Care Quality Commission

Southern Counties Care Limited

Birdsgrove Nursing Home

Inspection report

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Date of inspection visit: 16 April 2015
Date of publication: 07/08/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service caring?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out an unannounced comprehensive inspection of this service on 11, 16 18 & 20 February 2015. Breaches of legal requirements were found. After the comprehensive inspection, we issued the provider with two warning notices in relation to two of the breaches. We told the provider they should take action to ensure they met legal requirements by 7 April 2015.

We undertook this focused inspection on 16 April 2015 to check the provider now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Birdsgrove Nursing Home on our website at www.cqc.org.uk

Birdsgrove Nursing Home provides accommodation, personal care and nursing care for up to 87 people who are frail and older, or have nursing or dementia care needs. There were 52 people living at the home at the time of our inspection. The home was arranged over three units, Berkshire, Kent and Surrey.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Although the provider had taken some action to ensure that required maintenance checks had been completed,

Summary of findings

there was no formal maintenance schedule in place. There was a risk that future essential maintenance to ensure people's safety would not be completed because of the poor forward planning. Previous recommendations which had been made had been followed, including work on the passenger lift and replacement of equipment such as hoists and wheelchairs. A new call bell system had been installed on Kent wing to replace the faulty system. However, we found that three people had their call bells placed out of reach so were unable to summon help if the need arose.

We observed some instances of care staff being and kind and caring, but there were many more examples of staff not treating people with kindness and respect. People's care needs were not always met. Examples included people calling out for help and not being acknowledged, staff ignoring people when they entered a room and people not being supported to eat their meals in a caring way.

The provider was unable to demonstrate they had an effective system in place to ensure they monitored the quality of the service. It was unclear what plans they had in place to make sure they met the requirements of the regulations.

We found continuing breaches of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is currently considering the appropriate regulatory response to resolve the problems we found.

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 safe. Although some essential maintenance work had been completed an appropriate schedule for future maintenance was not in place. There was a risk people's safety would not be protected.

Inadequate

Is the service caring?
The service was not caring. People did not have their care needs met at all times and were not always spoken to with kindness and compassion.

People's privacy and dignity was not protected and staff did not communicate with people in a caring way.

Inadequate

Is the service well-led?
The service was not well led. The provider did not have an appropriate system in place to ensure they monitored the quality of the service they provided.

Inadequate

Birdsgrove Nursing 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 was 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.

We undertook a focused inspection of Birdsgrove Nursing Home 16 April 2015. This inspection was completed to check that improvements to meet legal requirements after our comprehensive inspection 11, 16, 18 and 20 February 2015 had been made. We inspected the service against three of the five questions we ask about services: is the service safe, is the service caring and is the service well led. This is because the service was not meeting legal requirements in relation to those questions. The inspection was undertaken by three inspectors.

During the inspection we spoke with seven people who use the service and observed care being provided to 22 people. We also spoke with two registered nurses (RN), five care workers, the registered manager, the quality manager and a company director.

We used the Short Observational Framework for Inspection (SOFI) to observe the care and support provided to people in two dining rooms at lunch time. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

At the visit we looked at three people's care records, audit and action plan information as well as records relating to the maintenance of the building and equipment.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection of Birdsgrove Nursing Home on 11, 16 18 & 20 February 2015 we found that people were not safe. This was because the provider did not identify, assess and manage risks relating to the health, welfare and safety of people who use the service and others. This was a beach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

As this focused inspection was completed after 1 April 2015, it was assessed against Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that although the provider had taken some action to improve safety concerns around the home they had failed to meet the requirements of the warning notice issued and continued to be in breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A maintenance list was available detailing the frequency that regular assessment, servicing and testing of equipment and safety procedures were carried out. It stated when they had last occurred and when they were next due to take place. However, not all dates had been correctly entered, for example, it was stated that the fire risk assessment for the service should be repeated every two years or as recommended in the report. The risk assessment had been carried out in April 2014 and the report stated a further assessment should be conducted in April 2015. The date entered on to the maintenance list for the next scheduled review to take place was April 2016. Potential risks associated with fire may not have been identified to ensure action to protect people could be taken in a timely way. This had not been noted by the registered manager when carrying out an audit of the maintenance records.

There was no formal schedule of regular maintenance checks such as testing of water temperatures and checking of window restrictors recorded. The maintenance officer told us they knew what had to be done on a weekly, monthly and quarterly basis and when checks were completed they were noted in the maintenance diary. When we reviewed the diary we saw there was no scheduled work planned into the diary. The results of the checks were recorded but records were not always dated accurately. Some records, designed to show recordings for one week or one month had had dates added for checks carried out at different times making it difficult to identify the findings for an individual set of checks. The registered manager confirmed there was no formal schedule of maintenance checks but showed us diaries completed by the maintenance officers indicating the checks they had completed. There was no forward planning entered into the diary to ensure maintenance staff were aware of what checks needed to be carried out and when. There was a risk that essential maintenance checks would not be completed which put people and others safety as risk.

