SCC Adult Social Care

Birchlands

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Birchlands is a care home without nursing and accommodates up to 52 people in one adapted building. The building is divided into seven different living areas each with its own communal lounge, dining area and bathrooms. There is also a large communal area on the ground floor. The service supports adults requiring care and support due to their physical health and those living with dementia. At the time of our inspection there were 40 people living at the service.

People's experience of using this service and what we found
There was a lack of provider and management oversight of the service. Safeguarding concerns, accidents and incidents and complaints were not robustly managed which led to the same concerns happening again. Quality assurance processes were not effective in driving improvement and there was a lack of joint accountability regarding actions being completed. Audits were not completed regularly and where concerns were identified these were not always acted upon. Values and a positive ethos were not consistent which led to clear differences in people's experience throughout the service.

Risks were not always identified and safeguarding concerns were not always reported promptly to minimise risks to people's safety. There was a shortage of permanent staff which meant agency staff covered over 60% of shifts. Strategies had not been implemented to minimise the impact of this and ensure that staff worked well together as a team. Staff did not always receive the training and supervision required to support them in their roles.

People did not always receive person-centred care. Staff were not always aware of people's backgrounds and there was a lack of interaction in some areas of the service. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the systems in the service did not support this practice.

In other areas of the service we found that staff treated people with kindness and respect. There was a range of activities available to people which they told us were enjoyable. This included the opportunity to go out in the local community. People's religious and cultural needs were respected and there was regular access to church services. A relatives' group was active in organising social events for people.

People told us they enjoyed the food provided although improvements were required in making mealtimes more pleasurable in some areas of the service. People had access to healthcare professionals when required. People's rooms were personalised and in some areas of the service pictures and information about people's life histories were displayed on bedroom doors to aid conversation.

People, relatives and staff told us they found the registered manager approachable, kind and hard working.

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.

Rating at last inspection
The last rating for this service was Good (published 22 August 2017). Since this rating was awarded the provider of the service has changed. We have used the previous rating to inform our planning and decisions about the rating at this inspection.

Why we inspected
The inspection was prompted in part due to concerns received about the care people both directly from the service and from contact with relatives. A decision was made for us to inspect and examine those risks.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Enforcement
We have identified breaches in relation to the action taken in relation to safeguarding concerns, how risks to people's safety were managed and the deployment of skilled and experienced staff. Person-centred care was not embedded into practice, people's dignity was not always respected and the principles of the Mental Capacity Act 2005 were not upheld. Complaints were not reported and acted upon and there was a lack of management oversight of the service.
Please see the action we have told the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? 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 always caring. Details are in our caring findings below.	**Requires Improvement**
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**

Birchlands

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 Care Act 2014.

Inspection team
The inspection was carried out by five inspectors.

Service and service type
Birchlands is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. 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 took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

As part of our inspection we spoke with five people who lived at the service and five relatives. We observed the care and support provided to people. We also spoke with 11 staff members, the deputy manager, the registered manager, senior manager, and members of the quality assurance team. We reviewed a range of documents about people's care and how the home was managed. We looked at 12 care plans, medication administration records, risk assessments, safeguarding records and policies and procedures.

