Larchwood Care Homes (South) Limited

Briar House

Inspection report

Losinga Road
Kings Lynn
Norfolk
PE30 2DQ

Tel: 01553760500

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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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 28 and 30 September 2016 and was unannounced. Briar House is a care home providing personal care for up to 62 people, some who live with dementia. At the time of our visit 52 people were living at the service.

There had been a change of manager prior to our visit and the new manager had not yet completed the process to register with us. 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 home has a new manager, who is in the process of applying to register.

There were not always enough staff available to meet people's needs and people sometimes had to wait for their care.

You can see what action we told the provider to take at the back of the full version of the report.

Staff knew how to safeguard people from the risk of abuse and how to report concerns to the relevant agencies. Individual risks to people's safety had been assessed by staff and actions had been taken to reduce or remove these risks. There was adequate servicing and maintenance checks to fire equipment and systems in the home to ensure people's safety.

People felt safe living at the home and staff supported them in a way that they preferred. Most recruitment checks for new staff members were obtained before new staff members started work, although gaps in employment histories were not always checked.

Medicines were securely and safely stored. Medicines were safely administered, and staff members who administered medicines had been trained to do so. Staff members received other training, which provided them with the skills and knowledge to carry out their roles. Staff received adequate support from the registered manager and senior staff, which they found helpful.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The service was meeting the requirements of DoLS. The registered manager had acted on the requirements of the safeguards to ensure that people were protected. Staff members understood the MCA and presumed people had the capacity to make decisions first. Where someone lacked capacity, best interests decisions had been made.

People enjoyed their meals and were able to choose what they ate and drank. Guidance for staff about how much people should drink each day was not always available and records showed that staff did not always accurately record how much people drank. Staff members worked together with health professionals in the

community to ensure suitable health provision was in place for people.

Staff were caring, kind, respectful and courteous. Staff members knew people well, what they liked and how they wanted to be treated. Staff responded well to people's needs and support was nearly always available. Care plans usually contained enough information to support people with their needs. Staff members knew how to care for people when this information was not recorded.

A complaints procedure was available and people were happy that they did not need to make a complaint. The deputy manager was supportive and approachable, and people or other staff members could speak with them at any time.

The provider monitored care and other records to assess the risks to people, although these did not always identify where care and staffing records were missing information or where systems were incorrect.

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.

There were not always enough staff in one part of the home, which meant people were sometimes kept waiting. Checks for new staff members were obtained before they started work.

Risks had been assessed and acted on to protect people from harm, people felt safe and staff knew what actions to take if they had concerns.

Medicines were safely administered to people when they needed them.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff members received enough training to provide people with the care they required.

The registered manager had acted on recent updated guidance of the Deprivation of Liberty Safeguards and staff acted in the best interests of people when they could not make decisions for themselves.

Staff worked with health care professionals to ensure people's health care needs were met.

People were given a choice about what they ate and drinks were available to prevent people becoming dehydrated. Staff did not always record how much people ate and drank correctly or in enough detail to assess whether they were eating or drinking enough.

Is the service caring?

Good

The service was caring.

Staff members developed good relationships with people living at the home, which ensured people received the care they wanted in the way they preferred.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People had most of their individual care needs planned for and staff responded quickly when people's needs changed. Staff did not always complete people's drink intake records accurately.

Activities and entertainment was arranged.

People were given information if they wished to complain and there were procedures to investigate and respond to these.

Is the service well-led?

Requires Improvement

The service was well led.

Audits to monitor the quality of the service provided were completed but did not identify all areas that required improvement. Actions had been taken to address those issues raised from the completion of the audits.

Staff members and the registered manager worked with each other, people's relatives and people living at the home to ensure it was run in the way people wanted.

Briar House

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 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 and 30 September 2016 and was unannounced. This inspection was undertaken by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this and other information available to us about the home, such as the notifications they had sent us. A notification is information about important events, which the provider is required to send us by law.

We spoke with eight people using the service and with four people's relatives. We also spoke with the registered manager, the deputy manager, 12 staff members and two of the provider's representatives at the time of our inspection.

We spent time observing the interaction between staff and people living at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at the care records for eight people, and we also looked at the medicine management process and records maintained by the home about staff training and monitoring the safety and quality of the service.

Requires Improvement

Is the service safe?

