Care Quality Commission

Southern Counties Care Limited

Birdsgrove Nursing Home

Inspection report

Warfield Road
Bracknell
Berkshire
RG12 2JA
Tel: 01344 42226100 000 000
Website: www.asterhealthcare.co.uk

Date of inspection visit: 11, 16, 18 & 20 February 2015
Date of publication: 28/04/2015

Ratings

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

Overall summary

This inspection took place on 11, 16, 18 & 20 February 2015 and was unannounced. Birdsgrove Nursing Home provides accommodation, personal care and nursing care for up to 87 older people who are frail, or have nursing or dementia care needs. There were 58 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.

People were not safe and there were a number of significant safety failings around the home. These included unsafe water temperatures which put people at significant risk of scalding and poor infection prevention and control (IPC) practices. The home in general was dirty, particularly in bath and shower rooms and the kitchen. We told the provider to take immediate action to

Summary of findings

address the concerns with water temperatures and standards of cleanliness. When we returned on day two of the inspection we found the provider had addressed these concerns.

Call bells on Kent wing did not work and people and staff were unable to call for help or assistance if it were needed. Windows had missing or damaged latches which posed a risk of injury, and they could not be properly secured. Servicing and maintenance work on the passenger lift had not been carried out during legally required timeframes. However, the lift remained in use. There was no maintenance schedule in place to ensure that the premises and any equipment was maintained to an acceptable standard.

There was not always sufficient staff to meet people's needs and during the inspection we frequently had to look for staff when people needed help and support. Staff knew what they should to safeguard people from abuse.

Although staff had an understanding of the Mental Capacity Act (2005) (MCA) and the Deprivation of Liberty Safeguards (DoLS), this knowledge was not always put into practice. In some cases consent to care was being sought from individuals who did not have the legal right to give it.

Food was nutritious but there was not always a suitable choice of meals for people. People were not well supported to eat their meals and monitoring of nutritional intake was poor.

Although feedback from people about the service was positive this was not supported by our observations during the inspection. We did see some examples of good care, but staff approach to people was poor overall. People were not always spoken to with kindness and compassion and staff were often patronising in their tone. People's privacy and dignity were not always respected and staff frequently entered rooms without knocking, including a bathroom where a person was showering. Staff were very task focused and did not pay attention to the individual needs of each person.

Care plans were not detailed. Risk assessments were brief and did not always include an appropriate management plan. Tick sheets were used to record people's care and care plans did not focus on the individual. There was minimal information about people's life histories, their likes and dislikes or hobbies and interests.

Activities were organised within the home, including arts and crafts, but not all people were supported to attend activities if they wished. There was little activity for people who were bedfast and minimal evidence of involvement with the local community.

The service was not well led. The quality monitoring system in place was not fit for purpose. Audits were not identifying areas for improvement. Where concerns had been identified action had not been taken to address them. Records in general were incomplete and could not be located promptly. Records were not always kept securely and there was a risk they would not remain confidential.

The registered manager was not aware of the day to day culture of the service including attitudes, values and behaviours of staff. They did not always respond appropriately when we gave feedback about the concerns we had identified. The registered manager did not know the people who used the service and some people appeared to be unfamiliar with the manager when they spoke with them.

There was a lack of understanding of the key challenges the service faced, particularly with regards to people's safety. Responsibilities and accountability was not understood by managers at all levels.

People received their medicines safely and as prescribed. Recruitment practices were safe and accident and incidents had been investigated. Referrals were made to healthcare professionals when needed and appropriate health information was handed over by staff between shifts. There was an appropriate complaints system in place.

We found the provider had breached the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in eight areas. You can see what action we took at the end of the full 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 safe. People's safety was not protected because the home was not clean. People were at significant risk of scalds because water temperatures were above safe limits.

There was not always enough staff to meet the needs of people who use the service. Staff knew what they should do if they thought someone was at risk of abuse.

Required maintenance of the building and some equipment had not been kept up to date.

Medicines administration, recruitment and accident and incident monitoring were safe.

Inadequate

Is the service effective?

The service was not always effective. Staff did not always meet the requirements of the Mental Capacity Act 2005 and seek consent appropriately.

