Borough Care Ltd

Reinbek

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 28 September 2017 and was unannounced. We last inspected the service in February 2017 when we rated the service as Good overall.

This inspection was prompted by information we received about an incident following which a person using the service later died. This incident was subject to an investigation under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). These Regulations require employers and those in control of premises to report specified workplace incidents. This inspection did not examine the circumstances of the incident. However, the information shared with CQC indicated potential concerns about how the service managed risks within the homes garden and surrounding external grounds.

This report only covers our findings in relation to these concerns. The concerns raised form part of the two domains; is the service safe and is the service well led. Our findings are reported under these domains.

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

Reinbek is registered with the Care Quality Commission (CQC) to provide 24 hour care and accommodation for up to 46 older people with a wide variety of conditions and frailties and some people who are living with dementia. People who used the service were cared for in accommodation over two floors. All rooms are single and 27 rooms have en-suite facilities The home also provides short stay and day care services. At the time of the inspection 46 people were using the service.

A general manager was in place and an application to become registered as manager with the Care Quality Commission (CQC) had been submitted. 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.

The provider had taken prompt action to help prevent a similar incident occurring by carrying out external ground work that ensured any identified garden risks were mitigated.

Care records, individual risk assessments/ risk management plans and appropriate garden monitoring/checking systems were in place. These systems ensured that where people wanted to spend time in the garden they would be enabled to do so safely.

A 'Garden Policy' was in place to ensure the safety and wellbeing of people using the service, visitors and staff when using the garden and external grounds

The provider had taken prompt action to help prevent a similar incident occurring. They had commissioned

an independent external health and safety advisor to identify existing control measures, hazards and severity of potential risks within the garden and external grounds.

The provider had followed the principles of the Duty of Candour, following the incident. The Duty of Candour sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, truthful information and an apology.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

The provider had taken prompt action to help prevent a similar incident occurring by carrying out ground work that ensured any identified garden risks were mitigated.

People knew how to obtain an emergency call pendant and these were provided to them prior to accessing the garden and external grounds.

Staff knew to complete a garden observation and monitoring chart for people assessed as being safe to use the garden and external grounds independently.

All staff were aware of the systems in place to help ensure people's safety when accessing the garden.

Is the service well-led?

Good

The service was well-led

People's individual risk assessments/ risk management plans had been updated to identify any potential risks when using the garden.

The provider had commissioned an independent external health and safety advisor to identify potential risks in the garden and external grounds.

The provider had introduced a 'Garden Policy' to ensure the safety and wellbeing of people using the service, visitors and staff when accessing the garden and external grounds.

The provider had followed the principles of the Duty of Candour, following the incident. They had carried out an investigation and contacted the person's family to provide an apology. This this aimed to ensure the provider was open and transparent.

Reinbek

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 28 September 2017 and was unannounced. The inspection was carried out by one adult social care inspector.

At this inspection we spoke with a person using the service who frequently used the garden, the general manager, the interim head of care and a care worker.

We reviewed the risk management plans for three people, garden observation charts, garden risk assessment, accident procedure and garden policy which indicated how the garden protocols were being managed following the incident. We also reviewed systems in place for monitoring the services environmental health and safety.

We spoke with the general manager and interim head of care about duty of candour, which looks at action taken by the provider following incidents, to help prevent them from happening again.

Good

Is the service safe?

Our findings

We looked at what action the registered provider had taken to ensure people who wanted to access the garden and external grounds, could do so safely.

A person we spoke with told us, "I feel very safe now. I always tell staff when I'm leaving the building; The staff check on me regularly, they bring me a cuppa, sit with me in the garden and have a chat. I have no problem wearing the pendant. All the staff are kind and remind me about wearing it. It's such a beautiful garden and I love to spend time in it."

Records showed that all staff had attended meetings to ensure they understood and used a garden policy to ensure people were being kept safe whilst in the garden and risks were minimised.

We spoke with a care worker to check their understanding of the garden policy and the action they should take to keep people safe when they were using the garden. They told us, "We do everything we can to make sure everyone is safe. We always make sure that when a person wants to use the garden we give them a pendant to wear when they are outside. Even though we know the resident's well we do regular checks more often than at 15 minute intervals, just to be sure. Some resident's don't ask for a pendant when they are going to the garden. So when we see them we give them a pendant to take with them and show them how and when to use it." This meant that people using the service were supported to understand what keeping safe means and were encouraged to alert staff if they had any concerns whilst in the garden.

The care worker we spoke with told us, "If the nurse call buzzer sounds, we just need to check our two way receivers or the calls monitor and it shows us the incident location." This meant that staff were aware of the garden policy and the action they should take to ensure people were safe and risks were minimised when they were in the garden. The care worker added, "If there was an incident in the garden, we would carry out a first aid check and contact the emergency services where necessary. We would continue to complete a falls log for the person, update the person's risk assessment, risk management plan, care records and the observation chart. We now have the records in place to complete a timeline of events and would also raise a safeguarding alert with the manager and local authority." This meant that staff were aware of the garden policy and the action they should take in response to ensure people were safe and risks were minimised in the garden.

