Care UK Community Partnerships Ltd

Birchwood - Newbury

Inspection report

Birchwood Road
Newbury
Berkshire
RG14 2PP

Tel: 0163533967
Website: www.birchwoodnewbury.co.uk

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18 February 2016

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 16, 17 and 18 February 2016.

Birchwood – Newbury is a care home that provides services over three floors. The ground floor, with ten beds is predominantly for people with low level care needs. The first floor offers accommodation for a maximum of 25 people and the second floor provides nursing care to a maximum of 25 people. Each floor is managed by a 'unit manager' who oversees the care provided.

The home is required to have 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. The home has been operational without a registered manager since June 2014, which is an offence under section 33(b) of the HSCA 2008. A manager was appointed in November 2015, who was in the process of applying to the CQC as a registered manager. However she ceased employment on 11February 2016. Measures to support the service had been implemented. This included an interim service manager, as well as support from the regional manager and director, until a manager is appointed.

Staff knew how to keep people safe by reporting concerns promptly. Systems and processes were in place to recruit staff who were suitable to work in the service and to protect people against the risk of abuse. Staff had the relevant training and experience to manage people's needs.

We observed good caring practice by the staff. People and relatives of people using the service said they were happy with the support and care provided. All people spoken with said they thought they were treated with respect and staff preserved their dignity at all times.

People were supported with their medicines by suitably trained, qualified and experienced staff. Medicines were managed safely and securely, with correct reference being made to the medicine administration records (MAR) when administering medicines.

People who could not make specific decisions for themselves had their legal rights protected. People's support plans showed that when decisions had been made about their care, where they lacked capacity, these had been made in the person's best interests. Care plans and risk assessments were updated in conjunction with people's changing needs. This meant that care was responsive and met people's care needs.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The DoLS provide legal protection for vulnerable people who are, or may become, deprived of their liberty. Applications had been made as required, and were recorded on the provider's computer system.

We found that quality assurance audits and governance of documents were completed by the service. This therefore allowed assessment and changes to be made where the service felt necessary.

People received care and support from staff who had received induction and shadowing from experienced staff. Staff stated they did not always feel supported by the management. They said they were not always consulted or listened to if they raised concerns, specifically in relation to staff deployment. It was found that supervisions and appraisals took place infrequently. This potentially affected the level of support staff had to carry out their duties. We found this was linked to the lack of consistent management of the service.

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.

People were safeguarded from abuse and staff understood how to report any concerns they had.

A robust recruitment procedure was in place.

Current staffing levels were minimal which led to task focused support.

Is the service effective?

Requires Improvement

The service was not always effective.

People received timely support from health care professionals.

Team meetings were held frequently, as were forums for people and their relatives.

Staff training was not all up to date. Supervisions and appraisals were infrequent.

The premises did not support people's continuing health needs, specifically in relation to the design of the building for people with dementia.

Is the service caring?

Good

The service was caring.

Staff worked in a caring and respectful way, involving people in decisions, where possible.

Staff knew people's individual needs and preferences. They gave explanation of what they were doing when providing support.

Is the service responsive?

Good

The service was responsive.

Systems were in place to manage complaints.

Activities were in place for the service as a whole. A newly appointed co-ordinator was developing individual activity plans for people.

Written care plans and appropriate risk assessments were reviewed regularly and updated as required.

Is the service well-led?

Requires Improvement

The service was not well-led.

The service has been operating without a registered manager since June 2014.

Staff deployment and training did not meet the needs of the people or staff.

Birchwood - Newbury

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 carried out by two inspectors and a specialist nurse advisor at the service on 16 and 17 February with follow up interviews on 18 February 2016. The inspection was unannounced on the first day.

Prior to the inspection the local authority care commissioners were contacted to obtain feedback specifically in relation to the service. In addition we referred to previous inspection reports, local authority reports and notifications. The provider is required to send the Care Quality Commission notifications of any significant events that are related to the service. This may include anything from a serious injury to allegations of abuse, to an event that can stop the service.

During the inspection we spoke with nine members of staff including the interim manager, regional management, the deputy manager, unit managers, health care assistants, a registered nurse (RGN) and the maintenance man. We further spoke with five visiting professionals, including the GP, occupational therapist, physiotherapist, RGN and a local authority care manager.