After the inspection
We requested for a range of information to be forwarded following the inspection. This included action plans, audits and staff training and supervision 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 the last inspection this key question was rated as Good. Since this rating was awarded the registered provider of the service has changed. We have used the previous rating to inform our planning and decisions about the rating at this inspection. At this inspection this key question has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Systems were not effective in ensuring people were protected from the risk of abuse. Due to the number of safeguarding concerns we received regarding the service, we requested an overview of all on-going safeguarding concerns prior to our inspection. The registered manager told us they were unable to forward this information as it required updating. During our inspection we reviewed the records which showed this information remained out of date and that actions required had not been recorded as completed. This meant the provider could not assure themselves that risks to people had been minimised.
- There were delays in safeguarding concerns being reported to the relevant authorities. Incident reports had not been fully reviewed for over three weeks. During this time, safeguarding concerns included people's safety monitoring equipment not being switched on, staff sleeping on duty, a person being hit by another person and people going in to other people's rooms. In addition, one staff member told us, "(Person's name) has told me the agency staff are rough. They've told me this four times and I've reported it, but nothing is done." Whilst immediate action had been taken in some instances, these concerns had not been reported to the local authority safeguarding team in order for them to consider investigating them.
- Reports did not always include detailed accounts of incidents and information. Following the inspection, we spoke with a professional who was conducting an investigation into an incident that occurred at the service. They told us the investigation had been difficult as staff statements did not record sufficient details and requests for additional information had not been responded to. This reflected our own experience in asking for additional information and copies of records.
- Incidents were not effectively reviewed to ensure any trends were identified. Each occurrence was being addressed in isolation rather than looking at a systematic approach to manage and monitor these risks. This meant lessons were not learned from incidents and their analysis in order to keep people safe.
- We found a number of concerns related to people's care at night. The registered manager told us there was no system in place for the management team to carry out night checks. Following our inspection, we asked for reassurances regarding the monitoring of people's care at night. A series of night checks were put in place, some of which identified further instances of staff sleeping and monitoring equipment not in use.

- Relatives were not always informed of incidents involving their loved ones. One relative told us they found out about an incident involving their loved one when this was mentioned to them by a staff member some time later. We requested they were updated regarding the outcome of the investigation into the incident.

The failure to ensure that effective systems were in place to protect people from the risk abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● We received mixed opinions from people, relatives and staff regarding staffing levels within the service. However, there were shared concerns regarding the high use of agency staff. One person told us, "There's enough of them but the trouble is we have a lot of new ones (agency staff)." The person indicated this meant it took longer for agency staff to do things as they did not know people. One relative told us, "It worries me so much that there are so many agency here. There are times when the agency are not really bothered." A staff member said, "The majority of time there are enough staff. It's just agency let them down."

● The registered manager confirmed that agency staff were used to cover approximately 60% of shifts during the day and approximately 80% of night shifts. They told us they felt the lack of consistency within the staff team led to many of the concerns noted within the service. They told us, "I want it to be safe. I want more permanent staffing so we can get to the stage where we can go home and feel staff were all competent and they could deal with whatever happened."

● The provider had not prioritised the recruitment of permanent staff. In the 10 months since the provider had taken over the running of the service only one new care staff member had been employed. The registered manager told us they were starting to look at incentive schemes in order to increase applications.

● The provider had not engaged staff in developing a positive culture between permanent staff and agency. This meant there was a lack of joint purpose which led to staff not working as a team to reduce the impact of high agency usage. The skills which agency staff were able to bring to the team were therefore not fully acknowledged.

● Staff were not always safely deployed. One person was known to move to different areas of the service and presented risks to themselves and others. For a period of over and hour in the morning with no access to support or supervision in their area. We informed a senior staff member when this happened again in the afternoon. They told us this should not have happened and addressed the concern with staff.

● In two areas of the service we observed people who were assessed as being at high risk of falls in communal areas with no staff member present to offer support if required. Staff also told us that they were required to support people to appointments which could leave them short of staff in individual areas.

The failure to ensure staff were safely deployed and had the skills required for their role was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recruitment checks were completed centrally by Surrey County Council HR department. We requested evidence regarding this but not all the information was provided by the service. However, there had been limited recruitment since our last inspection. Inspections of other SCC Adult Services care homes showed that safe recruitment processes were in place to ensure staff were suitable for their roles.

Preventing and controlling infection

● People and their relatives told us they were happy with the cleanliness of the service. However, we found safe infection control procedures were not consistently followed. Audits designed to identify infection control concerns had not been completed regularly and had failed to identify areas of concern.

● Soft furnishings such as dining chairs and lounge chairs were heavily stained in all areas of the service. People's wheelchairs were also dirty and contained a build-up of food debris. Pressure relieving cushions were torn leaving the foam exposed and unable to be cleaned effectively. We observed one person sitting on a pressure relieving cushion with no cover on.

● The sluice rooms were not routinely used to ensure soiled items were sanitised. A commode in one person's room was stained and had not been sanitised. Two staff members who worked regularly at Birchlands did not know the code for the sluice room locks. Sluice rooms were used as storage areas for mops and buckets which meant staff were unable to access the area easily for its intended purpose.

