Mrs C Cunningham

Birkdale Park

Inspection report

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Date of inspection visit:
20 April 2017
24 April 2017

Date of publication:
02 June 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Birkdale Park is registered to provided accommodation, nursing and personal care for up to 36 adults. The home admits older people with general nursing care needs. It is a large detached house on a main road leading to Southport town centre. There were 29 people accommodated at the time of the inspection. The home was last inspected in December 2014 and was rated 'Good' at that time.

This inspection was carried out over two days on 20 and 24 April 2017 and was unannounced.

At the time of the inspection there was a manager in post but they were not yet registered with us (the Care Quality Commission). 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. The manager had applied to be registered.

We found some anomalies with the way some medicines were being recorded and monitored. This meant there was a risk these medicines were not being administered consistently. We found the checking and auditing systems of medicines needed some improving to ensure all areas of medication management were being identified and routinely checked.

The manager and senior managers for the provider were able to evidence a range of quality assurance processes and audits carried out at the home. We found some supporting management audits needed to be further developed with respect to medicines. Some clinical records regarding health were not always clear. The manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home although criteria for submitting these needed reviewing.

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

We found some anomalies with the care of two people in the home and found that monitoring of care could improve and be more consistent. We made a recommendation regarding this.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were generally followed in that an assessment of the person's mental capacity was made but this was not always consistent.

We found the home generally supported people to provide effective outcomes for their health and wellbeing. We saw there was referral and liaison with health care professionals when needed to support people.

We found there were sufficient staff on duty to meet people's care needs. Staff said they were supported through induction, appraisal and the home's training programme.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We saw required checks had been made to help ensure staff employed were 'fit' to work with vulnerable people.

People we spoke with said they were happy living at Birkdale Park. Staff mostly interacted well with people living at the home and they showed a caring nature with appropriate interventions to support people.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained.

Care was organised so any risks were assessed and plans put in place to maximise people's independence and helped ensure people's safety.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken safeguarding training in-house. All of the staff we spoke with were clear about the need to report any concerns they had.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety checks were completed on a regular basis so hazards could be identified. Planned development / maintenance was assessed and planned well so that people were living in a comfortable and safe environment.

The home was clean and we there were systems in place to manage the control of infection.

When necessary, referrals had been made to support people on a Deprivation of Liberty [DoLS] authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. The applications were being monitored by the manager of the home.

We saw people's dietary needs were managed with reference to individual preferences and choice. Lunch time was seen to be a relaxed and sociable occasion.

People we spoke with and their relatives felt staff had the skills and approach needed to ensure people were receiving the right care.

People felt involved in their care and there was evidence in the care files to show how people had been included in key decisions.

Social activities were organised in the home. People told us they could take part in social events which were held.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. We saw there were records of complaints made and there had been a response to these.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We found some anomalies with the recording of some medicines which meant it was not clear if the medicines had been given as prescribed.

Staff had been appropriately checked when they were recruited to ensure they were suitable to work with vulnerable adults.

We found there were protocols in place to protect people from abuse or mistreatment and staff were aware of these.

There were enough staff on duty at all times to help ensure people's care needs were consistently met.

There was good monitoring of the environment to ensure it was safe and well maintained. We found that people were protected because any environmental hazards were routinely monitored.

The home was clean and we there were systems in place to manage the control of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were not always followed in that an assessment of the person's mental capacity was not consistent.

The service supported people to provide effective access to health care outcomes.

Staff told us they were supported through induction, appraisal and the home's training programme.

We saw people's dietary needs were managed with reference to individual preferences and choice.

Is the service caring?

Good

The service was caring.

Staff interactions were observed to be supportive and positive. Staff communicated well with people.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained.

People told us they felt involved in their care and could have some input into the running of the home.

Is the service responsive?

Requires Improvement

The service was responsive.

We found some anomalies with the care of two people we reviewed in the home and found that monitoring of care could be more consistent.

Most peoples care plans were being reviewed and people's care evidenced an individual approach.

There were social activities planned and agreed for people living in the home.

A process for managing complaints was in place and people we spoke with and relatives knew how to complain. Complaints made had been addressed.

Is the service well-led?

