Four Seasons Homes No. 6 Limited

Birkin Lodge Care Home

Inspection report

Camden Park
Hawkenbury
Tunbridge Wells
Kent
TN2 5AE
Tel: 01892 533747
Website: fourseasons@fshc.co.uk

Date of inspection visit: 26 May 2015
Date of publication: 03/09/2015

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection was carried out on 26 May 2015 and was unannounced. There were 32 people using the service at the time of our inspection, some of whom had a physical disability and some people living with dementia. The home provides personal and nursing care.

At our previous inspection on 11 and 12 February 2015 we found breaches of nine regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which came into force on 1 April 2015.

We issued three warning notices in relation to care and welfare, quality assurance and not having enough staff. We told the provider they must improve in these areas by 6 April 2015.

We also found a further six breaches of regulation. These were in relation to nutrition and hydration, obtaining

Summary of findings

consent, staff training and support, infection control, safety of the premises and record keeping. We asked the provider to tell us what action they were taking. The provider sent us an action plan and told us the regulations would be met by 3rd July 2015.

At this inspection we found that some improvements had been made towards meeting the warning notices, however, the provider had not completed all the actions they told us they would take. The provider was continuing to breach regulations in respect of care and welfare and quality assurance. We found that the impact for people using the service had reduced and people told us the care had improved.

Whilst carrying out this inspection we found that the provider had fully met five of the requirement actions ahead of their 3 July timescale. We found that there were still some breaches in record keeping and therefore the requirement action in respect of record keeping has remained in this report. We found a further breach of regulation in relation to providing a personalised service.

The registered manager was on long term leave from the service. A registered manager is a person who has registered with the Care Quality Commission to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. An acting manager had been appointed and had been in post for four weeks.

People said the service they received had improved since our last inspection. Comments from people included, "I'm quite satisfied with the way it is run" and "Things seem to be turning around." People said staff were caring and that there were more staff available to meet their needs. Comments included "We don't have to wait so long now", "They are very good at what they do, they help me when I need it" and "I can't wish for better carers". However, people felt that they did not have enough links with the local community or opportunities to go out.

The risk of people developing a pressure wound had reduced and staff had received further training to effectively manage these issues and prevent them occurring again. However there were no checks made of pressure relieving air mattresses to ensure they were working effectively for people's individual needs.

More staff were now available on each shift and the allocated numbers had been increased. Increases in staff numbers meant that staff had more time to engage in conversation with people throughout the day. However, some staff were still task centred and mostly engaged with people only when carrying out care tasks with them.

Improvements had been made to the training staff received. Nursing staff had received further training in managing the risk of pressure wounds. Staff had been trained in moving people safely and people were helped to move safely and in a way that promoted their comfort.

The risks associated with people losing weight had not been consistently managed. Two people who required their weight to be checked each week had only had this done monthly. This meant that nursing staff could not quickly identify if their weight loss was continuing and take action.

The provider had made changes to the values of the service and had begun to put these into practice, but these had not yet been embedded into the culture of the service.

People who spent most of their time in their bedroom did not have plans in place to meet their social needs.

Staff knew people well and treated them kindly. Most staff treated people with respect and upheld their dignity. However, we saw one occasion where a person's privacy was not respected whilst using the toilet and people's dignity was not always upheld whilst being hoisted.

People living with dementia did not have their needs properly assessed or planned for. They did not have plans in place to help them find their way around the service or to support them when they were distressed. Not all staff had received training in dementia to support them to do this.

The systems for monitoring the quality and safety of the service had improved, however, the acting manager had not completed the checks they had told us they would

Summary of findings

make on the effectiveness of the call bell system. Accurate and complete records were not consistently kept. This meant that the acting manager could not check that people were getting the care they needed.

We found that improvements had been made to the cleanliness of the premises and to the systems for managing the risk of the spread of infection in the service.

There were effective systems in place for checking the safety and security of the premises.

People's medicines were managed in a safe way and people received the medicines they needed.

All staff had been supervised by a member of the management team to ensure they had the skills to carry out their role.

People consented to their care and treatment before it was provided. The requirements of the Mental capacity Act 2005 were met when people could not give consent or make their own decisions.

People were provided with sufficient amounts to eat and drink to meet their needs.

People had their specific health needs planned for and met, for example people with diabetes who required checks of their blood glucose levels.

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

Summary of findings

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 consistently safe.

Risks were not always appropriately managed to reduce the risk of pressure injury or the management of people's weight loss.

There were enough staff to meet people's needs.

People were protected from the risk of the spread of infection in the service.

People's medicines were managed safely and they received their medicines in a timely manner.