● Laundry areas were not always managed safely to minimise the risk of cross infection. In one area a red

bag containing soiled items had been placed in a laundry bag for general items. The washing machine had a large build-up of soap and staining around the door.
● The registered manager informed us that due to sickness there were no housekeeping staff on shift on the day of our inspection. We observed staff from other roles completing cleaning tasks. Whilst we acknowledge this, the concerns described above were on-going and not specific to the day of our inspection.

Assessing risk, safety monitoring and management
● Risks to people's safety and well-being were not always assessed and managed. There was a lack of clear guidance for staff regarding supporting people who displayed behaviours which challenged. For example, displays of behaviour towards people and staff, including when going into other people's rooms unsupervised. We spoke with two staff members who were unaware people had guidelines regarding their anxiety and behaviours. Risk management plans were not always followed such as staff completing hourly checks on people's welfare.
● Guidance for supporting people with risks to their safety was not always fully completed or clear for staff to follow. One person who was at high risk of falls had three different risk assessments in relation to this. Each was in a separate area of the person's file and the rating of the risk was not consistent. Where people had catheters in place, guidance was not available for staff on signs which may indicate infection or that their catheter was not working efficiently.
● Staff did not always follow safe techniques when supporting people to move. On three occasions staff were observed to put their foot on people's walking aids whilst they were sitting or standing. Whilst using this incorrect procedure a staff member was unable to move their stance to support a person who was struggling. They told the person they were sitting down too quickly. The person replied, "It's because you didn't do it right. I don't normally have any problem."
● Pressure relieving equipment was not regularly monitored to ensure it was working effectively. Staff told us they were unaware of how some pressure relieving mattresses worked and were therefore unable to complete checks. This meant people were at risk of any faults with the equipment not being identified and acted upon which may increase the risk of skin breakdown.
● Personal emergency evacuation plans were not up to date and staff did not know where these were stored. This meant information required to support people being evacuated may not be available to management, staff and the emergency services. The fire evacuation plan had been signed by less than half of the staff team. One third of permanent staff had not completed fire training within the last three years.

The failure to ensure risks to people's safety were effectively managed and that safe infection control procedures were implemented was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In some areas we found that risks were managed well and led to improvements in people's health. For example, one person was found to be losing weight and assessed as at risk of malnutrition. The person was referred to healthcare professionals and provided with fortified foods. Staff weighed the person weekly in order to closely monitor their weight. These records showed the person was gradually putting on weight.

Using medicines safely
● People received their medicines in line with their prescriptions. The registered manager told us measures had been implemented to ensure all staff had received additional guidance and training in this area. This had led to improvements in the systems used and minimised errors.
● Medicines were securely stored and stock checks confirmed these were correct. Medicines administration records contained a photograph of the person, their GP and any known allergies.
● Guidelines were in place for the majority of people who were prescribed as and when required medicines

(PRN). However, we identified some gaps in this process. The registered manager assured us this would be addressed. We will review this process during our next inspection.

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 the last inspection this key question was rated as Good. Since this rating was awarded the registered provider of the service has changed. We have used the previous rating to inform our planning and decisions about the rating at this inspection. At this inspection this key question 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.

Staff support: induction, training, skills and experience

- Staff did not always receive training relevant to their roles and training was not always effective. The lack of consistent training was in line with concerns identified within the inspection. Records showed low numbers of staff had completed training in areas including safeguarding, infection control, moving and handling and the Mental Capacity Act 2005. The registered manager maintained a training matrix which showed staff had completed only 38.5% of the required training.
- Agency staff told us they completed training using their agency systems. There was no joint training completed in any area in order to ensure staff were working to the same and processes.
- Staff had not all completed training in areas specific to people's needs. For example, less than 50% of staff had completed training in the last two years regarding supporting people living with dementia. Records did not evidence staff completing training in relation to positive behaviour support, catheter care, pressure care or other specific health conditions experienced by people living at Birchlands.
- Staff told us they felt they could approach the registered manager if they had a concern although they did not always receive supervision. One staff member told us, "I haven't had supervision for a while but I know they've been busy. I can speak up if I need to say anything."
- Staff did not receive regular supervision to support them in their role. The supervision matrix highlighted staff should receive supervision every quarter. However, records showed that in the six months prior to our inspection only 12 staff out of 35 had received a supervision. This meant staff did not have the opportunity to discuss training and receive feedback on their performance.