Our findings

We asked people if there were enough staff and they told us that there were occasions when there were not and that they had to wait for assistance. One person said, "Well I just have to wait, sometimes up to half an hour" and "If they don't have enough people it means I can't go out." Another person told us that, "Sometimes you just have to be a bit patient." However, another person described how they had to wait for a drink because staff members were sometimes too busy to get them one. They said, "I get myself up, quite early, and I would really like a drink but have to wait until breakfast which isn't until 9am, it's a long time to wait."

One person's visitor also commented that staff did not always answer call bells very quickly. Another person's visitor told us that they were concerned that staff members were not able to spend as much time as they needed to with the person to make sure they drank enough.

Staff members also told us that they thought there were not enough staff available, although this was mainly on one floor of the home. They told us that there were the same number of staff on both floors but that people who lived on one floor needed a lot more help and assistance from staff.

Call bells rang throughout our visit to the home and we observed that most of the time, staff answered these quickly, although there were occasions when they rang for longer periods. We also saw that by late morning on the first day of our visit there were three times the number of people still in bed on one floor compared with the other.

The provider used a formal tool to calculate the number of staff required to meet people's needs. However, although we found that people's needs were higher on one floor than the other, the same number of staff worked on both floors. We have concluded therefore, that staffing levels had not been accurately assessed and there were not enough staff available on one floor to be able to meet everyone's needs in a timely way.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us in pre-inspection information that they completed recruitment checks before new staff started work and one new staff member confirmed this during our visit. We checked three staff files and found that most of the recruitment checks and information, such as Disclosure and Barring Service (DBS) checks, was available. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. These had been obtained before the staff members had started work. However, explanations for gaps in two staff members' employment histories had not been obtained. This meant that the provider took most of the necessary steps to make sure prospective staff members were as safe to work with people as possible but that improvements needed to be made to ensure their recruitment processes were robust.

People told us that they felt safe living at the home and that they could talk to someone if they had any

concerns. They told us that they would speak with one of the care staff or the manager. One person's relative told us "…we know she's safe here."

The manager had taken appropriate steps to reduce the risk of people experiencing harm. The staff members we spoke with understood what abuse was and how they should report any concerns that they had. There was a clear reporting structure with the manager or deputy manager responsible for safeguarding referrals. Staff members knew who to report to, both within the organisation and to external agencies, and how to do this. These contact details were available in the office and staff room for everyone at the home to see. Staff members had received training in safeguarding people and records we examined confirmed this. We were, therefore, confident that staff recognised and reported any safeguarding concerns correctly.

Risks to people's safety had been assessed and recorded. These were individual to each person and covered areas such as moving and handling, people's risk of developing pressure ulcers or from falling. Each assessment had guidance for staff to follow to reduce the risk so that people remained as safe as possible. We noticed that moving and handling assessments identified that there was an additional risk posed by behaviour that may challenge others, such as confusion or aggression. However, staff had not described how that increased the risk to the person or staff members. Our conversations with staff showed that they were aware of these assessments and they were able to explain how they followed the guidance.

Servicing and maintenance checks for equipment and systems around the home had been carried out. We spoke with the staff member responsible for checking bed rails and they were able to provide a detailed account of the checks they carried out to make sure that bed rails were properly fitted. However, after a recent change in documentation, some bed rail assessments did not assess whether it was appropriate for staff to use the bed rails or whether there were too many additional risks for the person. This posed a risk that people without previous assessments would have bed rails in place when it was not safe for this.

The registered manager confirmed that systems, such as for fire safety, were regularly checked and we saw records to confirm these were completed. We saw that fire safety equipment had received a maintenance check in the 12 months prior to our visit. Personal emergency evacuation plans (PEEPs) were available to guide staff or emergency services in the event of an emergency. We concluded that individual and environmental risks had been appropriately assessed and reduced as much as possible.

People told us that they received their medicines when they were due and on time. One person told us, "They always bring me my pills on time." Other people told us that staff were quick to offer and provide pain killers when these were needed.

Medicines were stored securely in a locked cupboard and trolleys for the safety of the people who lived in the home. We noticed that staff members recorded temperature checks for medicines stored in fridges and rooms, and that these were kept within acceptable temperature ranges. This reduced the risk of the medicine not being effective when given to the person.