People were not well supported to ensure they had sufficient food to meet their nutritional needs, and choice of food available was limited.

Staff were not being appropriately supported to meet people's needs by way of supervision and appraisal.

Inadequate

Is the service caring?

The service was not caring. People were not always spoken to with kindness and compassion. Staff did not communicate with people in a caring way.

People's privacy and dignity was not protected.

Inadequate

Is the service responsive?

The service was not always responsive. Care plans were task focused and did not centre on the individual. Not all of the relevant information was included in people's care plans to enable staff to support them in a way that met their needs.

Activities were organised within the home but not everyone was supported to attend activities if they wished. There was no evidence of community involvement.

The provider had a system in place to record and deal with complaints.

Inadequate

Is the service well-led?

The service was not well lead. Quality monitoring and audit systems were poor and did not identify areas for improvement. Records were inaccurate, insecure and could not be located promptly.

The registered manager did not have a good understanding of the culture within the home and was not familiar with the people who lived there.

There was no clear set of values and there was lack of understanding of key challenges the service faced, particularly with regards to the significant risks to people's safety.

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 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 was in response to significant safeguarding concerns at the home. The inspection took place on 11, 16, 18 & 20 February 2015 and was unannounced. The inspection team consisted of five inspectors, a pharmacist inspector and a specialist nursing advisor. Prior to the inspection we spoke with the local authority safeguarding team and commissioners, a representative from the Health and Safety Executive and Thames Valley Police. During the inspection we spoke with 10 people who use the service, seven relatives, 13 health care assistants, six registered nurses (RN), the clinical lead, nominated individual, company director and the registered manager. 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 could not talk with us.

We reviewed six people's care plans and risk assessments, 43 people's medicines administrations records (MAR), training records for all staff, and recruitment information for seven permanent members of staff and two agency staff. Other records we reviewed included quality monitoring audits, maintenance records and other records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

Although most of the people we spoke with told us they felt safe, people's safety was at risk because of a number of significant safety failings around the home. On day one of the inspection we found significant concerns with infection prevention and control (IPC). The general level of cleanliness throughout the home was poor. Bathrooms were dirty and smelt damp and musty. We found shower drains blocked with hair and slime. There were areas of significant lime scale build up and we found one shower curtain with faeces on it. Unsuitable flooring was in use in shower rooms which had lifted up and allowed water to seep underneath. We found peeling paint and wall and floor tiles which were dirty and in a poor state of repair. Commodes we inspected were ingrained with dirt around the wheels and there was evidence of faeces and urine on the underside of the seats.

Standards of cleanliness in the kitchen were poor. Hot trolleys and food storage containers were old and dirty. The laundry room was dirty and there was no system in place to ensure soiled and clean laundry were kept separately to prevent cross contamination. Clinical waste bins outside of the home were not secure or locked when they should have been.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We told the provider to take immediate action to address the concerns with standards of cleanliness. When we returned on day two of the inspection we found the provider had taken action and had cleaned all bathrooms and the kitchen. Old and dirty equipment, including commodes, had been replaced with new. Work was in progress to address the issues identified in the laundry. You can see what other actions we told the provider to take at the back of this report.

We checked the water temperatures from taps in bathrooms and shower rooms. We found on several occasions the water temperature was above safe limits. In two bathrooms we were unable to measure the temperature because it was higher than the thermometer could read. We found one set of taps that were plumbed in incorrectly and hot water came out of the tap marked cold. Another set of taps were both marked cold so it was difficult to establish which tap had hot water before turning it on.

Although staff knew what the safe temperature of hot water should be it was unclear whether water temperatures were being checked or accurately recorded prior to people getting into a bath or shower. Records of temperature readings were not always dated or fully completed. On one occasion a person was supported to have a shower and the water temperature was not checked by staff before the person got under the water.

People using the service were at significant risk of scalding because water temperatures were above safe limits, taps were incorrectly marked and water temperatures were not always accurately recorded before people got into a bath or shower.

This was a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We told the provider to take immediate action to rectify the water temperatures so people who use the service and others were safe. When we returned on day two of the inspection appropriate action had been taken and measures had been put in place to ensure water temperatures were within safe limits. You can see what other actions we have told the provider to take at the back of this report.