The lack of effective training and staff supervision was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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.

● People's legal rights were not always protected as the principles of the MCA were not followed. Information gathered from records and speaking with staff evidenced a number of people living at Birchlands needed support with making complex decisions. Despite this, we found that capacity assessments and best interests decisions had not been consistently completed where restrictions to people's liberties were in place. Restrictions included external doors being locked, the use of electronic sensors to monitor people's movement and lap belts on people's wheelchairs.
● DoLS applications had not been reviewed or monitored to ensure they contained all relevant information and were submitted in a timely manner. We asked to see a record of the DoLS applications which had been submitted or assessed. The registered manager told us they did not have an up to date list. They believed that applications had been submitted for some people but not for all those who required it. They acknowledged there was no systematic approach to ensuring this process was completed and reviewed.
● Two people's files showed that relatives had signed to consent to their loved ones care. However, there was no evidence that the relatives had the legal authority to provide this consent. No capacity assessment or best interest decisions had been completed regarding this decision.
● Some staff we spoke with demonstrated knowledge of the MCA. However, despite understanding the principles they were not putting this knowledge into practice.

The failure to ensure the principles of the MCA were followed in order to protect people's legal rights was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People's views of the food provided varied. One person told us, "It's all right sometimes but you don't know what you're getting." A second person told us "The food has always been good." One relative said, "The food seems quite nice. Not a bad quality. It can vary though if there are agency staff in the kitchen. The sandwiches the other Sunday looked awful."
● People did not always have a positive mealtime experience. Daily menus were not available to people in all areas of the service. Where these had been supplied, the options available were not the same as those listed. This meant people did not receive the meal they were expecting.
● People who required a modified diet such as their food being pureed, were not offered a choice. Staff told us pureed meals were prepared by the kitchen so they served the person whatever was provided on the food trolley. During the afternoon people requiring their food to be pureed had an option of yoghurt or mashed banana. However, no alternative was provided in the morning when others were offered homemade cakes.
● In some areas of the service people were sat at the dining table for over 40 minutes before their meal was served. Some people appeared disorientated by this and began to stand up and move around. Staff immediately brought them back to the dining table and asked them to be seated despite lunch not being available for some time. When lunch arrived one person stated, "About time too."
● In some areas of the service there was little atmosphere at lunchtime. Staff were seen to be walking around observing people with little interaction or discussion with people. There was no music playing and attempts to make the experience pleasant for people were limited.

The lack of person-centred support regarding people's choice of food and mealtime experience is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people's experience at lunchtime was more positive. People who did not require their food to be of a modified consistency were offered different food options. Two choices of main meals were offered to people at lunchtime. Staff showed people each option so they were able to see and smell the choices available. People were asked if they wanted more when they had finished.
● Where people required assistance to eat this was provided in a considerate manner. Staff sat alongside people to support them at their own pace. In some areas of the service staff responded well to people's needs and demonstrated understanding that some people may move away from the table and return to finish their meal later.
● People had access to drinks throughout the day. We observed staff offering people different options and providing support where required. A range of soft drinks and snacks were also available in each communal area.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had access to healthcare support when required. One person told us, "If I'm not well I see a doctor and I go to appointments." One relative told us their family member had regular reviews organised with a specialist nurse. They told us, "The staff always let us know how they've got on."
● Records showed that referrals were made to relevant healthcare professionals where required. These included the GP, community nursing services, occupational therapy and specialist consultants.
● People had access to dental care and oral healthcare plans were in place for the majority of people. Reports from people who had recently been seen by the community dentists reflected they were supported well with their oral hygiene.
● The registered manager told us they felt staff responded well to changes in people's health and referred to healthcare professionals promptly. However, they told us they had identified that some health care records required more detail. This had been discussed with staff and would be monitored going forward.
● The registered manager had recently completed training in 'Stop Look Care', an initiative aimed at identifying health issues early to prevent hospital admissions. They told us they aimed to roll out this training across the service.

