Premier Nursing Homes Limited

Briarwood Care Home

Inspection report

Normanby Road
Eston
Middlesbrough
North Yorkshire
TS6 9AE

Tel: 01642456222
Website: www.hillcare.net/our-homes/briarwood

Date of inspection visit:
19 January 2022
20 January 2022

Date of publication:
26 April 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Briarwood Care Home is a nursing home, which provides care and support for up to 49 older people and people living with a dementia. At the time of our inspection 23 people were using the service.

People's experience of using this service and what we found
Systems to monitor the quality and safety of the service were ineffective and failed to identify the issues we found. Record keeping throughout the home was poor. People's care records were not always complete and information we requested about the running of the service could not be located. Staff worked extensive hours and were poorly supervised and supported. The provider failed to act on the feedback sought from people and staff.

Risks to people were not always recognised and mitigated. Medicines were not managed safely. There were not enough staff on duty to ensure people's care and support needs were being met. Appropriate checks were not always conducted prior to agency staff working at the service. Safeguarding and accident and incident records were inaccurate and incomplete, which impacted on the provider's ability to analyse information and to learn when things went wrong. Effective infection prevention and control measures were not always in place. Areas of the home and equipment were visibly dirty.

People were not always treated with dignity and respect. Staff did promote people's dignity, independence and self-esteem. People were restricted from accessing toilets and bathrooms independently. Reviews of people's care and support needs were not always effective.

People's nutritional and hydration needs were not appropriately managed. People did not receive care and support from suitably skilled and experienced staff. Training and support for staff was not well managed. The home did not always work within the principles of the MCA. Staff did not always act upon guidance from health and social care professionals.

People were not consistently supported to have maximum choice and control of their lives and staff did not consistently support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not consistently support this practice.

Care plans did not always reflect people's current care and support needs. Information from health and social care professionals was not always added into care plans to ensure staff had up to date, accurate information. Information was not readily available in a format people could understand. People were not provided with opportunities to engage in meaningful activities and there was little social interaction between staff and people. The home had created a COVID-19 safe visiting area for relatives and friends to maintain contact with people.

The provider and regional manager were responsive to the concerns and shortfalls found at the inspection

and they took immediate action to address the concerns.

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

Rating at last inspection
The last rating for this service was good (28 May 2021).

Why we inspected
The inspection was prompted in part due to concerns received about the safe care and treatment of people. A decision was made for us to inspect and examine those risks.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, dignity and respect, meeting nutritional and hydration needs, good governance and staffing. Please see the action we have told the provider to take at the end of this report. 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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Briarwood 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.

Inspection team
The inspection was carried out by two inspectors, a pharmacist specialist, and an assistant medicines inspector.

Service and service type
Briarwood Care Home is a 'care home'. People in care homes receive accommodation and nursing 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager had resigned from their post the day prior to the inspection. We were supported by the regional manager during the inspection.

Notice of inspection
This inspection was unannounced.

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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We looked at records relating to the management of the service. These included medicines, accident and incidents, safeguarding, recruitment and quality assurance records. We looked at three people's care and support files. We spoke with 12 members of staff, including the regional manager, admin support, training officer, cook, domestic assistant, two senior carers, a nurse and four carers.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance systems, and training records.

Inadequate

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 good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• The provider had failed to ensure risks to people were managed safely. Guidance provided by health care professionals were not always followed and information passed between staff about risks to people was not always acted on.
• People's care records were not always accurate and complete. For example, some Malnutrition Screening Tool (MUST) calculations were incorrect.
• The provider did not properly assess and manage environmental and equipment-related risks to keep people safe. Environmental hazards, such as trailing wires and electrical, equipment had not been recognised and mitigated. Routine safety checks had not been completed for bed rails.

The provider failed to have robust systems to assess and mitigate the risks to people. This placed people at risk of harm. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection and replaced a faulty bed rail.

Using medicines safely
• Staff did not manage medicines safely.
• Rooms where medicines were stored, and equipment used to administer medicines were dirty. One room was disorganised, and a cupboard used to store medicines was unlocked and broken. The clinic room on the second floor was very cluttered and paperwork was disorganised.
• Medicines, including controlled drugs, had not been disposed of correctly in line with best practice.
• Staff did not always have clear guidance for safely administering covert medicines. Where this had been provided, staff were not aware of it.

The provider did not have effective systems for the proper and safe management of medicines. This placed people at risk of harm. This is a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection and put measures in place to improve the management of medicines.