We observed a staff member supporting a person who on occasion displayed behaviour which may cause themselves and others distress. The person was being supported in their bedroom on an isolated corridor on Kent wing. There were no other staff members in sight or within calling distance. We asked the staff member how they would summon help if the person became aggressive. They told us they would press a button on the wall which would trigger an alarm. The button the staff member pointed out to us was the reset button for the call bell system and not an alarm to call for help. There was no call bell attached to the call bell system in this room. The member of staff did not have an effective way to urgently summon help if the need arose.

We then reviewed the call bells in the other rooms on this corridor and found that none of the rooms had a working

call bell in them. This meant people who were in bed would not be able to summon help from staff should the need arise. There was no way other than shouting for people and staff to gain attention on this part of Kent wing.

We reviewed the maintenance records for the call bell system on Kent wing dated 17 November 2014 which stated the call bell system in Kent wing was not functioning. We spoke with the registered manager about this. They told us that although the problem had been identified no action had been taken to address the issue. People living on Kent wing were not independent and all of them needed assistance from staff with daily living tasks. There were no plans in place to repair or replace the call bell system. The provider did not manage the risks relating to the safety of people and others because they had not identified people and staff could not summon help if it were needed.

The windows on this corridor were insecure or missing latches. There were sharp edges on one latch which had the potential to cause injury to people who use the service and others. This risk had not been identified until our inspection. The provider did not have effective systems in place to identify risks relating to the health, safety and welfare of service users and others. This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An Industrial Safety Inspections report stated a thorough examination of the lift had been carried out on 7 February 2014. No further report was available for the legally required six monthly check. We were told an examination had not been carried out until 07 February 2015, which meant the inspection was six months overdue. A certificate was later produced to confirm this. However, we saw actions recommended on the report for 2014 had not been actioned and were carried forward to the 2015 report, for example, “fit smoke alarm to shaft ceiling, RSJ in lift shaft to be marked with correct safe working load if to be reused, motor room not to be used for storage.” In addition two new recommendations had been added; “lower section car toe trap plate detached and lift pit refit, consider fitting second light tube.” We were told the smoke alarm had been fitted but no evidence was available to confirm this and no other arrangements had been made to manage the other recommendations made. The lift remained in use. The provider did not have regard to appropriate professional and expert advice or manage identified risks relating to the health and safety of people and others.

The registered manager confirmed they did not have a maintenance schedule in place to ensure that equipment and premises were maintained to an acceptable and safe standard. The registered manager called maintenance contractors in as and when they needed to. The provider did not have an effective system in place to regularly assess and monitor the quality of the services provided and manage the risks to the safety of service users and others.

On Berkshire wing, at the end of day two of the inspection, we noted work was being completed on some people’s sinks in their bedrooms. When we returned for day three of the inspection two days later we visited the rooms to check if the work had been completed. In three rooms we saw planks of wood which had been removed from around the pipework under the sinks. The wood contained long nails sticking out from them which could have caused an injury to people, staff and others. One person had planks of wood resting against the table next to their chair. The person commented “it’s not very safe is it?” when referring to the wood and nails. The registered manager was not aware of the planks of wood and the risks to people’s safety until we pointed them out to her. Shortly after we made the registered manager aware of the risk the wood was removed. The provider was not managing the risks relating to the safety of people and others. These were breaches of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On day one of the inspection we found an unlocked cupboard on the first floor of Surrey wing. Inside there was an immersion heater which was not lagged. The temperature of the immersion heater was very high and had the potential to cause injury if it was touched by a person using the service. We pointed this out to the registered manager and asked them to make the heater safe urgently. On day three of the inspection we looked at the cupboard again, and found it was still unlocked and the heater not protected. A lock was put on the cupboard by the end of day three which was seven days after we pointed this safety hazard out to the registered manager. The registered manager was not managing the risks relating to

Inadequate

Is the service safe?

the safety of people and others, because the hot water tank was accessible posing a risk of injury. This was a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an emergency plan in place to provide information for staff in the event of an emergency situation arising. This gave instructions for dealing with emergencies such as failure of utilities and loss of other important systems. However, it did not refer to such events as the home becoming uninhabitable, requiring alternative accommodation, the outbreak of an infectious disease or severe staff shortage. There was a risk that people would not be kept safe in the event of an unexpected emergency. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the people using the Berkshire lounge and dining area had mobility issues and were consequently at high risk of trips and falls. The mat in front of the TV was old and worn and had curled up edges. People were at risk of tripping over the rug but this problem had not been noticed by staff until we pointed it out to them. The rug was removed as soon as we discussed it with the registered manager.