Requires improvement 

Is the service effective?
The service was effective.

People were supported by staff that understood their needs.

People were only provided with care and treatment they had consented to.

People were supported to eat and drink sufficient amounts to meet their needs.

People had their specific health needs met.

Good 

Is the service caring?
The service was not consistently caring.

People's privacy was not always respected.

People were supported to be involved in their care.

Staff had positive relationships with people.

Requires improvement 

Is the service responsive?
The service was not consistently responsive.

People did not always receive personalised care.

Requires improvement 

Is the service well-led?
The service was not consistently well led.

The service was not consistently led in a way that reflected the values of the organisation.

The acting manager had begun to demonstrate good leadership, but this was not yet consistent throughout the service.

Accurate and completed records were not always kept to ensure people's needs were met.

Requires improvement 

Birkin Lodge Care Home

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 26 May 2015 and was unannounced. The inspection team consisted of two inspectors, a specialist professional advisor, who was a nurse, 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.

We gathered and reviewed information about the service before the inspection, including information from the local authority and previous reports. We spoke with the safeguarding team and the commissioners of the service to gather their views of the care provided. We looked at notifications we had received from the provider.

We spoke with seven people and four people's relatives. We spoke with the acting manager, clinical lead nurse and five members of care staff. We also spoke with a member of the housekeeping team. We looked at the care and support that people received. We looked around the premises and at people's bedrooms, with their permission. We looked at care records and associated risk assessments for seven people. We looked at management records including audits, medicines records, staff rotas and records of staff training and support.

Requires improvement

Is the service safe?

Our findings

At our inspection on 11 and 12 February 2015 people did not always have the risks of developing pressure wounds on their skin managed properly. There were also not enough staff available during the day to care for people safely and meet their needs. We issued warning notices for these two regulations and told the provider they must improve by 6 April 2015. We also found breaches of regulations in the following areas. People were not protected from the risk of infections spreading within the service. The premises were not maintained securely and people's medicines were not managed in a safe way. We issued requirement actions to the provider. The provider sent us an action plan which said they would make the improvements by 3 July 2015.

At this inspection we found that some improvements had been made. However, the provider had not fully met the requirements of one of the warning notices.

People had a care plan in place that instructed staff how often they needed to be repositioned to relieve pressure on their skin. People's care plans had been updated to reflect the most current information about their skincare needs. Staff understood the care plans and we saw staff repositioning people, as instructed by their plan, throughout the day, to ensure they did not develop pressure wounds. Qualified nursing staff had received further training and guidance in preventing and managing pressure wounds. The deputy manager and the lead nurse were booked to attend further in depth training about caring for people's skin. Three people had a pressure wound at the time of our inspection; however, no one had developed a new pressure wound since our last inspection. Nursing staff were monitoring their wounds in detail and were recording the size of the wounds so that they could check the improvement on a daily basis.

Pressure relieving equipment, including mattresses and cushions were checked by maintenance staff monthly to ensure the equipment was in good working order. Checks had not been made of the setting of air mattresses to ensure it was the correct setting for each individual's weight. Care staff were not able to tell us what the setting should be for each person, so they would not be able to identify if the mattress was set correctly for the person. This placed people at risk of developing a pressure injury. Equipment had not been used effectively to reduce the risk of pressure injury.

The care plans had been reviewed and updated for people who had recently lost weight. This instructed staff to check their weight more frequently. However, in two people's case this information had not been added to the nurse's weight monitoring schedule and as a result their weight had not been checked more frequently. The people had not been weighed since the weight loss was noted and therefore the nursing team could not identify if a weight loss problem continued. Risks to individuals' wellbeing had not been managed properly in relation to their weight loss.

The examples above showed the provider had not taken appropriate steps to ensure the safe use of equipment and monitoring risks to people's wellbeing. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A system was used to identify the number of staff required to meet people's needs. The acting manager told us that eight care staff were required on a morning shift and seven on the afternoon shift with a registered nurse on duty on each shift. The staff rotas showed that, in the majority, these staffing numbers were provided. There were three occasions where there were only seven staff on shift on the morning shift and one occasion where there was only six in the afternoon. However, the deputy manager had worked on shift to ensure people's needs were met. There were staff vacancies and some agency staff were used to fill these. The acting manager told us that they had not been made aware by staff that they had been unable to secure additional agency staff. The acting manager was actively recruiting new care and nursing staff, with interviews being held on the day of our inspection.

Staff said the staffing levels had increased in the service since our last inspection and that this had made it easier for them to carry out their roles safely and effectively. At our last inspection we noted that call bells were ringing for long periods of time without being answered. At this inspection call bells were mostly answered quickly, and staff were seen to make regular checks of people that remained in their bedrooms.