Arrangements were in place to record when medicines were received, given to people and disposed of. The records kept regarding the administration of medicines were in good order. They provided an account of medicines used and demonstrated that people were given their medicines as intended by the person who had prescribed them. Where people were prescribed their medicines on an 'as required' (PRN) basis, we found guidance for staff on the circumstances these medicines were to be used. We observed staff members administering medicines, which they completed appropriately by giving people medicines in the way best for them.

Requires Improvement

Is the service effective?

Our findings

Records showed that people's weight was recorded and this enabled staff to take the necessary action if there were any concerns about unintended weight loss. We found that staff completed people's nutritional assessments accurately, which meant that they monitored the risk of people not eating enough. Staff took appropriate actions, such as providing soft or pureed meals, fortified meals with extra calories and referral to an appropriate health care professional. However, for those people who had been deemed as not eating enough, staff had not written a record of the food they had consumed in enough detail to fully describe the food eaten.

One visitor told us that they did not think staff always returned to help their relative to drink and that often drinks were not finished. We saw that staff did not always complete records to monitor how much people drank throughout the day. Records showed this visitor's relative did not receive anything to drink during the day, despite the visitor giving them drinks when they were there. We saw that another person's drink records also had gaps during the day. Other drink intake records were completed in more detail and showed that people were given drinks throughout the day. Because staff did not complete some records accurately there was a risk that if people were not given enough to drink this would be missed. This lack of detailed recording and guidance put people at risk if they did not eat or drink enough. Staff or other professionals may not be able to ascertain whether people had eaten enough for their needs.

People we spoke with told us that they liked the meals they were provided with. One person told us, "I can't fault the food here, they know what I can and can't eat." Other people told us that there was always enough to eat and one person commented that, "there's a choice at each meal and, if there's nothing I like I can ask for something different." A visitor also told us how pleased they were with the meals provided and said, "[Relative] has put on about a stone since she's been here." We saw that people were offered a variety of drinks throughout the day and people told us that there were regular drinks, biscuits and homemade cakes.

We saw that people were offered a choice of meal and people who had difficulty understanding this were shown the meals available. Where people needed help to eat, staff were available to provide this. We saw that staff members sat with people, explained what food they were giving people and encouraged them to eat as much as they could. However, we also noted that meals were delayed for those people who were cared for in bed as these were delivered when a staff member was available to assist the person.

Staff members received enough training to provide them with the knowledge and skills to meet people's care needs. People told us that they thought staff were able to meet their care needs. One person commented, "Some have specialist training."

Staff members told us that they received enough training to meet the needs of the people who lived at the service. They said that they had completed a mixture of practical hands on and theory training from the deputy manager and external trainers. They received annual updates to training and they were able to complete national qualifications. They told us that this included housekeeping and kitchen staff. One staff member told us that senior staff had received training from district nurses in diabetes management and

administration of insulin. This provided staff with skills and information, as well as ongoing support from the district nursing team.
Information sent to us before this inspection showed that staff had received training in a variety of different subjects including food hygiene, supporting people to eat and drink, and safeguarding adults.

Staff members told us that they did not have regular supervision meetings but that they felt well supported to carry out their job. They told us that the support came in other forms, such as team meetings, in which they could raise any issues they had. They could speak with the manager or deputy manager at any time and they felt that the deputy manager, in particular, provided them with support to carry out their roles as this person had worked at the home for a long time.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Staff members provided us with an explanation of the MCA and their role in ensuring people were able to continue making their own decisions as much as possible. We saw that staff members had received training in this area. We saw evidence of these principles being applied during our inspection visit. For example, people were supported by the staff to make decisions about the care they received, activities they took part in and what they did during each day.

We saw that some care records for people noted that they lacked capacity to make their own decisions in some areas. Staff completed mental capacity assessments for those decisions that people had difficulty making. However, these records did not contain details about how the person's lack of capacity had been assessed, which means there was no formal recording of how the decision had been made. Best interests decisions had been completed and information about how best to support people had been written into care plans. We saw that these records contained enough detail in regard to how staff members were to support people in continuing to make their own decisions where possible.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS require providers to submit applications to a 'supervisory body' for authority to lawfully deprive a person of their liberty. Staff had submitted applications to the local authority for people living at the home. The manager and deputy manager were aware of DoLS and the actions they needed to take if they had to deprive someone of their liberty in their best interests.
People told us that they had access to the advice and treatment from health care professionals and that staff members were available to accompany them if needed. One person told us, "they will arrange to either take you to the surgery or call the doctor out."