Staffing and recruitment
• There were not enough suitably trained and competent staff on duty to keep people safe. People had been

left for long periods of time without staff to support them.
• Skill mix and experience had not been considered in the way staff had been deployed and people were not supported by a regular staff team. The service had experienced a high staff turnover and agency staff, used to cover gaps on the rota, did not know people's care and support needs.
• Checks on agency staff were not always made. There was no robust system in place to confirm agency staff members' identity, Disclosure and Barring Service (DBS) status and training. One agency staff member had worked at the service without any prior checks being carried out and they had not received an appropriate induction.

The provider failed to ensure enough suitably trained staff were effectively deployed to meet people's needs. Systems were not robust enough to demonstrate agency staff had received appropriate checks and induction to the home to support people safely. This placed people at risk of harm. This is a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection and put measures in place to ensure robust checks were carried out before agency staff were deployed.

• The provider operated a safe recruitment process for the employment of permanent staff. Recruitment documentation was fully completed, references were gathered, and confirmation of an appropriate level DBS check obtained.
• The provider was actively recruiting to add to its regular staff team.

Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse
• Robust systems were not in place to ensure learning occurred when things went wrong. Accidents and incidents were not always recorded and reviewed.
• Safeguarding records were inaccurate and did not record all the safeguarding incidents the Local Authority Safeguarding team were aware of. The lack of appropriate recording impacted on the provider's ability to analyse the information and take future action to safeguard people.

The provider failed to ensure information was up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during the inspection. The regional manager had introduced a lessons learnt notice board in the staff room to improve communication and understanding.

Preventing and controlling infection.
• Areas of the home and equipment were dirty. Flooring was stained, dirty and contained food debris throughout the building. A toilet door, a shower chair and a yellow pedal bin in one bathroom were unclean.
• Staff did not always have access to personal protective equipment (PPE) and wear PPE required. One staff member did not wear a face mask and another staff member wore their mask incorrectly.

The home did not have effective systems to prevent and control the spread of infections. This is a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection and put actions in place to improve infection and control measures.

Visiting in care homes
• The service had created a COVID-19 safe visiting area. A screened visiting area in the ground floor lounge had been built with direct access from outside via patio doors.

Care homes (Vaccinations as Condition of Deployment)
From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. We found the service did not have effective measures in place to make sure this requirement was being met.

• Checks were conducted on professionals visiting the service. The records of staff member's vaccination status were not accurate and up to date. The regional manager set about addressing this matter.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet
• People were not effectively supported with eating and drinking. Staff did not support people who struggled to eat and there was no adaptive equipment available for people to use. Staff had left one person's meal for them whilst the person slept and then removed this uneaten.
• Fortified drinks were only available when the member of kitchen staff who knew how to produce these was on duty.
• People did not have choice about what they wanted to eat and drink and were not always offered hot drinks. Menus had one option at each mealtime and staff only served blackcurrant juice to drink. On the second day of the inspection staff forgot to offer hot drinks.

The provider failed to ensure the nutritional and hydration needs of service users were met. This is a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection and put measures in place to ensure people had better choice of food and drink.

Staff support: induction, training, skills and experience
• People did not receive care and support from suitably skilled and experienced staff. Induction training for agency staff lacked detail.
• Training was not up to date. Training records were not accurate and current.
• Staffs' competency had not been regularly assessed. One senior carer's competency review required for their role had lapsed.

We found no evidence that people had been harmed. However, systems were not robust enough to demonstrate staff had received appropriate training to support people safely. This placed people at risk of harm. This is a further breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection and put measures in place to ensure staff were suitably trained.

Ensuring consent to care and treatment in line with law and guidance
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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• Staff did not always work within the principles of the MCA.
• Access to bathrooms, toilets and some communal areas were restricted. Some doors were locked so people could only access these rooms with the support of staff. One person had limited access to their cigarettes.
• The service did not have an effective system to monitor people's DoLS applications to ensure people were not unlawfully deprived of their liberty. Record keeping was poor, some people's authorisations had expired, and we could not establish people's current status.

The provider failed to ensure people's personal preferences, lifestyle and care choices were met. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection and put measures in place to ensure people were not unlawfully restricted.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support
• Staff did not always act upon guidance from health and social care professionals. One person had received support from a healthcare professional which was outlined in a letter, but this information had not been added to the person's care support plan.