Although staff said there were enough staff to meet the needs of the people they worked with, we found there were insufficient staff on duty, particularly on Kent wing. We observed that staffing levels did not take in to consideration peoples social and welfare needs. We observed some people were left in their rooms for long periods of time with little or no verbal interaction or company. On three of the days of the inspection, we saw people were often in bed with their curtains and doors closed until late in the morning because there were not enough staff available to help people with their personal care needs. There appeared to be little staff presence throughout the day and we frequently had to look for staff when people needed support. This was a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place to ensure that people received their medicines safely, and as prescribed. People were receiving their medicines when they needed them and medicines were stored appropriately. There were appropriate arrangements in place for recording the administration of medicines and the records were clear and accurate. The provider had systems in place to monitor the quality of medicines management. They completed three monthly audits to check the administration of medicines was being recorded correctly. Records showed any concerns were highlighted and action taken.

Staff told us they had completed safeguarding training. They were able to describe how they would recognise signs of abuse. They told us what action they would take if they had any concerns. This included whistleblowing and reporting concerns outside of the organisation, if necessary.

Staff recruitment practices were safe. All of the required checks including Disclosure and Barring Service (DBS) and employment history checks were completed before staff began work with the provider.

Accident and incident forms were completed and a tool had been introduced to monitor any trends. Actions taken were appropriate and recorded in sufficient detail.

Inadequate

Is the service effective?

Our findings

People told us they liked living in the home. One person said: ''it was a hard decision to make but I have never regretted moving in here''. Another said: ''Staff look after us well''. Staff we spoke with knew about the needs of people who lived in the units they worked on. However, a relative told us that not all staff were knowledgeable about people's care. They said that the service seemed unable to transfer good caring skills from one staff member to another.

Staff told us they had good training opportunities mainly in-house, DVDs and on-line. Registered nurses told us they received specialised training from hospitals and district nurses. Examples they gave were catheter care, specialised feeding and using syringe pumps. Most staff told us they received regular supervision and appraisal. Staff said they had received a good induction which equipped them to work with people who use the service.

However, when we reviewed the training, supervision and appraisals records we found not all of them were up to date or completed. Records showed 42 out of the 63 staff listed had not been involved in a supervision session or appraisal at all. Only one of the personnel files contained evidence of an appraisal. We asked the registered manager about this and they were unable to explain why there were no records in the other files, or who had actually completed an appraisal or supervision session. This was a breach of regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said they received training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLs). This legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. Staff were able to explain when a DoLs referral would be necessary. Examples given were if someone wanted to leave the home but may put themselves at risk and the use of bed rails if people could not consent. All appropriate DoLs referrals had been made to the relevant authorities. They knew who to alert if people's capacity changed or there was a consent issue. However, when we asked staff to apply the principals to a working example they were not clear what should happen. For example, an RN explained one person had their clothes removed from their room because the "CPN said that's what we should do". A CPN is the community psychiatric nurse. The RN had not considered whether this was in the person's best interests and there were no records of a capacity assessment in this case.

Care plans did refer to people's general level of capacity for day to day decisions, but there was no evidence of any capacity assessments for decisions about specific aspects of people's care in their care plans. Staff who were responsible for writing care plans did not understand what a Lasting Power of Attorney (LPA) was or who had the legal right to make decisions on someone else's behalf. Some decisions were being made by next of kin or family members who did not have an appropriate LPA in place. Mental Capacity assessments had, in some instances, been completed by other professionals provided by the local authority and not by staff in the service. This was a breach of regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Food was provided by an external company and consisted of frozen, ready prepared meals which the service heated and served to people living in the home. Although the food was nutritious people did not have a good choice of what they had for their meals. People were shown the choice of two meals at the time they were served and did not have the opportunity to have an alternative meal if they preferred. The registered manager felt this was an acceptable level of choice. At breakfast all of the toast was served ready buttered and with jam already spread. No other choice of condiments were offered.