Requires Improvement

The service was not wholly well led.

The manager and representative for the provider were able to evidence a range of quality assurance processes and audits carried out at the home. With respect to medicines and consistency in assessing capacity for people, the audits had not picked up on the shortfalls we identified at the inspection.

Some clinical records regarding peoples on-going monitoring were not always clear.

Criteria for submitting statutory notifications to the Commission needed reviewing.

At the time of the inspection there was a manager in post but they were not yet registered with us (the Care Quality Commission).

Birkdale Park

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 checked 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.

This was an unannounced inspection which took place over two days on 20 and 24 April 2017. The inspection team consisted of an adult social care inspector and an 'expert by experience'. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we accessed and reviewed the Provider Information Return (PIR) as we had requested this of the provider before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also reviewed other information we held about the home. We contacted one of the commissioners of the service to obtain their views.

During the visit we were able to meet and speak with 11 of the people who were staying at the home. We spoke with four visiting family members. We spoke with six of the staff working at Birkdale Park including care/support staff, the manager and a representative of the provider [owner].

We looked at the care records for 13 of the people staying at the home including medication records, two staff recruitment files and other records relevant to the quality monitoring of the service. These included safety audits and quality audits including feedback from people living at the home and relatives. We undertook general observations and looked round the home, including people's bedrooms, bathrooms and the dining/lounge areas.

Requires Improvement

Is the service safe?

Our findings

We looked at how medicines were managed at the service. We found some anomalies with the recording of some medicines which meant it was not clear if the medicines had been given as prescribed.

We checked how external preparations [creams] were administered. We found creams for two people we reviewed had been supplied. We were told these were administered daily by care staff. One of these was recorded on the Medication administration record (MAR). The cream for the second person was not on the person's MAR. We asked whether the creams had been applied and we were told they had been applied that day. We were told the administration records were kept in people's bedrooms for care staff to sign when they had applied / administered the cream; we found these had not been completed. For example, one had last been completed the day prior to our inspection and contained gaps in recording over previous days; the second person did not have a recording chart in their room so there was no record of the cream being applied by the care staff responsible. The manager assured us the creams would have been applied but we were concerned about the lack of accurate records to evidence this.

A number of medicines were prescribed as 'when required' (PRN). A record was kept of PRN medicines and staff were following protocols for PRN medicines. For example, when to give a PRN medicine and the duration. We were told by staff that one person was prescribed PRN paracetamol but when we checked the person's MAR we found this was prescribed as a regular medication for pain relief. We found this record had not been completed fully; on some days the paracetamol was not recorded at all and on other days once or twice. Later in the day the person complained they were 'in pain' and they were given a dose of paracetamol. We were concerned that this person's pain relief was not being given as prescribed. A referral to the person's GP by staff would have been necessary to assess and alter the prescription. The management of this medicine did not ensure the best outcome for the person concerned.

The recording of paracetamol did not include the time of administration. This was important as the administration of paracetamol, to be given safely, should not be given less at less than four hourly intervals. We found this for all of the people we reviewed who were on paracetamol.

Some of the people living at the home where prescribed 'thickening' powder to thicken their drinks. This is to aid people who may have swallowing difficulties to accept fluids and reduce the risk of choking. For one person we saw the number of scoops of thickening agent needed was not recorded on their fluid chart, though talking with staff confirmed their knowledge of how many scoops to add in accordance with the dietician's instructions. The manager confirmed this information would be added to their fluid chart.

We asked what auditing mechanisms were in place to check if medication was being administered safely. The audits see did not identify any concern regarding the administration records for the application of external preparations [creams]; we noted, however, the audit tool did not contain reference to the checking of creams, times of paracetamol administration or of thickening agents. We questioned the effectiveness of this as the anomalies we saw had not been identified.

Following the inspection the manager and provider representative sent us an update telling us immediate action had been taken to review and update recording to ensure these medications were recorded accurately. Also the audit tools used had been improved to ensure both creams, paracetamol administration and thickening agents were routinely audited.