Nine people who use the service and four of their relatives were consulted during the inspection process. In addition we used the Short Observational Framework (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. This was used over lunchtime. We further completed general observations during medicine rounds, handover and activities to see communication and information sharing processes.

Care plans, health records, medicine records and additional documentation relevant to support mechanisms were seen for 12 people. In addition a sample of records relating to the management of the service, for example staff records, complaints, quality assurance assessments and audits were viewed. We looked at staff recruitment and personnel files for seven of the regular staff team.

Requires Improvement

Is the service safe?

Our findings

People were not always being kept safe. Staffing levels were not always sufficient to meet their care needs and keep them safe. We found that people who had specific support needs were able to walk around the service without staff knowledge of their whereabouts. For example, whilst speaking with a person in their room, another person walked in and began to look around. We redirected the person to their room, after establishing, through speaking with staff that this person has a history of walking into others rooms and taking their items. This was verified through checking the person's care plan that clearly identified this as a pattern of behaviour. The service were seeking to increase the staffing ratio for this person, to manage this behaviour. However, until this had been agreed the person was able to walk into other people's rooms because there were insufficient staff. . A relative reported, "Sometimes there aren't enough people around to help". Staff also felt there were insufficient numbers of staff available to keep people safe and to respond appropriately to care needs. One person on respite could be heard calling out both distressed and confused repeatedly during both days of the inspection. Although staff would visually check the person was okay, they were unable to spend time with the person to reduce their stress and confusion related to where they were. Rotas for the last six weeks showed that the minimum staffing requirements had been met. Where necessary the management had covered the rota personally to maintain minimum staffing numbers. Staffing hours were calculated based on core hours, to which additional staffing requirements were added following assessment of needs. The inconsistency with management meant that this information had not always passed on operationally and authorised to enable increased staffing. The interim management team recognised that this had further been exacerbated by inadequate deployment of core staff, and is further discussed in the report. The service was currently using agency staff specifically registered nurses (RGNs) as a result of current maternity leave. Where possible consistent agency staff were used to minimise the impact on people.

Staff employed at the service underwent comprehensive recruitment processes. They were vetted to ensure they were appropriate to work with vulnerable people. This included obtaining references for prospective staff to check on their behaviour in previous employment and a Disclosure and Barring Service (DBS) check. This safety check allows employers to ensure an applicant has no criminal convictions which prevented them from working with vulnerable people. A full employment history had been obtained for all staff and gaps in employment were explained.

Medicines were supplied and delivered by a community based pharmacy. They were stored safely and securely. We observed a medicine round completed by one of the RGN's. Correct procedures were followed. The name of the person was checked against the medicine administration record (MAR) which was then correctly signed off by the RGN when the medicine was administered. Audits of medicines were completed regularly to ensure procedures were followed. The RGN at the time of the medicine round was not involved in any other task. This means that their role was very specific at that time, this is done to minimise the chance of distraction and errors.
Staff had a good understanding of both the safeguarding and whistleblowing procedures. They were able to explain the actions they would take if they witnessed or had concerns about abuse. Training records showed staff had undertaken training in safeguarding people against abuse very recently and this was refreshed on a

regular basis.

Incidents, accidents and falls were frequently monitored, with any noticeable trends being further explored, assessed and managed. This meant that similar incidents could be prevented by proper management. The service worked in partnership with external visiting professionals (the falls team) in relation to this area, who monitored the trends with the home, producing a report. Staff were further trained in this area of specialism, enabling them to pick up early warning signs of possible risks and implement strategies to prevent similar incidents from reoccurring. This had been an effective way to keep people safe, as successful measures were implemented to prevent additional incidents.

The service had a comprehensive evacuation plan. Colour coded dots were placed on people's doors to indicate the specific plan that was to be followed. However, documents that were related to the dots were printed in black and white, meaning the colour coding was not visible. We spoke with management regarding this, and were advised that colour printouts would be made available. Fire drills were completed regularly to ensure that staff knew what action to take in the event of a fire emergency. Fire equipment was regularly tested to ensure it was safe to use. The contingency plan which gave clear instructions for staff to follow should there be an emergency was regularly reviewed. This contained details of alternative accommodation in the event of a need for evacuation. An emergency box contained copies of people's care documents to be taken with them.