The way people were supported to eat and drink was inconsistent. Some staff provided good support while others did not. People who took meals in their rooms were not well supported with their meals. On all days of the inspection we saw cold and uneaten food on some people's tables. Snacks and drinks were sometimes left out of people's reach.

Food intake was not well recorded for people who required this. For example, one resident was at risk of malnutrition due to swallowing difficulties. According to records for breakfast they ate "all" of their porridge. There was no indication of how much the portion size was. Other food intake charts we reviewed did not contain this information. An RN and the registered manager were unable to explain

Inadequate

Is the service effective?

how they monitored people's specific food intake other than completing 'all' as the amount of food eaten. We could not be sure people were eating food in enough quantity to meet their nutritional needs. Other people who required more specialist nutritional support had their needs met for example, Percutaneous endoscopic gastrostomy feeding (PEG). PEG feeding is used where patients cannot maintain adequate nutrition with oral intake. This was a breach of regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they liaised with GPs and the community mental health team with regard to people's health and care needs. Appropriate referrals were made when needed. The GP visited the home regularly. We also saw the chiropodist and optician visit the home while we were there. Appropriate health information was handed over by staff between shifts.

Inadequate

Is the service caring?

Our findings

People told us they were treated with dignity and respect and were well treated by staff. People described staff as: ''wonderful, kind and caring''. A relative described their family member as being: ''loved and well cared for''. They said that (their relative) had a very good relationship with most of the carers. Although feedback from people and relatives about staff was positive, this was not supported by what we observed during the inspection.

We did see some examples of good care and staff interacting well with people. However, staff approach to people was poor overall. People who were in obvious distress were sometimes ignored. Staff did not respond to people's needs quickly enough, particularly people taking meals in their rooms. Staff were very task focused and did not pay attention to the individual needs of each person.

Staff did not speak to people appropriately. Terms such as "dear" and "darling" were frequently heard. Tone of speech from staff was frequently patronising. Not all people were spoken to with kindness and compassion particularly on Kent wing. There was a lack of interaction from staff and on almost every visit to Kent and Surrey lounges there was only one member of staff in the room who was sitting writing notes and not interacting with people. Lounge rooms other than Berkshire wing were almost silent except for the TV, and we did not observe staff engaging in any meaningful conversation. Berkshire lounge was slightly better as this was where the activities co-ordinator was based. However, the TV was often on very loud, and people were having their hair and toe nails cut in this room. This did not protect people's privacy and dignity.

We observed the care and support people were receiving during lunch in the Berkshire Lounge. During a ten minute period there was only one staff interaction with the five people who were being observed. Staff did not ask people if they wanted clothes protectors and did not explain what they were doing. One person was wheeled in then out of the dining room after staff had conversed with each other but not the person. Another person was helped out of a wheelchair with staff instructing them to move a leg or arm. Staff did not make it clear to the person why it was necessary or what they were trying to achieve. The person was confused and did not understand the instructions. One staff member grimaced and tutted several times when they were helping a person to eat. This occurred when the person was taking a long time to eat a mouthful of food. The person was not asked if they were ready for the next mouthful. Staff overall did not treat people with dignity and respect. For example, one person was left in a soiled incontinence pad while being served lunch. The pad was not changed for over an hour despite it being very obvious it was soiled.

People's privacy was not always respected. We saw frequent examples of staff entering people's room when they were receiving personal care without knocking. We observed an RN enter a bathroom twice without knocking when a resident was showering. The resident could be easily observed by other people in the corridor. On another occasion we knocked on the door of a room and were told by a member of staff to come in only to find a resident sitting on the bed fully undressed.