These findings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some medicines need to be stored under certain conditions, such as in a medicine fridge, which ensures their quality is maintained. If not stored at the correct temperature they may not work correctly. The temperature of the drug fridge was recorded. This meant the medicines stored in this fridge were safe to use. Medicines were administered from a medicine trolley. These were securely locked when not in use. We observed part of a medicine round and the staff member administered medicines safely to people.

All medicines were stored in a locked clinic room. The temperature of the room was recorded and for five days in April 2017 showed a temperature above the recommended safe storage temperature for medicines of 25C. On the first day of the inspection the recorded temperature was 26.3C. We pointed this out so that managers were aware of the need for further monitoring.

Controlled drugs were stored appropriately and we saw records that showed they were checked and administered by two staff members. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation.

People at the home had their medicines administered by the staff. People had a plan of care which set out people's care needs and also medicines to be given. The information recorded around medicines helped to support staff to safely administer medicines.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported to senior managers. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report through any concerns they had. We saw that the local contact numbers for the local authority safeguarding team were available. We saw there had been a safeguarding investigation at t home in March 2016 and the home had liaised well with the safeguarding team at social services to investigate the issues concerned.

We saw Birkdale park's policy for safeguarding adults and this lacked some detail which we discussed and the manager advised this would be updated. After the inspection we were sent a newly revised policy which included specific information on the reporting of alleged abuse.

We asked if people felt they/their family member was safe living at Birkdale Park. Everyone said yes to this. Most people did not elaborate on what they felt kept them safe, but agreed when prompted that such things as staff, security systems and equipment helped. Relatives outlined their reasons: "They've put a mattress next to [person's] bed for whenever they are distressed and might try to get out. Also, this chair [person sitting in] has been chosen specifically because it's safer for [person] to sit in", "[person] is being looked after well and has improved since being here. They have a profiling bed to avoid bed sores", "[Person] can't do very much for themselves now and is looked after here safely" and "[person] says they want to go home but we know that's not possible and they are so much safer here."

When observing general areas at Birkdale Park, we saw that measures had been taken to promote safe movement around the home. This included handrails along most corridors and where there were any

slopes. A range of equipment to enable people to move around independently and use the bathrooms and their own rooms safely was evident, and equipment to enable staff to support people in moving and using bathrooms was also evident. People were alerted to, and as necessary prevented from walking on, any wet floors by appropriate safety signage and we saw no cleaning substances or personal toiletries left within reach anywhere.

We saw one person being transferred from chair to wheelchair using a hoist. This was done carefully and safely, with carers taking time to check and readjust the person's position as necessary.

There was fire equipment in all areas and we saw personal emergency evacuation plans [PEEP's] were available for the people resident in the home. This helps to ensure effective evacuation in case of an emergency.

We found arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed on a regular basis where obvious hazards were identified. Any repairs that were discovered were reported for maintenance and the area needing repair made as safe as possible. We reported one possible hazard during our inspection and this was immediately rectified.

All maintenance / safety certificates were up to date. Renewal dates for these were on display in the administration office as a regular audit. Overall there was good attention to ensuring safety in the home and on-going maintenance.

We looked at how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We looked at two staff files of staff recently employed and asked the manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw appropriate checks had been. It is important that robust recruitment checks were carried out to help ensure staff employed are 'fit' to work with vulnerable people.

There were plenty of staff on duty throughout the day and on the whole routines such as meal times appeared to be organised so that people needing support or personal care could have their needs met without leaving others unsupported or without some support. Carers had oversight of people seated in lounge areas either by being actively present, for example giving support to people, or in passing, which happened at frequent intervals. People in their own rooms were also given oversight 'in passing' or in some cases by their use of call bells.

We asked people and their relatives if they felt there were enough staff to support everyone when needed, during both the day and the night. Everyone said they felt there were sufficient staff most of the time; one person commented, "Yes there's enough staff, more or less; at night too." Another person said, "Yes there are, but they don't pop in very often [chooses to stay in own room much of the time]. Sometimes when I ask to go out for a walk [in wheelchair] they say they can't because they're short-staffed." For 29 people living in the home at the time of our inspection there were normally two nurses and six care staff.

Staff interviewed told us they felt staffing was generally sufficient. Staff told us that they enjoyed working in the home and felt there was a good atmosphere and good team work. One staff told us, "We all get on well and there is enough staff." Another commented that the home was well run and "Everybody knows what they are doing."