At the previous inspection the call bell system on Kent wing did not work and neither people nor staff had the means to summon help if they required it. At this inspection we saw a new call bell system had been installed.

We found one cupboard containing substances hazardous to health that was unlocked. Some of the people who use the service live with dementia and may not recognise the risks associated with these substances. We brought this to the attention of the registered manager. The room was then locked to ensure unauthorised people could not access the hazardous substances.

These were continuing breaches of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is currently considering the appropriate regulatory response to resolve the problems we found.

At the previous inspection we found recommendations made by engineers who carried out the servicing on equipment such as the passenger lift, were not always followed through. At this inspection we found action had been taken. Recommendations such as fitting a smoke alarm in the lift shaft, removal of a specialised bath which had failed a Lifting Operations Lifting Equipment Regulations (LOLER) service from use and the marking the RSJ beam in the lift shaft with the safe working load had been completed.

The provider had replaced equipment such as wheelchairs and hoists used to move and position people where the service engineer had reported them as no longer fit for purpose. An asbestos survey had been completed and action had been taken to comply with the recommendations of marking areas where there was possibility of asbestos being present. Most windows that had not been secure at the last inspection had been

Inadequate

Is the service safe?

attended to and could now be closed effectively. However in one room the window could not be opened to assist ventilation in the room and in one bathroom the window could not be closed or secured. Missing latches had been replaced and broken ones mended so they no longer had the potential to cause injury.

The provider had put in place contracts with specialist companies to ensure safety of equipment, collection of waste and legionella testing were carried out to legally required standards.

Inadequate

Is the service caring?

Our findings

At our comprehensive inspection of Birdsgrove Nursing Home on 11, 16 18 & 20 February 2015 we found that people were not well cared for. This was a beach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

As this focused inspection was completed after 1 April 2015, it was assessed against Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the provider had failed to meet the requirements of the warning notice issued and continued to be in breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed many incidents of people receiving care that was inappropriate or that did not meet their individual needs. We heard one person calling out to go to the toilet in a distressed way. Members of staff who were near the person's room did not respond to their distressed calls. We went into the person's room and spoke with them. We reassured them and said we would get someone to come and help them. The person said: "no-one would take any notice". The person did not have their personal care needs met and staff did not ensure their welfare was protected.

We heard another person calling out for help. They wanted to get back into bed and told us they were tired and their back was hurting. We went into their room and found the person was distressed. While speaking with the person they suddenly grabbed an inspectors hand and stood up. The inspector supported the person to bed. They expressed their thanks and said they had wanted to lie down for a while as they were so tired. At no time did staff come into the room to help the person and there were no staff in sight. We had to find a member of staff to tell them what had happened. The person's care needs were not met and staff did not respond to their calls of distress in an appropriate way.

We spoke with a third person who was still in bed in their night clothes. It was mid-morning and the person told the Inspector they had been awake since 7.00 and they were waiting for two staff to help move them from their bed to their chair, wash them and help them get dressed. The person said they were unsure if they were going to be washed today as they had not been told. They said "you have to get used to it here, it's a routine".

We left the persons room and shortly afterwards heard them shouting for help. They were shouting: "please help me" and "help me please". The person was in very obvious distress and their shouts for help were loud enough for any staff nearby to hear them. No staff responded to the person's calls for help. We went into their room and reassured the person and they became calm. We said we would get a member of staff to come and help them. One inspector spoke with a care worker on the corridor outside the person's room and told them the person needed help. The care worker said they were helping another person and: "I'm doing her, I don't want this one wandering off as well". The care worker did not approach the person to reassure them or explain what the delay was in providing their care.

We left the room as the person remained calm. Shortly after we left the room they began shouting for help again in the same manner. An RN was observed standing in the corridor near to the person's room not reacting to their cries for help. We had to find another member of staff and ask them to come and help the person with their personal care needs. A few minutes later a care worker arrived to assist the person. The person's cries for help were repeatedly ignored. The person's care was not appropriate and did not meet their needs.

Care workers did not have easy access to people's detailed care records. They were kept locked in filing cabinets which only RNs and other senior staff had access to. Care workers only had access to a daily record sheet which was a tick sheet of tasks completed and did not include information to inform staff on how to meet each person's choices and preferences. RNs we spoke with said they would advise care workers of people needs and preferences verbally. There was a risk that care workers would not know what an individual's care needs and preferences were because they did not have access to people's detailed care plans.