Staff had access to sufficient supplies of personal protective equipment, such as gloves and aprons. We saw

Requires improvement

Is the service safe?

that staff used these when providing care and carrying out cleaning duties. Staff washed their hands regularly throughout the day. Housekeeping staff had a good understanding of how to safely use and store cleaning products and how to prevent the spread of infection through effective cleaning and regular hand washing. The housekeeper had a system for checking the cleanliness of the premises each day and records were kept of these checks. Records showed that people's bedrooms, communal areas and bathrooms were cleaned and checked daily. The premises were clean and staff had the necessary equipment to prevent and control the risk of infection. Improvements had been made to the cleaning of the premises and there were no areas of the home with unpleasant odours.

The security of the premises had improved and visitors were no longer able to let themselves into the building without staff being aware of their presence. There were effective systems in place for checking the safety of the premises, including the operation of fire alarms and firefighting equipment. People said they would be supported by staff to the fire evacuation point in the event of a fire in the building. We saw that fire drills had taken place and the procedure for evacuation had been followed.

Medicines were stored securely and the temperature of storage areas was being monitored. People told us that they received their medicines at the correct time and a relative told us they were confident that their relatives received the pain relief they needed. Nursing staff understood what medicines people were prescribed and why. They were aware of possible side effects and knew what allergies people had. Changes to people medicines were documented clearly and their care plan updated. Records of medicines administered to people were maintained accurately. There was clear guidance for nursing staff to follow when administering people's medicines. For example, when to administer a medicine that was prescribed to be given 'as required' and any medicines that should not be given together. Excess medicines were returned to the pharmacy following secure procedures. This meant that people's medicines were managed and administered safely and in line with recommended guidance.

People said they felt safe in the service. They told us they were treated well by the staff and they felt their belongings were secure in the service. One person said, "I don't have to bother about anything". People told us that there had been a shortage of staff prior to our last inspection; but that this had "Greatly improved" and that "We don't have to wait so long now for help now".

Staff understood the risks for each individual they were caring for, for example they knew who was at risk of dehydration or falling. People had risk assessments within their care plan file for these risks and staff followed the guidance contained within these.

Staff had been trained in moving people safely and followed safe practices. Two members of staff were available to help people to move using hoisting equipment. Staff showed they were confident in moving people safely and reassured people throughout the process. People told us they felt safe when they were being helped to move.

Good

Is the service effective?

Our findings

At our inspection on 11 and 12 February 2015 we found that the provider had failed to ensure they had suitable arrangements in place to enable staff to be supported to deliver care and treatment to services users effectively. People's rights were not protected because suitable arrangements were not in place to show that assessments of people's mental capacity were completed. People were not protected against the risks of inadequate hydration due to the lack of accurate monitoring of fluid intake and records. We issued requirement actions to the provider. The provider sent us an action plan which said they would make the improvements by 3 July 2015.

At this inspection we found that improvements had been made. Nursing staff had received further training in specialist nursing procedures, such as pressure area management, catheterisation and venepuncture. Nursing staff received clinical supervision monthly, with the lead nurse, and they told us they could raise any issues with a member of the management team at any time. All staff had met with their line manager, to discuss their work. One member of staff told us the training was 'reasonable' and that most of it was e-learning. Another staff member said that they had received a wide range of training and told us 'We are always learning.' Staff had received most of the training they needed to carry out their roles. Training courses had been booked to address the gaps in staff knowledge and to provide refresher courses for staff to update their skills.

Staff told us that they had a detailed induction when they started working in the service. They shadowed more experienced staff and completed training courses and a workbook. Most staff felt they were well supported in their roles. People said the staff knew how to meet their needs. One person said, "They are very good at what they do, they help me when I need it". Another person told us, "The regular staff know what help we need, but sometimes the agency staff don't because they don't come here often".

Not all staff had received training in caring for people living with dementia. Some staff told us they were unsure how to help people living with dementia to be engaged and occupied. We have made a recommendation about this. **We recommend that the provider seek further guidance on the provision of appropriate training for staff in the care of people living with dementia.**

Staff showed a good understanding of the process to follow when people did not have the mental capacity required to make certain decisions. Assessments of people's capacity to make decisions had been carried out in line with the 2005 Act. People were asked their consent before care was provided and their records showed they had been involved in their care planning to ensure they agreed to the care that was to be provided. The clinical lead and deputy manager had undertaken recent training in the Mental Capacity Act and Deprivation of liberty safeguards (DoLS) and showed through describing the process to us that they understood the requirements.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. The manager understood when an application should be made and was aware of the Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. DoLS applications had been made as required for people to ensure they were not deprived of their liberty unnecessarily.