There had been no reports of safeguarding concerns since the past inspection. The manager advised us of some examples of incidents, such as incidents of pressure ulcers, which might normally be referred /

reported as a safeguarding concern to the local authority with a notification also to us, CQC. Following our feedback the representative for the provider told us all nursing staff had been made aware of the criteria for notifications that needed to be made.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility, pressure relief and the use of bed rails.

When we looked round the home we found it to be clean. There were no unpleasant odours. Staff had access to personal protective equipment (PPE), such as aprons and gloves and we saw they used this when providing care. This meant that appropriate action was taken to ensure the home was clean and the risk of infections or contamination limited. All of the people living at the home and visitors we spoke with told us the home was always maintained in a clean and hygienic state. Several people commented that their rooms were cleaned every day and all said they were confident that staff followed hygienic practices.

Requires Improvement

Is the service effective?

Our findings

We looked to see if the service was working within the legal framework of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff had applied for three people to be supported on a Deprivation of Liberty Safeguards (DoLS) authorisation. The applications were being monitored by the manager of the home. We saw that if people were on a DoLS authorisation there was a supporting care plan to reference this. The home also used a tool to assess whether a person might need referring.

The staff manager were able to discuss examples where people had been supported and included to make key decisions regarding their care. For example We saw examples of DNACPR [do not attempt cardio pulmonary resuscitation] decisions which had been made. We could see the person involved had been consulted and agreed the decision or the decision had been made in the person's best interest after consultation with advocates [family members]. We found examples in care records were people had signed to consent to parts of their care plans and assessments.

We also saw that the manager was keeping a good record of people whose relatives had Lasting Power of Attorney [LPA] and we heard the manager talking to a relative about the importance of producing the relevant documentation for the home to see and retain a copy so they were clear about issues around consent to care and treatment.

Overall we found staff had enough understand of the issues concerned. Assessments in the care files showed mental capacity assessments were being made for key decisions and it was apparent sometimes people's mental capacity fluctuated. Staff therefor understood the people's ability to consent did change depending on the decision to be made.

We did find that not all records were clear however; for example, one person who had been assessed for the use of bedrails to help ensure their safety. The assessment recorded they had capacity to consent to this but the assessment was signed by a 'friend'. Initially staff told us the person had LPA but later we saw this was not the case. We discussed the need for audits to ensure these anomalies in recording were picked up.

During our inspection we reviewed the care of five people living at the home. We found examples of good practice were there had been effective liaison with supporting health care professionals. In one instance a person had been experiencing psychological distress and the staff had ensured a review by the community mental health team (CMHT). We spoke with a visiting professional who told us that the home generally

liaised well and reported health concerns effectively. We were told, "The right information is available when we come and if we ask for any follow up actions they are carried out."

Care records contained references to ongoing review and liaison with health care professionals such as peoples GP, dietician, district nurses and other professionals. We also saw that people could access chiropody, audiology and optician services as required.

All of the people and visitors we spoke with felt that staff were competent and had the skills to carry out care. One person told us, "Yes, I think they do know what they're doing." Another person commented, "I think so; they seem to deal with people okay. They're patient too."

The provider information return (PIR) for the service told us: 'We subscribe to the CQC website for social care news, RCN and NMC publications. This information provides evidence based practice on a wide range of topics to improve health outcomes and prevents the risk of inappropriate or unnecessary treatment and care given to our residents'.

The manager told us the home has strong links with the local hospice and staff have attended formal training in end of life care. The PIR stated: Queens court hospice also provide training and information on best practices throughout the year and we are also members of their nursing Home "Home loan" scheme which enables us to use their equipment which is checked regularly and all qualified nurse receive training on the equipment to be used. Queens's court also has a Palliative care link nurse scheme that we attend every three months'.

We looked at the induction process for new staff employed at the home. Staff we spoke with explained the induction process which included a standard checklist of information carried out over the first few days of employment, some shadowing of experienced staff and attendance at mandatory training such as moving and handling, safeguarding of vulnerable adults, fire safety and general health and safety.