Adapting service, design, decoration to meet people's needs
● Areas of the service were in need of refurbishment. In some rooms there were holes in the plaster where pictures had been removed. Some seating arrangements were low to the floor which made it difficult for people to sit down and stand up easily. The registered manager informed us this was an on-going project with safety of the building being the first priority. We will assess the progress during our next inspection.
● People's individual rooms were personalised and relatives and staff told us this was encouraged. Each person had their name on their bedroom door with pictures relevant to them or their interests. This supported people in identifying their own room. People and their relatives had been encouraged to decorate rooms with small items, pictures and ornaments to help people feel at home.
● People had access to all areas of the service via the lift. Corridors and doorways were wide enough to enable access for people using mobility aids and bathrooms were adapted.
Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider had recognised there were challenges in the service and as a result had placed a suspension on new admissions. This meant a limited number of assessments had taken place since the provider had taken over the management of the service.
● Where assessments had been completed, we found this contained relevant details to make decisions regarding if the service could meet people's needs. Assessments covered areas including personal care, mobility, healthcare needs and personal histories.
● Where people's needs changed the service requested people's needs were reassessed to establish if the

service could continue to meet their needs or if additional nursing care was required.
● Recognised assessments and recording processes were used to establish people's nutritional needs, oral health care plans and medicines administration.

Requires Improvement

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 the last inspection this key question was rated as Good. Since this rating was awarded the registered provider of the service has changed. We have used the previous rating to inform our planning and decisions about the rating at this inspection. At this inspection this key question has changed to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- There were mixed responses from people and their relatives regarding how they felt they were treated by staff. One person told us, "They're a good lot here. We get well looked after." One relative told us, "Most of them are very kind but some can be a bit sharp with them [people]." A second relative said, "You get warmth and friendliness. They talk to people as individuals, not as people with dementia. I am glad they are here; they are so well looked after."
- Staff did not always acknowledge and respond to concerns. During the afternoon people in one area of the service were sat in the lounge area. The television was on although this was not working properly. The picture was disrupted and froze frequently, intermittently squeaking. The staff sat apart from people writing notes and did not acknowledge this. We asked the staff member if the television was broken. They replied they thought this was due to the weather and returned to their notes. When a senior staff member came into the room we again highlighted the problem. They said they would report the issue and left the room without speaking to people or attempting to resolve the issue. The television remained on.
- Staff took time to let the inspection team know the fire alarms were about to be tested. We asked if people had been made aware. The staff member said they were aware as they were used to them. When the alarms sounded, we observed some people jump and one person shouted for them to shut up. Staff then offered reassurance.
- Staff did not always demonstrate a caring approach. One person had been sat waiting for their lunch for over 30 minutes. They asked the staff member if they could have a cushion as the chair was hard and uncomfortable. The staff member did not respond to their discomfort. A second staff member supported the person when they returned to the room.
- Relatives told us they found it upsetting that they regularly found their loved ones wearing other people's clothes and their belongings missing. One relative said, "I labelled all of mums stuff but there are times mum is wearing other people's clothes. It's not great, not very dignified for mum." Another relative told us they had experienced their loved ones wearing glasses that did not belong to them as well as other items of clothing. When visiting one person's room we saw toiletries with another person's name on and items of clothing which clearly did not belong to them.
- Attention was not always paid to people's personal appearance. People's nails were not always clean and men had not shaved. One relative told us that having a shave everyday was important to their loved one but

this often didn't happen.