Regular maintenance checks were carried out on the building and equipment. The newly appointed maintenance man completed as many of the tasks as possible. A list of work was produced. If specialist skills were needed, external contractors were called.

People were protected against environmental risks to their safety and welfare. The management and maintenance man completed daily visual checks of the premises to note any concerns. Hot water temperatures, fire exits, slip hazards and similar checks were completed as part of routine health and safety monitoring. The furnishings appeared in good condition and well maintained. Service contracts were in place to regularly service equipment, such as the lifts, hoists and fire equipment. During the inspection we were told that one of the lifts was out of order, this was fixed and in working order the next day.

We recommend that the service consider re-evaluation of the current staffing levels and deployment are assessed.

Requires Improvement

Is the service effective?

Our findings

People were cared for by a team of staff who underwent a detailed induction process. This included, in accordance with the company's policy and procedure, completion of the company's mandatory training. Additional training was sought that would be supportive to staff in their role. Before commencing work staff shadowed more experienced staff until they felt confident to work independently. The training matrix showed that all mandatory training was completed. Not all supportive training courses had been completed by staff prior to commencing work, however they were booked onto courses. The provider was in the process of developing a training role, that would enable the trainer to come into the service and deliver face to face training to staff that would be bespoke and relevant to their people. Currently, training was delivered through e-learning and external training providers.

Staff had not received regular supervision and annual appraisals, as per the company policy. This was linked to the previous inconsistency in management, and had been recognised by the new senior management team. As a result all staff had received supervision within the last couple of months. A rolling programme of supervision had been developed by the service that would alert management when supervision was due. This was seen as a positive process to prevent the possibility of ineffective support mechanisms re-emerging. Meetings with management were held daily by senior staff from all floors of the service. In addition meetings were held on each floor between the floor manager and the staff working there. This provided staff and management with the opportunity to address any specific concerns related to people for whom they were providing care, and provide updates on operational issues.

People and family felt that staff had the skills they needed to complete their jobs effectively. One person said, "They are very good here. They know how I need to be supported and make sure that I am cared for properly."

People's right to make their own decisions where possible, were protected. Staff understood the principles of the Mental Capacity Act 2005 (MCA). They told us they had received training in the MCA and understood the need to assess people's capacity to make decisions. The MCA provides the legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. Staff stated how they asked for permission before doing anything for, or with a person. The requirements of the Deprivation of Liberty Safeguards (DoLS) were being met. Staff were able to describe why people were on DoLS and the implications for caring for them. People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA.

People received effective health care and support. They were able to see their GP and other professionals such as the occupational therapist (OT) or physiotherapist as and when required. We spoke with five visiting professionals who were involved in delivery of health related services to the service. The service noted who had requested to seethe GP as well as people who they felt needed medical consultation. The GP would visit each person in their room, ensuring people's dignity and confidentiality was maintained. Information was shared with the staff team and noted in records for reference. A visiting professional reported "Can't fault them on anything they deliver. They follow through on advice."

The visiting OT and physiotherapist were complimentary of the staff, although they did report, that some people were kept in bed as staff were unaware they could be further helped and supported. However, with continual input by the West Berkshire Care Home Support Team, referrals had been made to the OT for further assistance. Training was being delivered to the staff in relation to seating and mobility, so that they could recognise and understand what additional support could be sourced for people.

People were offered drinks throughout the day. If people were in their bedrooms or in the lounge, these were offered and available to them positioned in close proximity to where they were seated. The kitchenettes on each floor had additional drinks openly available. Snack baskets were positioned in communal areas, and offered to people between meals. These contained both healthy and sweet options for people.

A SOFI observation completed over lunchtime, showed people were offered a selection of drinks as well as two options of hot meals. Plates were made up to show people what was available to eat. Visual cues are an effective way to help people with dementia to process information, specifically when making choices. People were relaxed whilst eating, with one person singing along to the music being played. Whilst two staff members were present during the serving of food, only one was able to stay and offer assistance in the dining room, as one assisted someone in their bedroom. This member of staff was supporting one person with eating. One person was observed to fall asleep on several occasions during the course of the meal; this resulted in them not eating all their food.