There was information within people's care records about their individual health needs and what staff needed to do to support people to maintain good health. We found evidence that people saw specialist healthcare professionals when they needed to. For example, one person received advice from a variety of professionals, including the community mental health team, while another person saw district nurses and a speech and language therapist.

Good

Is the service caring?

Our findings

People told us they were happy living at Briar House and that staff were kind and caring. One person told us, "I can't fault the carers, thay can't do enough", while another person said, "the staff are very caring, they look after us well." Visitors to the home echoed people's views of staff members and added that they trusted staff. Two visitors told us they were very happy with the level of care that their relatives received. One visitor commented, "[Relative] says staff are superb and look after her really well." They also said they felt that their relative was very happy living at the home.

During our inspection we found that staff were kind and considerate towards people, and developed caring relationships with them. We heard and observed laughter when people joked and talked with each other and with staff members. They were relaxed with the staff who were supporting them and the interactions we saw them have with staff were positive. The deputy manager and the staff members knew people well and spoke with people in different ways to ensure the person they were speaking with understood their meaning.

Staff that we saw were polite and respectful when they talked to people. They made eye contact with people and we observed staff communicating with people well. They were patient with people who found it difficult to verbally communicate and consequently understood their requests. One person's visitor told us how their relative had become upset when they had suggested something to the person. However, a staff member then suggested the same thing but in a different way and the person agreed but without becoming upset.

Staff involved people in their care and listened to their responses. People told us that staff asked them what they wanted and listened to their responses. One person said, "Yes,…I make my own decisions".

We saw that staff asked people what they would like to do and offered them options to help them decide. For example, we saw that staff members asked people where they wanted to eat their midday meal or spend their day. Once in their chosen location we saw staff members discuss with people where they wanted to sit. People were given choices about what to eat, drink and where to spend their time within the home. We saw that people were able to complete personal care tasks when they wanted to throughout the day and this was not limited to first thing in the morning. From our observations it was clear that people were consulted about their care.

Care records provided staff members with guidance about how able people were and we saw that people were encouraged to continue as much as possible for themselves. There was information in relation to the person's individual life history, likes, dislikes and preferences written within the person's care records.

People agreed with us when we asked if staff respected their right to privacy. We observed that staff respected people's dignity and privacy. They were seen quietly asking people whether they were comfortable, needed a drink or required personal care. We saw that the deputy manager spoke with people often to discuss how their day had gone and to talk about any difficulties they had. Care records indicated where people had contact with their families and information was recorded when staff members had

involved family members in people's care.

Good

Is the service responsive?

Our findings

Care plans were in place to give staff guidance on how to best support people with their identified needs such as personal care, communication, nutrition and with mobility needs. People told us that staff members helped them when they needed this, although they had to wait at times. Staff members told us that care plans were a resource in terms of giving information to help provide care and that all staff members helped to record details about people's daily lives.

We observed that staff were responsive to people's needs. They encouraged people to drink when they indicated that they were thirsty, to eat when they were hungry and to attend to personal care if this was required.

The care and support plans that we checked showed that staff had assessed people's individual needs before they moved into the home. This was to determine whether or not they could provide them with the support that they required. Care plans were in place to give staff guidance on how to support people with their identified needs such as personal care, nutrition and mobility needs, as well as with specific needs such as for oxygen use. We saw that although there was a variable level of detail, there was enough information in most plans for staff. However, we saw that people's care plans did not provide enough guidance for staff about how much people should drink or what to do if they did not.

Plans to guide staff on how to manage people's individual needs in relation to diabetes also did not give enough guidance about how to do this. We spoke with two staff members about one person's diabetes and what they would do if they had any concerns. Both staff members provided us with clear and appropriate explanations about the actions they would take and the signs that would prompt them to become concerned. One of the staff members was able to describe in detail about the person's needs and their usual blood sugar range. We saw that staff recognised and acted quickly in dealing with an urgent situation when a person's blood sugar reading was low. They then spoke with us about the information in the person's care plan and recognised why it was important to have individual information about how their diabetes affected each person. The staff member told us they would update these care plans with this information as soon as possible.

Staff members had reviewed care plans regularly and updated them when people's needs changed. They had also completed records that showed when care had been given, such as repositioning charts and daily notes. These provided an on-going summary of the care that people received and meant that records were up to date.