People's independence was not always promoted. One example was of a person being taken to the lounge when they obviously did not want to. The carer said to the person they wanted to come to the lounge and the resident accused the staff member of lying and repeatedly asked to be taken back to her room. The person was not supported back to their room until they had repeatedly asked to do so. This was a breach of Regulation 9 and Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 and Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Care plans were to some extent, individual to each person. There were full details about people's needs but the plan of care was not detailed enough to enable staff to meet those needs. Risk assessments were very brief and did not include a plan to manage any identified risk. The registered manager did a pre-admission assessment for people before they moved to the home, but this information was not always included in the plan. Plans did not include the person's life history or much detail about their likes or dislikes, hobbies or interests. Although some people we spoke with said they were involved in care planning, care plans had minimal evidence of how people were involved in making decisions about their care. Staff we spoke with were unable to demonstrate how the person was involved. Care plans were reviewed regularly.

Staff did not have easy access to people's care plans, and daily activities such as washing and dressing were recorded on a separate sheet kept apart from the person's care plan. This was a tick sheet which did not provide any information for staff about people's preferences.

One person had been identified as being at high risk of pressure ulcers. There was no pressure area management plan in the person's care records. 2 hourly observations were being completed for the person but there were no instructions for staff with regard to the risk of the person developing a pressure ulcer. We also observed the person had a significant amount of dried mucus on their lips and a yellow tongue. Oral care did not appear to have been provided for the person for some time. There was no assessment of the need for support with oral health care and no record that this had been provided for this person. When we told staff about the individual's lack of oral health care, they were not aware of the problem. The provider had not carried out an assessment of the needs of the person or delivered care to meet their individual needs.

A person who was using a wheelchair was supported into the Berkshire lounge by an RN. The person did not have their feet supported in the foot rests of the wheelchair. The RN caught the person's foot on a table leg and the person cried out in pain. The RN ignored the service user, offered no apology and did not check whether any injury had occurred. The RN did not respond to the person's obvious distress or ensure the welfare and safety of the person. This was a breach of regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Residents and relatives meetings were held quarterly and discussions took place regarding such things as activities, trips and outings. Minutes of the meetings were recorded. However, the minutes of the last meeting held in December 2014 were not available at the time of the inspection. Some people said they were not involved in residents meetings and there was no information from the provider about what actions had been taken following these meetings.

Activities were organised on most days in the Berkshire lounge. These included arts and crafts, jigsaws and scrabble. Activities staff were enthusiastic and communicated well with people. However, there was minimal evidence of that people were supported to be involved in the local community. There were no activities for people who were bedfast, or on the other units in the home. We did not observe people on units other than Berkshire being supported to join activities with other residents. This was a breach of regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a system to record and deal with complaints. The complaints log showed complaints had been recorded, investigated and responded to in an appropriate way.

Inadequate

Is the service well-led?

Our findings

There was a quality monitoring system in place and there were various audits completed around the home. Examples included kitchen cleanliness, environmental audits and infection prevention and control (IPC). However, audits appeared to be a tick box exercise and were not identifying areas for improvement. For example, the most recent IPC audit had not identified any concerns with levels of cleanliness around the home. Other audits which had not identified areas for improvement included water temperatures, kitchen cleanliness and organising of the laundry. The registered manager was auditing everything every month and had no method of prioritising. Monitoring at provider level was also poor and had not identified concerns. The registered manager frequently said audits were other staff member's responsibility, but they had not assessed if the person had the appropriate skills to complete the audit, or checked if the audit was accurate. The registered manager had not identified any areas for improvement and did not have any on-going action plan to drive improvement.

The results of other audits we reviewed, including equipment and environmental safety, were the same on each occasion the audit was completed. Areas for improvement had been identified but there was no evidence action had been taken. The areas for improvement appeared repeatedly on subsequent audits. The provider did not have an effective system in place to ensure they regularly assessed and monitored the quality of the service provided.

We reviewed the maintenance records for hoists, a parker bath and chair lifts, which were all maintained and serviced by an outside company. All were due to be serviced by end of February 2015. The maintenance officer said they had been trying to book a service but the engineer was on holiday and therefore had not got a fixed date for the service to take place. No evidence could be produced to satisfy inspectors that the service would be completed in the legally required timescale until the last day of the inspection. Engineer reports reviewed from August 2014 for hoists stated that some of the parts of the hoists were out of service life and required replacement by February 2014. The registered manager and maintenance officer were unsure if this work had been carried out.