The failure to ensure that people were supported with dignity and respect at all times was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In other areas we observed staff treating people with kindness. One person was trying to lay on the sofa but was struggling to get comfortable. The staff member supported them with cushions and asked if they wanted a blanket to keep them warm. Later in the afternoon we saw staff in the same area sat chatting with people, holding their hands, singing and laughing. People were clearly comfortable with the staff supporting them and enjoyed the interaction.
● Staff offered encouragement to people when they were mobilising or transferring. Reassuring touch was used along with gentle verbal prompts. People clearly responded to this approach from staff.
● Discussions with some staff demonstrated a caring approach and knowledge of people's personalities and preferences. One staff member told us, "We love our residents and they love us. We have so much fun and we all have our relationships with them."
● People religious and cultural needs were known to staff and respected. People's care records contained information regarding their beliefs and the support they required. One person's care plan stated their religion was important to them. Staff we spoke with were aware of this and the person's room contained items important to their faith. Regular non-denominational services were held which staff told us were well attended.
● People were supported to maintain their independence. Staff encouraged people to maintain their mobility and move around the service independently when they were safe to do so. People's care plans contained information on what people were able to do for themselves such as eating, drinking and elements of their personal care. One staff member told us, "If it takes longer for them to do it that's fine. It's important for them to keep doing what they can."
● Staff were observed to knock on people's bedroom doors and wait for a response before entering.
● We observed staff offering people choices in a range of areas. People were asked where they would prefer to sit, if they wished to go to the lounge and given a choice of drinks whenever they were offered.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. Since this rating was awarded the registered provider of the service has changed. We have used the previous rating to inform our planning and decisions about the rating at this inspection. At this inspection this key question has changed to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- The level of interaction between people and staff varied across different areas of the service. In some areas, staff appeared detached from people and focussed on tasks being completed rather than sitting and engaging with people. One relative told us, "Some of them are brilliant but others don't seem to [engage with people]." One staff member told us, "We've got a really nice team on this unit but it's a completely different atmosphere on some units. It's like some of them (staff) can't be bothered."
- People's care plans did not always contain comprehensive information in relation to their needs. Records were inconsistent and completed on a range of different forms which meant information was difficult to access. This was of particular concern due to the high number of agency staff used across the service who were not always fully aware of people's care needs and preferences.
- During the inspection we asked two agency staff members where we could access care plans for people in the area of the service they were working. They were unaware of where care records were stored and told us they had not had the opportunity to view them. This meant they were not fully aware of the needs and wishes of the people they were caring for.
- Information regarding people's life histories and preferences was not always known to staff. Not all staff were aware of people's interests and family members which meant they were not always able to generate conversations with people. Information within people's care plans varied in detail.
- Daily records were not always completed in a person-centred way. Tasks were recorded such as people's personal care being completed but no personalised information was not always included such as people's mood, how they interacted with others, activities they enjoyed or things they had found interesting.
- The care people wanted when nearing the end of their life was not consistently recorded. Some people did not have end of life care plans in place and there was no indication this had been discussed with them or their loves ones. Other people had brief plans which stated where they wished to be cared for and who they would like to be informed.
- The registered manager acknowledged that care plans and the communication of people's needs required continued improvement. They told us, "The standard of recording is not as it should be yet but it's starting to get better."

The failure to ensure people received person-centred care was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- In some areas we found staff knew people's needs well and responded to their approaches appropriately.

Some staff we spoke with were able to describe people's needs in detail. One relative told us, "There are core staff here who have been here for years and they know her so well."
● Communication files had been introduced in each area of the service which gave an overview of any handover information staff needed to know. The registered manager told us they felt this system was beginning to take affect and improve the way staff were updated.

Improving care quality in response to complaints or concerns
● People and their relatives told us they would feel comfortable in raising concerns. One person told us, "Well I would just tell the staff if I was unhappy." A relative told us, "The new manager seems nice. I think I could say something if I needed to.
● Despite these comments we found complaints were not always recorded and responded to. The complaints log was not routinely updated. This recorded that only one complaint had been received since the provider took over the management of the service in April 2019. However, relatives told us they had raised concerns including the lack of communication in respect of incidents and health appointments, clothes going missing, limited interaction in some areas of the service and family members wearing other people's clothes.
● As concerns had not been recorded and tracked there was no mechanism for the registered manager or the provider to identify trends. This meant they were unable to ensure that effective action was taken to improve the service and prevent the same concerns happening again. Relatives informed us the concerns they had expressed had not been resolved.