People were offered drinks regularly and those at risk had their fluid intake monitored. Staff knew who required support to drink and made sure they regularly offered people support to have a drink. People that remained in bed were provided with jugs of juice or water within their reach. Cold drinks were available in the lounges for people to serve themselves as they wished.

We saw that people had pleasant mealtime experiences. They were provided with food that they had chosen and were given sufficient time to enjoy their meal before a dessert was offered. People were provided with three meals a day and biscuits, cakes and fruit were made available to people through the day and evening. There was a choice of drinks, which were replenished when needed. Hot drinks were delivered during the day and people were provided with fresh water jugs in their bedrooms each day to keep them hydrated. Staff checked that people remaining in their room had enough to drink.

The food was served hot and people told us they enjoyed the food. One person said, "They will give you something else if you ask." And another said, "I think the food is lovely." People appeared to be enjoying their meals and chatted socially with each other and with staff throughout. The acting manager joined people for lunch and chatted with them throughout the meal.

Good

Is the service effective?

People had their health needs met by nursing staff. People who required regular blood glucose monitoring for diabetes had this done. We heard staff reporting concerns about people's health and wellbeing to the registered nurse during our visit, for example concerns about low fluid intake. This was also included in the handover to the next shift. A visiting dentist and chiropodist were available for people to use or they could choose to continue using their own preferred practice.

Requires improvement

Is the service caring?

Our findings

We saw that staff mostly respected people's privacy and dignity by knocking on their doors before entering and only discussing personal information about people in private areas. However on one occasion we saw that staff hoisted a person onto a toilet with the toilet door open. When people were hoisted in communal rooms, staff did not take action to ensure their dignity by adjusting their clothing to ensure they were covered. **We recommend that the provider review staff practice to ensure people's right to privacy is consistently upheld.**

Everybody said they were treated in a caring way by staff. One person said, "I find that they care" and another said, "I can't wish for better carers". People said their dignity and privacy were respected. They said that staff never entered their rooms without knocking and made sure doors were closed when personal care was being given. One person commented that there was now a good atmosphere in the home; they said, "Carers come in and we have a joke."

We saw that staff demonstrated patience and kindness when supporting people. However, some people still experienced a task centred approach to their care. By this we mean that they had positive interactions with staff, but these were usually only during care tasks. Some people remained in their bedroom for most of the day and only saw a staff member when they were being helped with personal care or provided with meals or drinks.

Staff knew people well and understood what was important to them. Staff showed an interest in people and asked them questions about their family and their own well-being. Staff addressed people in the way they preferred and we saw that staff understood when they needed to change the way they communicated for individuals, for example by positioning themselves on the correct side of a person who was hard of hearing in one ear. Staff provided reassurance to people when hoisting them to move them to other seating. They did not rush people and listened to them throughout the task.

People and other relevant people, such as their relatives, had been involved in developing the person's care plan.

Requires improvement

Is the service responsive?

Our findings

The specific needs of people living with dementia had not been assessed or planned for. One person's records identified that they had difficulty finding the toilet, but no adjustments had been made to the environment to help them find their way, As a result their records showed some episodes of incontinence. The person did not have a care plan in place to help them with the symptoms of their dementia. People living with dementia did not have care plans in place to tell staff how to support them when they became confused or distressed. We saw that one person spent a lot of their time in their room shouting. Some staff said they were unsure how to support this person to be meaningfully engaged in activities of interest. The person had no care plans in place to guide staff in helping the person to be occupied in the way they wished.

People were not always provided with social activities that were personalised to them and kept them occupied in the way they preferred. The activities worker was on leave on the day of the inspection, and there were no social activities arranged for people to occupy themselves. People said that usually there was an activity during the day, but that nothing had been arranged in the absence of the activities worker. Most people with high support needs were cared for in their bedrooms. We saw that there was no care plan to ensure people were provided with appropriate social opportunities and to reduce the risk of social isolation.

Some people were not dressed at lunchtime. Staff told us this was not unusual and reflected their wishes, but there were no records to show that they had been offered and declined care. We saw that many people remained in wheelchairs in the lounge instead of being transferred to more comfortable armchairs. This did not promote their comfort. Their care plans did not identify that this was their preference.

The provider had not always ensured that people received a personalised service that met their individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they received the care they needed and wanted. They said that they had a care plan that addressed their needs and that staff, "Know what we need".