The home was aware of and had introduced the Care Certificate as part of the induction. This the governments blue print for induction training in care homes and is an identified set of standards that health and social care workers adhere to in their daily working life. The standards cover areas such as, infection prevention and control, safeguarding adults, working in a person centred way and duty of care. The Care Certificate requires staff to complete a programme of training, be observed by a senior colleague and be assessed as competent within twelve weeks of starting employment. We were advised that at least one staff had previously gone through this.

We discussed other formal qualifications in care which staff had achieved or were enrolled on. We saw that staff was undertaking accredited qualification made up of units such as, NVQ (National Vocational Qualification) or Diploma under the QCF [Qualifications and Credit Framework). With regards to formal qualifications in care the manager told us ten of the nineteen current care staff had obtained such a qualification in care. This was confirmed by records we saw.

Staff support included supervision meetings conducted by the manager with individual staff. Staff we spoke with felt they were fully supported by the managers of the home and could speak with the manager and other senior members of the staff team at any time.

We asked people and their relatives what they thought about the quality of the food at Birkdale Park and if they thought there was enough to eat and if people were able to choose what to eat.
All responses were positive about the quality of the food, and all said there was always plenty to eat and

drink. People commented, "The food's very good and there's everything you could want", "There's enough for me, yes. They come round and ask [what they want to eat]" and "Lunch was nice today; there's enough choice and if there's anything else you'd rather have you can always say." A relative said, "[Person] was apparently shouting for fish and chips at night time so I was concerned they might be hungry and this was their way of saying it. I mentioned this and now they have some supper at 8pm before bed."

We observed snacks and lunch being served and people eating these. Cups of tea and coffee or cold drinks were offered during the morning and the afternoon, when biscuits, including some that were home-made, were also offered. One person was offered milkshake and drank a small amount. The care staff said this was done to both keep a person hydrated and provide additional nutrition.

Lunch was a hot meal of chicken casserole with cabbage and mashed potatoes, or egg salad, followed by bread and butter pudding. Both meals were quite easy to eat for anyone with difficulty and both looked appetising and attractive. One person who chose to sit alone told us that this was because they found it more pleasant. Two people eating in their own rooms told us that this was their choice and preference. There was staff available for those people needing extra support.

Good

Is the service caring?

Our findings

Relationships between staff and people living at the home were positive. Staff were friendly and warm, but respectful, and people seemed relaxed with support and care. We saw staff behaving very gently towards people when giving support. We also heard staff use a kind and friendly tone of voice when speaking to people, including when they needed to raise their voices or repeat things, to help people with hearing loss.

We asked people how staff treated them/their family member and if they were always kind and caring in their manner. Responses included, "Mostly; the door is open all night [by person's choice] and they pop their heads round; one of them is lovely", "They're lovely, the staff; they'll do anything for you", "Mostly they're nice and friendly" and "Yes, they are kind." A relative commented, "The staff, I find, are very focused on trying to keep [person] happy. Some are brilliant and treat [person] – and me – as very important people."

People were also asked if staff respected their dignity and privacy. Again positive responses were given, and when prompted people agreed with given examples of basic measures, such as staff knocking on doors before entering, closing doors and curtains when providing care, and generally treating people with respect. Bedrooms had a notice prominently displayed reminding staff of the importance of respecting people's dignity at all times.

When asked about care plan involvement and four of the six people living at the home spoken with and all four relatives, were aware of their/family member's care plan, and remembered signing or discussing/reviewing it.

One relative said, "I have LPA for health and I looked at [person's] care plan at the start. I'm now involved in any changes and have drafted the end of life preparation statement." We saw in care records examples where people or their relatives had been involved in their care.

It was evident that family and friends could visit as and when they/their family member wanted, and visitors sat in both shared and private rooms as suited them. When asked about this, everyone confirmed this. Several visitors also commented on being made to feel welcome and offered drinks. They felt the home was very homely.

We saw that people had access to advocacy support if needed. One person was engaged with the local advocacy support service and was getting support regarding their finances. The local advocacy service was advertised in the home.

Requires Improvement

Is the service responsive?