The failure to ensure complaints were monitored and acted upon was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.
● As highlighted throughout the report, communication and interaction from staff varied across the service. We spoke with two relatives who felt staff communication had had a positive impact on their loved ones. One relative told us, "In the seven years she's been here, they have turned her around. They don't respond to negativity and don't over-react. They always deal with things in a calm manner." A second relative told us their loved one had initially been reluctant to spend time in communal areas. With encouragement from staff their confidence had grown and they were now joining others in the lounge.
● Communication care plans varied in details and guidance. For some, this included guidance on sensory loss and we observed people received the support they required with this. For other people additional information would have been beneficial.
● Some people's bedroom doors gave information regarding their interests to prompt communication. Staff told us they were looking for ways to expand this to ensure people's communication needs were known.
● Staff were observed to make eye contact when speaking with people and sit or kneel beside them. One person was reluctant to move from the central communal area when the morning activity had finished. Staff acknowledged this but came back later to ask again, giving verbal encouragement. The person responded positively and accompanied the staff member back to their living area.

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 and relatives told us they enjoyed the activities provided. One person said, "There is always

something going on and they try and make them enjoyable." One relative said, "It's brilliant, they get everyone joining in and lots of variety." We observed staff and relatives joining in activities together.

● Dedicated activities staff were employed and a programme of activities was in place. One activity co-ordinator told us, "There are three of us which is good because we all have different skills that work together."

● Group activities were held each day in the central communal area and included quiz's, music sessions, exercises and visiting entertainers. In addition, activities staff spent one to one time with people who preferred a quieter environment.

● People had the opportunity to go out to various places of interest including local shops, cafes and garden centres. One relative told us, "They take him on the outings, they take him to go the shops." We observed one person become anxious about not being able to go out. The activities co-ordinator reassured then they were going shopping the following day. This made the person smile and generated conversation.

● Visitors told us they were made to feel welcome by staff and there were no restrictions on the times they could visit. One relative told us, "The staff are great and make time to chat with us."

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 the last inspection this key question was rated as Good. Since this rating was awarded the registered provider of the service has changed. We have used the previous rating to inform our planning and decisions about the rating at this inspection. At this inspection this key question 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

- The views of people and their relative regarding how the service was managed varied. Comments included, "I am happy with Birchlands and if I was worried, I would always bring it up with management. [Manager] is always willing to have a chat with me and she updates me about anything that has happened.", "It's okay but I don't always know what's happening, it seems a bit disjointed." And, "Things don't seem to get done and we're not informed. I never used to worry but I do now."
- There was a lack of management oversight of the service. The provider had assigned additional management resources to the service to support the registered manager. However, roles and responsibilities had not been defined which had led to a lack of organisation in monitoring the service.
- The service improvement plan was not effective in developing processes and driving improvement. The document was long with the overview page totalling over 130 action points. Each point was then broken down into additional actions. The registered manager and senior staff told us this made it difficult to comprehensively review and monitor progress made and action still required. The majority of the deadlines for actions to be completed had been missed although senior staff told us that some actions had been met in part.
- The majority of the actions listed were assigned to the registered manager. This had led to a lack of accountability for senior staff in ensuring actions were completed. Senior staff referred to working on points from the action plan, 'to help the registered manager out'. This demonstrated a disjointed approach to addressing concerns and ensuring consistent improvements across the service.
- Actions were responsive to specific situations rather than implementing overarching systems. This meant similar themes continued to emerge through safeguarding concerns, accidents and incidents and complaints.
- Systems were not implemented to monitor concerns and ensure learning to prevent them from happening again. Minutes from a night staff meeting on 6 November 2019 showed poor practice had been discussed and staff informed this was not be acceptable. Concerns included staff sleeping on duty, sensor monitoring equipment being disconnected and marks such as bruising, redness or sores not always being reported. Despite these concerns being highlighted, no night checks had been completed by senior management team. Incident records for February 2020 detailed these concerns continued to be identified.
- Quality assurance processes were not embedded into practice and did not always identify areas where improvement was required. The registered manager told us a range of monthly in-house audits were

completed by senior staff. These included infection control, daily health and safety checks and catering. However, audit files showed these had only taken place once in the past 12 months and records had not been fully completed. The issues we found during the inspection had not been identified. No review or checks on the audit processes had taken place.