People's bedrooms were personalised and decorated in line with their requirements. This allowed people to feel comfortable in their environment. However bedroom doors did not identify who lived in each bedroom. Memory boxes were not used. No signage was available for people who were living with dementia to orientate them to the right areas. Whilst some small areas for reminiscing had been created, these were incomplete and appeared half hearted, with items that went missing not being replaced. This was leading to people becoming confused and upset, as they were unable to find the room they were looking for. The home was not making relevant alteration to accommodate the changing health needs of people.

We recommend that the service seek advice and guidance from a nationally recognised source with regard to appropriate training for staff in relation to dementia care and dementia friendly environments.

Good

Is the service caring?

Our findings

People were treated with care and kindness. During the inspection we observed staff speaking to and approaching people in a caring way. Staff were observed gently placing their hand on people's shoulder or on their hand, and coming down to the same level when talking to them. This was witnessed throughout the days of the inspection. One family member said "[Name] is treated like a person. The atmosphere is calm and caring", whilst a person using the service reported "they look after me well here". One of the visiting professionals stated, that this was the type of service she would consider for herself. As the staff were considerate to people's feelings and genuinely delivered a caring and good service.

Care plans were devised through discussion with family members and people using the service. Where necessary external professional advice was sought, and incorporated into the care plan. It was evident that staff knew people well and responded to their needs appropriately. However, at times due to minimal staffing levels, staff became "task focused" and were unable to spend additional quality time with people to have a general conversation.

People's personal history was recorded and used to establish things they liked and disliked. This was generally used in conversation by staff when assisting people. For example, a person who had returned from an external activity told a member of staff and one of the inspector's about their experience and how they recalled their youth, as a result of the activity. We observed staff continuing the conversation when assisting them with general tasks in their room, and within the communal lounge area. The service had recently appointed an activities co-ordinator who was in the process of developing a comprehensive history of people's favourite activities, to incorporate into both individual and group activities, if appropriate.

People's right to confidentiality was protected. All current records were kept securely on each floor in the relevant office. However we did find that files that were due to be archived had been left on the floor in the unlocked office / summer room on the ground floor. This was discussed with management who advised that one of the secure cupboards had been moved from the office, hence the content emptied. We were reassured that all files would be removed and securely archived. This had been completed by the second day of the inspection. Visits from health professionals were carried out in private in people's own rooms. We observed staff protected people's rights to privacy and dignity as they supported them during the day and any personal care was carried out behind closed doors. Staff were observed asking before entering people's room. People we spoke with told us staff would explain things to them before completing personal care tasks. his was reflected in the daily records which although concise stated whether personal care was offered and completed.

Residents and relatives meetings were held at the service frequently. This provided people with the opportunity to discuss any issues and offered a chance to meet together. The outcome of the meeting was detailed and presented on a board near the main entrance. The service further updated the board, to illustrate what actions had been taken as a result of the meeting, and what was outstanding. Relatives of people told us that the meetings were a good opportunity for them to discuss concerns. Recent changes to the service had raised many issues and questions, which were answered and actioned as result of the

collective group meeting.

Good

Is the service responsive?

Our findings

People had their needs assessed prior to them moving into the service. The staff were responsive to people's needs and to the impact of their presence on others. It was recognised that people on short-term respite did at times impact on long term residents. For example one person recently admitted on respite care was continually calling out during the day, irrespective of whether staff responding to them. Staff stated that this continual vocalisation potentially affected other people using the service, who were used to a quieter environment. Staff were in the process of completing a more comprehensive working document to determine how to respond appropriately to meet the person's needs. This included liaising with the family and external professionals. This document would then be used for all future respite stays.