Our findings

We were concerned about some aspects of care for two of the people we reviewed. One person had returned from hospital the day previous to our visit. The person had complex health care needs that required close monitoring. The care plan was specific around the need to ensure a good fluid intake and for 'Staff to monitor input and output'. This was particularly relevant as the person had an indwelling catheter. Close monitoring of this was important to ensure the catheter remained patent. When we saw the person in their bedroom we could not find any charts to ensure the monitoring of fluid balance. There were two charts in place dated 10 and 14 March 2017 but no other fluid monitoring charts were available. The nurse advised us they would ensure monitoring was carried out.

In addition we could not find a record of when the catheter was due to be changed. Staff, when we asked, were not aware [we did see records for other people where available – 'catheter passports']. Following feedback the date of catheter change was sourced. The representative of the provider told us, "All [people] with catheters in situ to have a catheter passport in place on admission. All trained staff to be made aware of the importance of the documentation on admission and re- admission."

Another person we found to be in some distress in their bedroom and they were shouting for staff for a period of 30 minutes. We asked staff about this and also reviewed the person's care plan. The care plan told us that the person 'gets distressed' regularly and the plan was for staff to withdraw if needed as too much stimulus made them further distressed. We saw the person had also been reviewed by the CMHT in the past. The care plan was somewhat contradictory however as is also mentioned the person responded to touch and this helped in reducing agitation; this was confirmed by staff and our observations at another time. We suggested better monitoring was needed as we were not clear how frequent the person was isolated, without support, and the outcomes of this and whether this had any positive effect [this was not apparent on our visit]. The manager advised they would review the care plan to be more specific about intervention and measuring of incidents when the person was isolated in their room.

We would recommend that on-going monitoring of peoples care needs is more detailed on occasions and meets best practice.

We asked people how staff knew what they liked/disliked, or about their interests, and if they could choose what they wanted to do, such as activities, life choices or people they want to be with. People told us they were able to make choices. They said they could choose how and where they wished to spend their day, what meals they would like served and what time to get up and retire at night. A number of people chose to spend time in the lounge whilst others preferred to spend time in their own room. We asked people if they were given any choice about who provided their personal care, including being able to choose only male or female carers. Most people said they couldn't remember being given any choice of carer but one indicated that they had refused a carer of the opposite sex.

We spoke with one person who told us staff were very supportive and always asked them where they preferred sit and whether they wanted to join people in the main lounge or not.

Care records were completed, for example people's food and fluid intake and positional change when being nursed in bed. A care plan provides direction on the type of care an individual may need following their needs assessment. The care plans we saw recorded information which included areas such as, personal care and physical wellbeing, medication usage, communication, sight, hearing, mental health needs, skin integrity, nutrition, mobility, sleeping and social care.

Care plans were specific to the individual and there was reference to people's life history to get to know people's social care needs in more detail. These records, along with staff's daily written evaluation/notes meant care files contained important information about the person as an individual and their particular health and care needs.

We asked what sorts of things the home provided to keep people interested, active or involved. We were made aware that the home employed an activities coordinator, who was one of the care staff and who carried out the activities role part-time. All care staff provided some activities on a rota basis as part of their role. On the day of our visit, we saw evidence of past activities through items and photographs on display around the home. We were also shown evidence recorded in a file maintained by all staff under each person's name and we saw a variety of games, books, art materials in a large cupboard in the lounge.

During part of the afternoon one carer encouraged two people to colour in pictures with coloured pencils and to play a board game with one another. Another carer tried to engage people in catching and throwing a balloon. A hairdresser was available at the home, and people were able to use this facility on a fortnightly rota basis.

People were asked if there was a choice of activities to participate in and whether staff asked what activities they would like. Everybody was aware of there being some activities, even if they didn't choose to take part, but no one could recall being asked what they would like to see as activities at the home. Several said they preferred to read or watch television.

One person told us, "The staff do take me out in the wheelchair, to the shops and places. I don't take part in other activities." Care staff mentioned this person as enjoying coming to the lounge whenever outside entertainers visited. A relative said "[Person] always liked classical music and it keeps them calm, so I showed staff how to put Classic FM on the TV and when I've come in sometimes, it's been on."