We examined a sample of observation charts that instructed staff to complete 15 minute checks for all service users that were escorted into the garden area. These records made clear that staff were to ensure emergency call pendants were issued to people to enable them to summon support if needed. The general manager told us that 15 minute checks were considered the maximum time a person would be in the garden before being checked on by staff. They told us that garden checks were always carried out more frequently to ensure people could be located and were seen to be safe at all times.

We reviewed the risk management plans for three people identified as being at risk of falls and who liked to go into the garden without support from staff. One of the risk management guidelines clearly stated that a

person did not tell the staff when they were going into the garden and instructed staff to encourage the person to inform staff when they intended to do so. Staff were instructed to make 15 minute checks on the person whilst they were in the garden, to ensure the person is wearing an emergency call pendant and is shown how to use the pendant each time they are in the garden. The risk management plan of another person identified as being at high risk of falling, instructed staff to encourage the person to inform staff when going out to the garden. The plan also instructed staff to reduce the risk of the person falling by discouraging them from standing on the ornamental garden stones, to provide the person with an emergency call pendant and carry out observations at 15 minute intervals recording their observations on the garden observation sheet. The third risk management plan we examined was for a person who liked to use a back door to access the garden independently. The person was identified as being at high risk of trips and falls and often went outside without informing staff. Management guidelines instructed staff to encourage the person to tell staff when they were leaving the building and provide this person with a pendant. The record also instructed staff to make 15 minute checks to ensure the person was safe.

When we walked around the garden we saw that the provider had made improvements to the garden to ensure access to the garden area was safe. For example, paving stones on pathways surrounding the garden had been levelled and replaced with new ones to prevent injury from trips and falls. Safety rails were now in place to assist people's mobility when using the garden ramps. Areas in the garden identified as being a safety risk had been cordoned off with fencing to prevent access.

The provider recognised that the garden paving stones had the potential to become slippery underfoot during wet/ icy weather and had arranged for grit boxes to be put in place.

A maintenance officer followed weather warnings to identify when gritting was required and carried out regular checks, gritting external pathways routinely. This task was to be carried out by an external contractor at weekends. This meant that where reasonably practicable the provider had made sure that people were protected from risks and avoidable harm in the garden.

Good

Is the service well-led?

Our findings

We looked at what action the provider had taken to help prevent the type of incident which prompted this inspection from happening again.

We saw that a 'Garden Policy' introduced in July 2017 was now in place. The aim of this policy is to ensure the safety and wellbeing of all service users, visitors and staff who access the garden are safe and secure. A policy is an agreed way of working within an organisation.

We examined the garden policy and saw that it related to relevant guidance contained within the Health and Social Care 2008 (Regulated Activities) Regulations 2014 Regulation 12(2a) Safe care and treatment, assessing the risks to the health and safety of service users of receiving care or treatment. The policy also relates to the Borough Care Ltd risk assessment and resident at risk procedures. This ensured standardisation in operating the garden policy and that staff were clear about their role and responsibilities to people when they accessed the garden.

We saw records were in place to assess, monitor and mitigate the risks relating to the health safety and welfare of people who used the service when accessing the garden. Records were in place for people who regularly accessed the garden and were at risk of falls. Risk management plans examined contained enough detail to manage and minimise any identified risks to people using the garden independently.

The provider had introduced daily garden safety checks. These checks were undertaken by the general manager during their daily walk around the home. We examined additional records that showed routine internal and external environmental checks had been undertaken to help ensure that any environmental risks to people were minimised. For example records showed that checks on windows and window restrictors, doors, lighting and heating, fire equipment checks and fire drills were carried out frequently and were up to date.

An accident and incident policy and procedure was in place, reviewed regularly and a future policy review date was planned. Records of any accidents, incidents and safeguarding concerns were recorded and analysed to check if themes or patterns had emerged. Where this was noted it was reported, analysed and actions taken were recorded.

We looked at records to show that the provider had made appropriate notifications to the Care Quality Commission (CQC), The Health and Safety Executive (HSE) and the local authority adult social care safeguarding team where necessary. HSE is the body responsible for the encouragement of workplace health, safety and welfare.

We spoke with the interim head of care and general manager about duty of candour. The aim of the duty of candour regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment,

including informing people about the incident, providing reasonable support, providing truthful information and an apology. Providers must promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. There should also be a commitment to being open and transparent at board level, or its equivalent such as a governing body.

We found that the provider had systems in place to support this and had where required followed them accordingly. Where necessary the provider had commissioned independent advice and investigations to identify the root cause of incidents.