Since our last inspection we identified only 2 staff had completed this.
● We saw staff placing snacks such as biscuits on either on bare tables or a serviette and not plates, which is an infection risk. A drinks trolley had 2 buckets for food waste next to fresh drinks.
● Infection control had improved however, there were no records of cleaning schedules being completed and there were still areas of the home that needed cleaning such as the chandelier in the entrance lobby. A shower room on the 1st floor had an odour and cleaning gloves were found on top off open personal hygiene products. We spoke to 2 cleaners who stated "We don't keep cleaning records. Staff check our work; the deputy checks it regularly."
● On our last inspection 1 bath had a badly repaired scratch which increased the risk of infection as the bath could not be effectively cleaned, on this inspection the bath remained in the same condition. There was also a further bath that had a badly repaired scratch.

The provider had failed to ensure that systems to prevent and control infection were implemented effectively. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the site visit the manager stated that infection control training would be completed, and all staff will be up to date with all their training by 28 February 2023.
● We were somewhat assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were somewhat assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured that the provider was admitting people safely to the service.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes
● The provider allowed visits to the care home in line with government guidance.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider had failed to act on allegations of abuse immediately on becoming aware. This placed people at increased risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were no incident reporting processes in place, which increased the risk of potential safeguarding not being identified. For example, a staff member told us "just tell [manager], don't do incident reports

unless they fall."

● We were not assured the provider took timely action to investigate concerns. For example, a person had sustained an injury to their hand, this was raised with the manager who stated, "staff told me they found it like this." The manager informed us they had completed a wound record; however, they were unable to produce this at the time of request. We asked for this to be sent, the record we received was dated after our call and 9 days after the injury occurred. Information we received regarding how the injury occurred was raised to the manager who told us that they would investigate.

● Not all staff had received safeguarding training , this included care, kitchen and ancillary staff.

The provider failed to have clear incident reporting procedures in place. This placed people at risk of harm. This was a continued breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We noted that the provider had made appropriate notifications to CQC where these were relevant since the last inspection.

● After the site visit the manager stated that all staff will be up to date with their training by 28 February 2023.