We requested clarification of the above points and this was not provided to us until the last day of the inspection. The registered manager had to contact the outside company for evidence the hoists were safe to use as they did not have records available to demonstrate the required work had been completed. The provider did not identify, assess or manage risks relating to the health, welfare and safety of service users and others because accurate records had not been kept. These were breaches of regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected against the risks of unsafe or inappropriate care because accurate and up to date records were not kept, stored securely or located promptly. The provider could not find paperwork necessary to ensure people were safe in the home when we asked for it. Records containing personal information was hung on noticeboards and not kept securely. Filing cabinets containing people's care records were not locked. This may have resulted in them being accessed by unauthorised personnel. Records throughout the home were poor. They were not always dated, signed by staff or fully completed. This was a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some feedback about the quality of service had been sought from people but the registered manager had not sought the views of staff or other people involved in people's care such as the GP. The provider completed a survey with residents in March 2014 but there was minimal evidence that areas for improvement had been highlighted and actioned. The registered manager told us this year's survey was planned but did not provide us with any evidence to support this. The registered manager had sought feedback about the quality of food after a recent change to menus. Action was taken after feedback given about the menu choices was poor and the menu was revised. However, the registered manger did not seek further feedback after the menu was revised, to ensure people were happy with the changes made. The provider was not regularly seeking the views of people, those acting on their behalf or staff in relation to the quality of service provided. This was a breach of regulation 10 Health and

Inadequate

Is the service well-led?

Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have a clear set of values. The registered manager was not aware of the day to day culture of the service including attitudes, values and behaviours of staff, particularly on Kent wing. The provider did not encourage open communication with people and staff. There was a lack of transparency during the inspection. The registered manager did not always respond appropriately when we fed back our concerns and important documents were not available when requested.

Leadership was not visible at all levels. The registered manager was not familiar with residents and some residents appeared to be unfamiliar with the registered manager when they spoke with them. Senior managers were not clear in how they supported the service to improve and could not give any appropriate examples of how they had helped the service in the past or any plans they had for the future improvements. There was a lack of understanding of the key challenges for the service, particularly with the evident risks to people's safety. Responsibilities and accountability was not clearly understood by managers at all levels.

Registration requirements were met and the registered manager had been in post for over two years. The registered manager sent us notifications of incidents as required by law, but these did not always contain all of the relevant information relating to the incident.

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 10 HSCA (RA) Regulations 2014 Dignity and respect The provider did not treat service users with dignity and respect or support services users independence and involvement in the community. Regulation 10(1)(2)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not ensure care and treatment of service users was only provided with the consent of the relevant person. Regulation 11(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The provider did not ensure the nutritional and hydration needs of service users were met. Regulation 14(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure there were sufficient numbers of staff or that staff received appropriate training, supervision and appraisal. Regulation 18(1)(2)(a).

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not maintain accurate records, or store them securely. Regulation 17(2)(c).

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	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person did not take proper steps to ensure that each service user was protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of the carrying out of an assessment of the needs of the service user; and the planning and delivery of care and, where appropriate, treatment in such a way as to meet the service user's individual needs and ensure the welfare and safety of the service user. Regulation 9(1)(a)(b)(i)(ii)

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person did not protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems to regularly assess and monitor the quality of the services and to identify, assess and manage risks relating to the health, welfare and safety of service users and others. Regulation 10(1)(a)(b)(2)(a)(b)(iii)(iv).

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control

This section is primarily information for the provider

Enforcement actions

The registered did not ensure care and treatment was provided in a safe way for service users by assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated. Regulation 12(2)(h).

The enforcement action we took:
We issued the provider with an urgent Section 31 Notice of Decision and imposed a condition of registration. Southern Counties Care Limited must not admit any service users to Birdsgrove Nursing Home without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The registered person did not ensure all premises and equipment used by the service user were properly maintained. Regulation 15(1)(e).

The enforcement action we took:
We issued the provider with an urgent Section 31 Notice of Decision and imposed a condition of registration. Southern Counties Care Limited must not admit any service users to Birdsgrove Nursing Home without the prior written agreement of the Care Quality Commission.