Adapting service, design, decoration to meet people's needs
• The home did not provide an enabling environment for people living with a dementia. The environment did not support people to orientate the building independently. Whilst some signage was available on bathrooms and toilets, these facilities were locked which could lead to confusion for people.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity: Respecting and promoting people's privacy, dignity and independence
• People were not always treated with dignity and respect. For example, some bedrooms were positioned overlooking a busy main road and foot path and their curtains and blinds remained open when they were sleeping in bed.
• Staff did not promote people's dignity, independence and self-esteem. Staff operated a 'bath rota' which stated what day each person was offered a bath. Staff did not encourage and support people to access the aids they required and to wear appropriate footwear. Some people walked around the home barefooted, and other people did not have their dentures or spectacles.
• People were unkempt. One person's personal care records showed they had showered once over a 17-day period.
• Staff did not meaningfully engage or interact with people. During breakfast, one staff member had stood and watched over people for 15 minutes without speaking to them or offering to help. Another staff member had led one person to the toilet by the had without speaking to them.

The home failed to ensure people's personal preferences, and care choices were met. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection and put measures in place to ensure people received appropriate support with their personal care.

• Despite our findings, people told us they were happy. One person told us, "The staff are grand, a great team."

Supporting people to express their views and be involved in making decisions about their care
• Reviews of people's care and support needs were not always effective. There was no record of any action taken to address the concerns one person had expressed about the adaptive equipment they used to access the shower.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.

• Care plans did not always reflect people's current care and support needs. Information from health and social care professionals was not always added into care plans to ensure staff had up to date, accurate information.
• Care plan reviews were not effective. Incorrect information and gaps in information had not been identified and resolved. One person told us about adjustments they wished to make regarding their care and treatment, but the changes had not been made to their support plans.
• Care plans were not always personalised. Staff referred to one person using a name they did not prefer and their care plans also referred to them by this name.

The provider failed to maintain accurate, complete and contemporaneous records in respect of people's care and treatment. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection and put measures in place to ensure people's care records were updated.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• Information was not readily available in a format people could understand despite people's communication needs being assessed as part of their initial assessment. The regional manager told us that if people requested a different format, it would be made available.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People were not provided with opportunities to engage in meaningful activities and there was little social interaction between staff and people. The member of staff who organised activities was off work and arrangements had not been made to cover their role.

The provider failed to ensure people's personal preferences, lifestyle and care choices were met. This was a

further breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
• The service had a complaints system in place. Complaints were investigated and an outcome was sent to the complainant. Complaints were collated and analysed by the provider.

End of life care and support
• At the time of the inspection there was no-one receiving end of life care. Systems were in place for people needing end of life care. People had end of life care plans in place but these lacked detail.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• We found widespread failings in the provider's systems for monitoring the safety and quality of the service The provider had failed to ensure compliance with regulations.
• Audits contained errors which limited any opportunity for learning and improving the service.
• Record keeping was poor. People's care records were not always complete and information we requested about the running of the service could not be located.
• Statutory notifications to CQC following significant events at the service were not always submitted as required.
• Staff worked extensive hours and were poorly supervised and supported. Some staff told us they felt under pressure to work additional hours due to a lack of staff

The provider failed to maintain accurate, complete and contemporaneous records and have effective systems to assess, monitor and improve the quality and safety of the service. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The provider responding immediately during and after the inspection and put measures in place to improve the oversight of the running of the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The provider failed to act on the feedback sought from people and staff. In March and September 2021 people gave negative feedback regarding the mealtime experience. Whilst areas had been identified for improvement, the required changes had not taken place and were present when we visited.

Working in partnership with others
• The home was not always receptive to guidance and support from health and social care professionals who were involved in people's care and support.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The provider were aware of their responsibilities under the duty of candour. The regional manager was open and transparent throughout the inspection. They were proactive in addressing issues we had

highlighted and when possible resolved issues immediately or put actions in place to mitigate the risks.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people's personal preferences, lifestyle and care choices were met. 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service did not have effective systems to prevent and control the spread of infections. The provider did not have effective systems for the proper and safe management of medicines. The provider failed to have robust systems to assess and mitigate the risks to people. 12(2)(a), (2)(b), (2)(g), (2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure the nutritional and hydration needs of service users were met. 14(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure enough suitably

Treatment of disease, disorder or injury	trained staff were deployed to meet people's needs. Systems were not robust enough to demonstrate agency staff had received appropriate checks and induction to the home to support people safely.Systems were not robust enough to demonstrate staff had received appropriate training to support people safely. 18(1), (2)(a)

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The home failed to keep accurate, complete and contemporaneous records regarding people's care and treatment. The provider failed to ensure information was up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. The provider failed to maintain accurate, complete and contemporaneous records and have effective systems to assess, monitor and improve the quality and safety of the service. 17(1)

The enforcement action we took:

A warning notice was issued.