Staff told us people were checked hourly if they could not summon help. However, records showed these checks were not always carried out. For example, we looked at one person's records at 9:50am and saw they had not been checked since 7am. Another person had not been checked for over an hour on two occasions during the day. The same person required turning every two hours due to being at risk of developing a pressure ulcer. We found one

Is the service caring?

occasion when they had not been turned for two hours and forty minutes. There was a risk that people's care needs would not be met because appropriate welfare checks were not carried out.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who use the service who could not talk with us. We carried out a 30 minute observation in the Berkshire lounge. During the observation people were waiting for their lunch to be served. Staff prepared the area and supported people to put clothes protectors on after asking them if they wanted them and explaining what they were for. During the observation there was some interaction between people and the staff supporting them. However, it was mainly in response to questions asked by people. There was little communication instigated by the staff other than in relation to the task being carried out. For example, asking people what they would like to eat or drink and were they ready for the next mouthful of food.

There were examples of staff ignoring people when they entered a room and speaking with other members of the care staff over people's heads. For example one member of care staff entered the Berkshire lounge while people were waiting for their lunch to be served. They approached another member of staff who had been speaking with a person and without apology to the person interrupted to gain the attention of the staff member. They continued to speak with the member of staff and did not interact with the person waiting for their lunch.

During the meal, support was offered to people to eat and drink. However, staff assisted a number of people at the same time, giving no-one individual personalised attention. For example, the registered manager sat between two people and began to assist one person and gave a spoon to another person who became upset and threw it down. The registered manager then tried again and said, "come on [name], you can feed yourself." Again the person became upset. A member of staff told the registered manager that the person was usually supported by staff to eat their food. The registered manager then began to assist the person with their food at the same time as supporting the other person they had begun to help earlier and additionally going to help another person cut up their food.

People were not always spoken to or about in a respectful manner. For example, on three occasions during the lunchtime observation one person was referred to in terms such as "sweetie", "darling" and "my love." Although some staff sat or stooped down next to a person when they were speaking with them to ensure they were at the same level, this did not always happen. We saw examples of staff speaking down to people whilst standing over them and speaking to others over people's heads.

These were continuing breaches of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is currently considering the appropriate regulatory response to resolve the problems we found.

We saw some examples of staff being kind and caring to people. For example, a member of the housekeeping staff went to find out what a person needed when they heard them calling. They reassured the person and explained staff were assisting other people. They went to tell care staff that the person needed help and returned to tell the person someone would come soon. We observed activities in the Berkshire lounge. People were being supported by activity staff. People were engaged in the activity and there was a friendly conversation between the people taking part and the activity staff member. At the end of the activity one person said they felt cold and the care worker immediately responded and asked if they would like a blanket. They covered the person up and checked they were feeling warmer.

Inadequate

Is the service well-led?

Our findings

At our comprehensive inspection of Birdsgrove Nursing Home on 11, 16 18 & 20 February 2015 we found that the service was not well led. This was because the provider did not regularly assess and monitor the quality of the service they provided. This was a beach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

As this focused inspection was completed after 1 April 2015, it was assessed against Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the provider had failed to meet the requirements of the warning notice issued and continued to be in breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the start of the inspection we asked the registered manager to provide us with documentation to demonstrate appropriate action had been taken to meet the requirements of the regulations and gave them approximately one hour to gather the information together. After one hour and 50 minutes the documents had not been provided and we had to ask for them again. Documents requested included evidence of audits and maintenance work completed and an audit and maintenance schedule. We also asked for an up to date action plan that demonstrated what plans the provider had in place to ensure they monitored and improved the quality of service appropriately.

We were given an audit file which we had previously reviewed at the last inspection. New information in the audit file included information about an asbestos report, a parker bath being taken out of service, a building survey and information about maintenance for the passenger lift. Other information remained largely the same. There was no new evidence in the folder to demonstrate what, if any, audits had been completed.

We asked the registered manager and quality manager to explain what new audits had been completed and what action plans were in place. The explanation given by both was confusing. We could not establish from our conversation what audits had been completed and what the action plan consisted of. It remained unclear if any such documents were in place.

We spoke with the quality manager to discuss the action plan further. We were shown a list of tasks that needed to be completed. There were no dates or schedule for when the tasks would be completed. The quality manager explained they were “pulling everything together” and would then summarise actions required. We were not shown a fully completed action plan or list of audits completed since the last inspection, or a schedule for future audits, despite giving the registered manager several opportunities over the course of the inspection to do so. The provider was unable to provide evidence to show that systems to monitor the quality of service had been established and operated effectively. They were unable to demonstrate they assessed and monitored the quality of service to ensure they met the requirements of the regulations.

This was a continuing breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is currently considering the appropriate regulatory response to resolve the problems we found.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People's care and treatment was not appropriate, did not meet their needs, and did not reflect their preferences. Regulation 9(1)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
The Care Quality Commission is currently considering the appropriate regulatory response to resolve the problems we found.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use the services were not protected from the risks of poor quality and unsafe services because systems or processes were not established or operated effectively. Regulation 17(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
The Care Quality Commission is currently considering the appropriate regulatory response to resolve the problems we found.