People had been involved in planning their care which reflected some of their preferences. Staff knew how people preferred to be cared for, for example those that preferred to get up early and those that preferred to have a lie in. People's preferences about how they took their medicines were recorded and there was information for staff about people's likes and dislikes of particular foods. This meant that staff had information about these preferences so that they could deliver the care people wanted.

A relatives and residents meeting was scheduled for the following day to seek people's views about the service provided and to inform them of improvements that were to be made. For example, the planned refurbishment of the building. All had been invited to add to the agenda and it was an opportunity for everyone to meet the acting manager.

The service operated a resident of the day scheme. This meant that once a month each person was the focus of a review of their needs and their care. They were asked about the care provided and their plans were updated. Staff said that this meant that everyone had their care plan reviewed at least monthly and it was a 'good way for staff to keep up to date with the care plan'.

Requires improvement

Is the service well-led?

Our findings

At our inspection on 11 and 12 February 2015 we found that the provider did not have effective systems for monitoring and improving the quality and safety of the service. We issued a warning notice about this and told the provider they must improve by 6 April 2015. At this inspection we found that improvements had been made, but there was still a breach of regulation.

Following our last inspection the provider wrote to us and told us they were now carrying out audits of the response times to call bells. The acting manager told us they had done this informally, but there were no records to evidence this had happened or to show what action had been taken. The manager did not have a way to check that staff were answering call bells within a reasonable time. However people did tell us that the staff response to their call bells had improved since the last inspection.

At our inspection on 11 and 12 February 2015 records were not being properly maintained for the purpose of safe delivery of care. This meant that the manager could not check whether people were receiving the care they needed. We issued a requirement action to the provider and they told us they would make improvements by 3rd July 2015. At this inspection we found that improvements had been made and the service was working toward meeting their action plan timescale of 3rd July 2015. However, they had not yet fully met the regulation.

There were gaps in the completion of fluid and repositioning charts, for example one person had no record of any fluid intake for the day of the inspection, however we had seen them being supported to have a drink. There were gaps in the charts required to be completed by staff to show they had checked the safety of people remaining in their bedrooms. Some people needed to be checked every 30 minutes, but their records showed hourly checks. The inconsistent completion of records meant that the acting manager was not able to effectively monitor that people were receiving the care specified in their care plan.

Staff checked medicines as part of the daily handover, however the record to confirm this had not been completed since 21 May 2015. This placed people at risk because errors in the administration or storage of medicines would not be identified.

The acting manager had introduced a system for the nurse in charge to check that all records in people's bedrooms were completed each day. This had been started on 19 May 2015, but had not been completed on any further occasions. We found gaps in the completion of records, which meant that the acting manager could not be sure that people had received the care they needed.

Effective systems were not in operation to ensure the safety and quality of the service. Records for the purpose of running the service and delivery of care were not consistently completed. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said the service had 'greatly improved' since our last inspection and that "Things seem to be turning around." People told us that the new manager had visited them and spoke with them to get their views of the service and how it could be improved. One person said, "I'm quite satisfied with the way it is run." People and their relatives said that they felt the current management team were open and honest and kept them up to date with changes in the service. One person told us that, "The administrator is outstanding. She is also good at contacting us."

The provider had developed a clear vision and set of values, based on the principles of personalised care. They had begun cascading this to staff and people. Daily 'flash' meetings were held with all heads of department and the acting manager to discuss the issues of the day and how people's needs could best be met. The values of the service were incorporated in the discussions at each meeting. However, the values of the organisation had not yet been fully embedded in a consistent way throughout the service. We saw examples of care that was not personalised and examples where people's right to privacy and dignity was not upheld.

There had been a further management change since our inspection in February 2015. The acting manager in post at this inspection had been working in the service for four weeks. They told us it was planned they would remain at Birkin lodge until the registered manager returned to work. The acting manager was aware of the majority of the risks and challenges that faced the service and had an action plan to ensure improvements were secured and sustained. They told us the registered provider had been supportive in

Requires improvement

Is the service well-led?

ensuring they had the resources necessary to make the improvements, for example an increased staffing budget and a refurbishment budget. A plan for refurbishment of the premises was in place and set to begin in July 2015.

Recent quality audits had been carried out in the areas of medication, pressure area care and choking risks. These had contributed to the action plan the acting manager was working through to make improvements to the care and service.

Staff said they felt the communication had improved in the service and that handovers were more effective. One staff member told us, “There is a good team. We work very well and communication is good.”

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People did not always receive personalised care that met their individual needs, particularly those living with dementia.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The risks to people's well-being were not always effectively managed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered provider did not ensure effective systems were in place to monitor and improve the quality and safety of the service.**