Care records were written in a way that promoted people's wishes and preferences. They included details about people's preferences, such as particular food likes and dislikes, hobbies and interests people had. Staff members told us that they used the care records to provide information about people so that they were better able to hold conversations with them. From our discussions with staff it was clear that they knew people and valued their opinion and company. They were able to tell us in detail about the people living at the home.

People told us about some of the activities that were available for them to participate in. One person told us, "I like the bingo and I like to go out." Another person said, "…they come up and ask me if I want to play Bingo, I know I don't have to if I don't want to but they always ask." We saw that there were organised activities and things for people to do each day. Staff encouraged people to participate and information about what was available was posted on notice boards. There were dedicated staff who concentrated their time specifically on helping people each day to occupy their time. We saw that people played games, such as dominoes, or were helped to continue previous hobbies, such as knitting. When these staff members were not occupied with group activity, they spent time individually with people in their rooms.

People told us they would be able to speak with someone if they were not happy with something. They would approach the deputy manager or a staff member and they were confident that their concerns would be resolved. Visitors also told us that they would raise any concerns with the deputy manager or a staff member.

A copy of the home's complaint procedure was available and provided appropriate guidance for people if they wanted to make a complaint. There were appropriate details about other organisations to contact if a complaint had not been resolved.

The deputy manager told us that complaints were immediately dealt with and we saw that seven complaints had been made in the previous 12 months. Records showed that these had been acknowledged and investigated, although not all complaints had been responded to within 28 days.

Requires Improvement

Is the service well-led?

Our findings

Information about how the service was monitored and people's views of the home showed that there were processes in place to assess and monitor risks to people and to develop and improve the service. However, we found that these processes did not always identify when systems were not working as well as they should. The manager or deputy manager completed audits, such as for the domestic environment, care plans and medicines management, every one to two months. They submitted the results of these audits electronically to the provider to feed into their overall monitoring system. The Regional Manager also completed a quality monitoring report every month to provide an overview of the monitoring systems used at the home.

These audits identified some issues and action was taken to address them. However, they were not detailed enough to identify that there was a shortfall in staffing numbers and the staffing tool used had not recognised that more staff were needed on one floor. This meant that people had to wait for care and we observed that people who needed help to eat also had to wait for their meals. Not all recruitment information for new staff had been obtained, food and fluid records were not always completed in enough detail and some complaints had taken too long to be responded to. Some care plans did not contain enough information for people's individual diabetes needs, and although staff members responded in the correct way, the records did not provide an accurate description or plan to meet these needs. This meant that while audits identified some issues of concern around the home, and these were resolved, they were not detailed enough to identify all issues.

Analysis of accident and incident records had been carried out and looked at the type of accident or incident that had occurred. This was an ongoing part of the electronic quality monitoring system and subsequently fed into on-going analysis. The analysis identified statistical information, which also provided ongoing graphs to show how many of these had occurred over a period of time. However, this was not in enough detail to show trends or themes, such as whether falls occurred more at one time of day or in one area.

People told us about meetings where they could share their views of the home, although not all of the people we spoke with chose to attend these. Staff members also told us that they could put their views of the running of the service forward at staff meetings. They were informed of any changes in subsequent meetings.

People we spoke with liked living at the home and enjoyed spending time with the staff who worked there. One person said, "They respect me for who I am … It's well managed." Another person also told us that they were happy now and that they thought the home was well managed.

Staff members spoke highly of the support provided by the whole staff and provider team. They told us that staff worked well together and that they all got on and covered for each other if additional staff were required. They told us the deputy manager was very approachable and that they could rely on them for support or advice. Staff members said that if they needed to contact the deputy manager out of normal

working hours, they were able to do this easily. We observed this during our inspection, when staff were able to discuss their concerns and any aspects of their work with the deputy manager. They were aware of the management structure within the organisation and who they could contact if they needed to discuss any issues.

Staff said that they were kept informed about matters that affected the service through supervisions, meetings and talking to the registered manager regularly. Staff knew what was expected of them and felt supported.

People told us that they knew that there was a new manager, although not everyone had met them. They told us that the deputy manager was approachable and available at any time. They told us that they were friendly and easy to talk to. We found that staff reported incidents to us and to the local authority as required. At the time of this visit the home had a registered manager, although this person was no longer in post. They have cancelled their registration with us since our visit. There was a new manager in post when we visited, although they had only been working at the home for less than a week at that point. They confirmed that they were in the process of applying to register with us (the Care Quality Commission).