HC-One Oval Limited

Birch Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Birch Court is a 'care home' providing accommodation, nursing and / or personal care for up to 150 older adults; some of whom lived with dementia. At the time of the inspection 71 people were living at the home across three separate units.

People's experience of using this service and what we found
Recruitment processes were safely in place, but staffing levels were not safely or effectively managed. Observations during the inspection and feedback we received, confirmed that inadequate staffing levels was impacting the provision of care people received. One relative expressed that the home was "grossly understaffed."

People were not receiving a safe level of care, areas of risk were not robustly reviewed or safely managed. Care records contained information and guidance that staff needed to follow as a measure of managing risk and keeping people safe, but this was not always followed.

Infection prevention and control (IPC) measures and arrangements were not embedded and we were not assured that people were protected from risk. Both internal and external premises were unkempt, shortfalls were not identified or responded to in a timely manner.

Poor quality assurance and governance measures meant that the quality and safety of care people received was compromised. The provider did not ensure that quality performance measures were robustly in place, that areas of risk were safely managed, or regulatory requirements were complied with. Ineffective audits, tools and governance checks meant that the provision of care was not suitably assessed, monitored or improved upon.

Medication procedures had improved. People received their medicines by trained and competent members of staff, people received support with their medicines in line with administration guidance and 'as and when' (PRN) protocols were in place. However, we identified some areas that need strengthening. We have made a recommendation regarding this.

Staff were passionate about providing care and support that people needed but they told us they didn't feel valued or supported in their roles. Staff expressed that they were under a lot of pressure, weren't listened to when raising concerns about staffing levels and their well-being was impacted upon.

Rating at last inspection and update
The last rating for this service was 'requires improvement' (published 17 December 2019). We found breaches of regulation in relation to safe care and treatment and staffing. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made. We found the provider was still in breach of multiple regulations.

Why we inspected
We carried out an unannounced inspection to follow up on concerns we had received from the Local Authority in relation to staffing levels and the impact this was having on the quality of care people were receiving. The information The Care Quality Commission (CQC) received indicated that there were concerns around staffing as well as safe care and treatment.

Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

We looked at IPC measures under the 'safe' key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

Our report is only based on the findings in those areas at this inspection. The ratings from the previous comprehensive inspection for the effective, caring and responsive key questions were not looked at during this visit. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used to calculate the overall rating at this inspection.

The overall rating for the service has remained 'requires improvement'. This is based on the findings at this inspection. We found evidence that the provider still needs to make improvements.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches in relation to safe care and treatment, staffing, premises and equipment and good governance. Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will 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. We will request that the provider submits further action plans to determine if they have addressed the breaches of regulation we identified.

We will meet with the provider following the publication of this report to discuss how they will continue to make changes to ensure they improve their rating to at least 'Good'. We will work with the local authority to also monitor progress.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Birch Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection prevention and control measures in place. This was conducted so we could understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors, two 'Experts by Experience' and a specialist nurse advisor. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Birch Court is a 'care home'. People in care homes receive accommodation, nursing and / or personal care as a single package under one contractual agreement. The Care Quality Commission (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 inspection
We reviewed information we had received about the service since the last inspection. We also sought feedback from the local authority who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information providers are required to

send us with key information about their service, what they do well, and improvements they plan to make. We used all of the information we received to plan our inspection and formulate a 'planning tool'.

During the inspection
We spoke with the registered manager, an area manager, 15 members of staff, one-unit manager, a registered general nurse, and 22 relatives about their experiences of care their loved ones received.

We reviewed a range of records; these included seven people's care records, multiple medication administration records, and three staff personnel files in relation to recruitment. We also reviewed a variety of records relating to the management and governance of the service, including policies and procedures.

After the inspection
We continued to review evidence that was sent remotely as well as seeking clarification from the provider to validate evidence found. We looked at audit and governance data, as well as infection prevention and control policies and procedures. We also informed the local authority of the concerns and areas of risk we identified.

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 'requires improvement'. At this inspection this key question has deteriorated to 'inadequate'. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the safe care and treatment people received. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Safety monitoring and the assessment and management of risk was not effectively established; people's safety was compromised.
- Care records contained the relevant guidance information, but this was not always complied with. For instance, observations confirmed that one person was not receiving adequate diabetic support and another person who was at risk of choking was not being closely observed during mealtimes.
- There were measures and processes in place to manage and mitigate risk, but these were not effectively overseen. For instance, diet / fluid and repositioning charts were incomplete and mattress pressure checks were not safely monitored.
- We observed poor health and safety measures throughout the home. We found multiple broken nurse call bells, an open fire door which should have been closed, flashing / broken light bulbs which were reported in April 2021 and in one instance, there was exposed wires in a person's bedroom; this was addressed once raised by inspectors.
- Regulatory compliance certificates were in place and in date. We saw gas and electricity compliance certificates as well as an up to date fire risk assessment.

Staffing and recruitment

At our last inspection the provider had failed to deploy sufficient numbers of suitably qualified staff across the home. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

- Staff were safely recruitment but poor staffing levels meant that the quality and safety of care was

compromised.
● Poor staffing levels and task-led care rather than person centred care was observed; staffing dependency levels were not reflective of the dependency support needs of the people who lived at the home.
● Relatives confirmed that poor staffing levels was impacting the care their loves ones received. One relative confirmed that their loved one (as well as others) are just "left in bed."
● Staff also told us, "We have to make them [people] wait all the time" and "Staffing is not good, often short staffed on the floor, [we] can't give the best to the residents."
● Staff expressed that their concerns regarding poor staffing levels were not listened to. One staff member told us, "Our unit manager has highlighted this many times, but nothing happens. There will be an accident or an oversight if this continues."
● Staff were safely recruited into their positions. Suitable references were obtained, employment histories were provided and Disclosure and Barring Service (DBS) checks were completed.