● Provider audits of the service were not regularly completed. Senior managers told us that due to the pressures in the service they had been supporting the registered manager to review actions and had not completed audits in line with the schedule. This meant the provider did not have a system of reviewing progress or assuring themselves people's needs were being met.

● Where audits had taken place, this had not led to improvements. For example, a provider audit completed in July 2019 had identified a review of people's needs in line with the Deprivation of Liberties Safeguards (DoLS) was a high priority. However, we found this had not been completed and the registered manager was unaware of what action had been taken to complete these reviews.

● Reviews of individual records and systems had led to training and guidance being provided in some areas such as malnutrition screening and medicines administration. Checks had also been introduced in wheelchair safety. We will check these systems have been fully embedded into practice during our next inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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

● There was a lack of shared values and positive culture across the service. There were significant differences in the care people received in different areas of the service which relatives and staff attributed to the high use of agency staff. Processes had not been implemented to create a cohesive team spirit between different staff groups to establish common goals and accountability.

● Staff told us there were delays when resources were requested which did not make them feel appreciated. One staff member told us staff had requested a number of items including new towels for people several months ago. They said, "They promised us, but we've still not got them. It makes me feel unvalued and unsupported. It's not their fault (people) that things aren't right. They deserve to have the best care. We will club together ourselves to buy things for them because we care."

● The reporting and response to incidents, risks and concerns was inconsistent. Processes were not always followed in a timely manner to minimise risks to others and ensure robust management oversight of safeguarding, accidents and complaints. Inconsistencies were also identified in the way relatives were informed and updated when incidents and accidents occurred.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

● Whilst systems to improve communication amongst staff had been made within individual areas of the service, mechanisms for sharing messages across teams were limited. Staff meetings were held separately with no standard agenda items to share messages and for staff to receive joint feedback. Heads of departments did not meet regularly to share suggestions or feedback in order to drive improvement.

The lack of effective management oversight and good governance was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had not notified CQC of all significant events that had happened in the service. Services that provide health and social care to people are required to inform the CQC of important events. We identified safeguarding concerns during the inspection which the provider had failed to notify us of. This meant we were unable to effectively monitor the service provided. The provider submitted these notifications

retrospectively following our inspection.

Failing to submit statutory notifications was a breach of Regulation 18 of the of the Care Quality Commission (Registration) Regulations 2009.

● The provider had acknowledged there were significant concerns with the service provided to people at Birchlands. They had asked for additional support from the local authority in planning improvements.
● Staff told us they felt the registered manager worked hard and was approachable. One staff member said, "The manager had a jolly hard job. She works very hard. She knows she has things to learn. She has an open door which is really a blessing. She has an open-door policy for residents and has them with her having a cup of coffee. I think that's important." A second staff member said, "(Registered manager)is really hands-on. She is trying really hard to sort everything out."
● Residents meetings were run regularly by the activities team. Feedback was gained on the areas such as housekeeping, catering and activities people would like to do.
● The registered manager told us they had not yet collated feedback from people, relatives or staff regarding the running of the service. They said they intended to do this in the near future.
● A family group had been established and met regularly to discuss the service and ways in which they could support people and staff. One relative told us they were able to raise any concerns and the management team was always in attendance. They told us part of the group's role was organising activities and events, "We have organised a summer fair, a Christmas fair, quizzes, there is a craft day coming up, we had a pamper day a few weeks ago. [Manager] always comes along and supports whatever we do."

Working in partnership with others
● The service had established positive relationships with local community groups. People received visits from a nursery group which was a positive experience for both people and the visiting children.
● In addition to church groups held in the service, people also took part in a regular service held at a local church which was designed for those with additional needs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to ensure statutory notifications were submitted in line with regulations

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people received person-centred care and had a positive mealtime experience

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that people were supported with dignity and respect at all times

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure the principles of the MCA were followed in order to protect people's legal rights

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

personal care	care and treatment The provider had failed to ensure risks to people's safety were effectively managed and that safe infection control procedures were implemented

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure that effective systems were in place to protect people from the risk abuse

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to ensure complaints were monitored and acted upon

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure effective management oversight and good governance

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff were safely deployed, had the skills required for their role and had received effective training and supervision