Care plans were frequently updated to accurately reflect changes in care and health needs and how to manage these. Risk assessments were updated in line with changing health, social and behavioural issues. These were presented simply to ensure staff could appropriately respond to people's needs. We spoke with a visiting nurse regarding one person whose behaviour had become more complicated over time. Staff recognised that these changes were related to deterioration in health needs. An application to increase the staffing for this person had been submitted. In the meantime the person's behaviour had intensified. Measures to manage this had been discussed with relevant external professionals Families had raised concerns regarding this person taking items from other people's rooms. The service had considered placing door alarms on all doors; however this was recognised as impacting on other people's freedom and human rights. Staff were trying to manage this to the best of their ability whilst extra resources had been requested.

Staff were generally observed to be able to recognise when people were becoming agitated or anxious, and where possible this was managed through diversion strategies. Staff spoke with people to divert their attention to other topics in an attempt to decrease anxiety. However, staff reported they felt there was insufficient staff to enable them to do their job effectively and responsively. There were several reasons for this including maternity cover, current staffing vacancies, sickness, and recent resignations.

People were supported to maintain relationships with their family and friends. We saw visitors were welcomed warmly to the home and were offered drinks during their visit. Relatives told us, "We are welcomed at all times. I come at different times; my [family member] is always clean and is offered food… I do sometimes have to help [family member] with eating. We asked the family member to elaborate further, and were told because sometimes staff are busy helping others.

People and their relatives were aware of how to make a complaint and told us they would speak to one of the management. Complaints were dealt with quickly and resolutions were recorded along with actions taken. Some of the relatives of people we spoke with told us that they had raised complaints and concerns with the previous manager. These had now been resolved.

Requires Improvement

Is the service well-led?

Our findings

The service has been operating without a registered manager since June 2014. This is an offence under section 33(b) of the Health and Social Care Act (HSCA) 2008. This stipulates the need for a manager who is registered with the Care Quality Commission (CQC) to manage the regulated activity. In November 2015 a manager was appointed and had submitted an application to the CQC for registration, however, shortly before the inspection they ceased employment. The provider had placed a senior management team to work in the service location in an aim to develop the service whilst actively recruiting for a new manager.

The service has a history of poor sustainment of leadership due to the lack of a registered manager. The clinical lead position was also vacant, meaning that decisions related to nursing care are being made by each individual RGN on shift at the time. This could potentially lead to inconsistent management and lack of oversight of people's nursing care needs. This had been recognised with instruction of the new management team to deal with these issues.

Staff raised concerns regarding management of the service stating that they received infrequent supervision and support. This had led to them feeling demotivated and poorly appreciated. One member of staff reported, "I had got to the stage where I didn't want to come into work. I love my job, but I just couldn't cope." All staff had recently had supervision. However the inconsistency in this had left staff feeling vulnerable and unsupported. We are unable to comment on how this impacted on staff as this process had only commenced and we had not observed consistency in the supervision process. However staff morale reportedly had improved.

Communication in the service had historically been a significant concern. Important decisions had been made without consultation with staff and people. This had resulted in a negative impact on the welfare of people and staff. We were told of an incident from December 2015 where shift patterns were changed across the service without discussion. Staff were no longer working on a designated floor, but were expected to work across all floors. This led to poor consistency, people not knowing who they were being cared and supported by, and increased anxiety and poor welfare for both people and staff. A petition had been delivered to the manager, by staff raising concerns about the impact such a decision would have on people. However, the manager implemented the rota changes irrespective. Since the presence of senior management it was recognised that the deployment and organisation of staff had led to poor consistency of care. Changes have been made to reinstate the original working patterns of staff. This illustrated that the new management were both listening to concerns raised by relatives and staff, and responding to these appropriately and in a timely fashion.

There was strong evidence of working in partnership with external professionals. Some of the documentation used within the service was written in collaboration with the external professionals involved in people's care. Treatment plans were reviewed regularly by all the people involved in the delivery of care.

Quality Assurance Audits completed by the new management, highlighted areas where future development was needed. An action plan was generated from this information to ensure that systems remained in line

with good practice guidelines. Feedback was sought from people, relatives, professionals and commissioners to see how the service could be improved. Consistent concerns were raised regarding the lack of consistent management of the service and how this was impacting on people and staff. Comprehensive audits were completed of all care related documents, and those related to the maintenance of the premises. No concerns were highlighted in these areas of the service.