Preventing and controlling infection
● Poor IPC arrangements and procedures were in place; we were not assured that transmission of infections were effectively managed.
● The internal and external environment was poorly maintained; inadequate hygiene practices were in place. For instance, we found dirty bed linen, radiators, vents, and garden areas and furniture that was not fit for purpose.
● We found multiple IPC risks; PPE was not always appropriately disposed of, continence aids were not correctly discarded and people's personal equipment such as falls mats / sensor mats and Zimmer frames were not effectively sanitized.
● Cleaning schedules, daily 'walk rounds' and IPC audits were ineffective; they were not identifying the concerns that needed to be addressed.
● Although the inspection team did not have their temperatures taken or asked to complete a covid-19 declaration form, we received confirmation from staff and visitors that these measures were in place.
● Staff were provided with adequate PPE; they had received relevant IPC training and were observed wearing the correct PPE throughout the inspection.

We found no evidence that people had been harmed however, the provider failed to ensure that premises and equipment were clean, suitable for purpose and well maintained. This placed people at risk of harm. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicine procedure and practices had improved since the last inspection. However, some processes need to be strengthened.
● Topical creams were not always safely stored away in people's bedrooms, thickening agent documentation was not always accurately completed, and medication cupboards found in treatment rooms were not always locked.

We recommend that the provider strengthens their medication processes to ensure policy is complied with.

● People received support with their medicines as prescribed, by trained members of staff.
● Medication administration records were accurately completed and safe 'as and when' (PRN) needed protocols were in place.
● People's care records contained relevant information in relation to medication support and risks that needed to be managed.

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

- Systems and processes to safeguard people from the risk of abuse were in place, trend analysis was taking place and lessons were learnt where possible.
- Staff explained how they would raise their concerns and the importance of protecting people from harm.

Requires Improvement

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 'requires improvement'. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

● Quality performance measures and management of risk was not effectively in place and regulatory compliance was not met.
● Ineffective governance and quality assurance measures meant that people were exposed to unnecessary risk and the provision of care was not sufficiently monitored, reviewed or improved upon.
● Continued breaches of regulation meant that the provider was not clear about their roles and responsibilities and the importance of complying with The Care Act, 2014.
● Overall governance and monitoring systems failed to identify shortfalls; improvements in the provision of care were not effectively addressed. For instance, IPC audits and 'twice daily walk rounds' were not identifying the concerns we identified during the inspection.
● There were no assurances that the Home Improvement Plan (HIP) was effectively identifying and addressing areas of improvement. For instance, the HIP indicated that IPC arrangements were in place and people's safety was not compromised.

We found no evidence that people had been harmed however, the systems that were in place were not robust enough to demonstrate the quality and safety of care was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, we received evidence to suggest that quality performance and area of risk management had improved; new processes had been embedded to quickly identify areas of concern.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;
● We were not always assured that a positive, person-centred, inclusive approach to care was being achieved.
● Poor staffing levels meant that the quality of care was compromised. One staff member told us, "We have no time to do anything with the residents. This is impacting the level of care in a way yes."
● Staff expressed that they always give '100%' to the people they care for and relatives told us staff were kind, caring and 'brilliant'. However, we identified that people were not always receiving a tailored level of

care that was centred around their support needs.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● The home did not always endeavour to include people, staff and the public in the quality and safety of care being delivered. We received mixed feedback about the level of communication and engagement from the home.
● Methods of communication were not consistently established. One relative told us, "They [staff] promised that they'd ring me with updates every month but it hasn't happened" and "[Staff member] keeps us updated on visits and rings with solutions not just the problems".
● Staff told us they felt supported by their unit managers but not by the provider. Staff told us, "We're not appreciated at all" and "Morale is very low. Don't feel at all valued."
● Satisfaction surveys were circulated to relatives but there was no evidence of how they were capturing the thoughts, views and suggestions of people who lived at the home.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong.
● The provider understood their duty of candour responsibilities, however open, honest and transparent conversations were not always taking place.
● We received mixed feedback about the level of communication. Relatives told us, "I visited and noted a nasty cut on [persons] arm – nobody was around to explain it" and "They [staff] always ring if there's a problem – I feel I know what's going on."
● Accident and incident recording procedures were in place; investigations took place, trends were analysed to establish if risk could be further mitigated.

Working in partnership with others
● The home worked in partnership with other external agencies.
● People received care and support from external professionals such as speech and language therapists, falls teams, district nurses and local GP's. One relative told us, "[Person] had another fall and the falls team have been in, including physio."

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Safe care and treatment was not always being provided; people's safety was compromised and they were exposed to unnecessary risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	The premises and equipment were unclean, often not suitable for the intended purpose, or well maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The quality and safety of care was not always monitored, assessed or improved upon. Processes and systems were not always effectively identifying areas of improvement and the provision of care people received was compromised.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that suitable levels of staff were deployed across the home. Poor staffing levels meant the quality and safety of care people received was compromised.

The enforcement action we took:

A warning notice has been issued in relation to poor staffing levels and the impact this is having on the people who were living at the home.