We spoke with the new activities coordinator who told us they would be spending 12 hours weekly involved in this role. They had also been given extra support by being enrolled on a training course for providing activities for people.

People had access to a complaints procedure and this was available to people within the home.
A system was in place to record and monitor complaints and there were 12 complaints recorded since January 2016. Those we viewed had been responded to appropriately in line with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

As part of the feedback to the manager and senior managers we identified some key areas of the homes management where improvements were needed. Most notably the auditing processes regarding medication management. Existing audits were not fully developed to identify the issues we found in administration of medicines. Similarly, standards around the monitoring of some people's on-going care needs and the records surrounding these as well issues of consent for people when restrictions such as bedrails were in place.

Management awareness of the criteria for reporting issues through the safeguarding process was also not always clear. The manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home. We discussed the fact that CQC had not received any notifications to safeguarding in the last three years and how some incidents have, perhaps, met these criteria but have not been reported as such. For example people admitted to the home with pressure ulcers. We also saw a 'complaint' investigated by the, then, registered manager in March 2016 which was completed in liaison with Sefton social services safeguarding team and contracts monitoring department for which we had not received a statutory notification. We received a response from the provider following the inspection which said, "Birkdale Park's safeguarding policy to be revised to include procedures on how to report any Safeguarding issues. Staff training to be updated to cover Sefton's Safeguarding reporting."

The management team have, since our feedback responded and acted on these identified areas of concern; for example we were told audit tools and records for mediation have been improved. The representative of the provider sent some assurance that improved monitoring would improve the overall governance arrangements further and told us, "I am now personally involved in auditing the audits on a monthly basis so that I have the assurances too."

These findings were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of the inspection there was a manager in post but they were not yet registered with us (the Care Quality Commission). A registered manager is a person who has registered with the Care Quality Commission to manage the service. The manager had applied to be registered.

We found the manager and senior staff exposed a positive ethos of care in the home. This was provided by the manager and nursing staff displaying a good clinical skills and a solid knowledge base. Staff, people living at the home and visitors all spoke positively about the manager who was described as supportive, open and a consistent presence in all areas of the home. Comments from people and their relatives included, "I know [deputy manager] they are very nice, a very good person, I think", "Whenever I come in, they [staff] all say hello to me. I think it is managed well and they seem to be working hard to maintain and improve the place" and "I feel like I can trust them and that I can mention anything. [Manager] is very down to earth and [owner] is often here and seems to know everybody."

The manager told us they felt supported by the provider's development of the governance arrangements and support which had helped them to develop standards in the home. The manager was open and we saw they could reflect positively on the feedback we gave as we went through the inspection.

There was a clear management structure for the service from the providers, senior managers registered manager, senior nurses and senior care staff. The provider visited the home regularly and attended many of the weekly management meetings held.

We reviewed some of the current quality assurance systems in place to monitor performance and to drive continuous improvement. Internally, we saw audits carried out for medication safety [these required further improvement], care planning and routine checks for health and safety regarding the environment and infection control.

We were showed an outline of the governance audits which were displayed in the main administration office. These were centred around the 'Big 8' audits consisting of Safety [daily weekly and monthly audits], Utilities [gas, electric],clients views, HR files, Food / hydration, Infection control, maintenance and medications. It was explained by the provider representative that these audits maintained the 'heart beat' of the service. Each week a management meeting was held to discuss any feedback and action any plans from issues identified.

The service had also developed good systems for getting feedback from people living at the home and their relatives as well as staff. We saw a series of surveys and meetings aimed at seeking feedback about the home. For example a recent meeting held in February 2015 was attended by seven relatives and discussed issues current in the home. There were three monthly surveys sent out to gauge satisfaction and get feedback about the service. We saw the general satisfaction was high with no concerns raised.

From April 2015 it is a legal requirement for providers to display their CQC (Care Quality Commission) rating. 'The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided'. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for Birkdale Park was displayed for people to see.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always administered safely. Medication administration records [MARs] were maintained but some recording of medicines were not clear or consistent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance With respect to medicines, the audits had not picked up on the shortfalls we identified at the inspection. Some clinical records regarding on-going monitoring of care were not always clear. Criteria for submitting statutory notifications to the Commission needed reviewing.