Care Quality Commission

Bupa Care Homes (CFHCare) Limited

Birch Court Nursing and Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service effective?	**Inadequate**

Overall summary

This focused inspection took place on the 5 and 6 August 2015. The inspection was unannounced. The last inspection was a comprehensive inspection which took place in February 2015, when the registered provider was found to be meeting all the requirements for a service of this type with an overall rating of Good.

Birch Court provides nursing and personal care for a maximum of 150 people across five units. Personal care is provided for up to 30 older people living with dementia in Brook House. Nursing care for up to 30 older people living with dementia is provided in Waterside House. Nursing care for up to 30 older people is provided in Moss House and Fern House. At the present time Bank House is empty. All bedrooms are single and are on the ground floor. There are no en-suite facilities.

There was a registered manager in post. 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 registered manager was on annual leave at the time of our inspection and the home was being managed by the deputy manager a qualified nurse who was also known as the clinical services manager.

Although people told us they had enough to eat and drink, monitoring and recording of food and fluid intake was ineffective, which meant vulnerable people were at risk of dehydration and malnutrition.

Summary of findings

We found that the registered provider did not provide the people who lived in the home with the protection afforded by the Mental Capacity Act 2005. The unit manager on the Waterside unit and staff did not have a thorough understanding of the deprivation of liberties safeguards and the conditions upon which they had been granted. This lack of knowledge resulted in people's human rights not being protected.

Staff lacked basic knowledge and skills on the management of challenging behaviour and there was a risk that the medicine was being given unnecessarily and not in line with the prescribers directions.

We identified breaches of the relevant regulations in respect of person-centred care, need for consent, safe care and treatment, records and staff training. You can see what action we told the provider to take at the back of the full version of the 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 effective?

The service was not effective because staff did not have a thorough understanding of the deprivation of liberties safeguards and the conditions upon which they had been granted, which resulted in people's human rights not being protected.

Staff lacked basic knowledge and skills on the management of challenging behaviour and medication was not always managed safely.

Monitoring of food and fluid intake was ineffective which meant vulnerable people were at risk of dehydration and malnutrition.

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Birch Court Nursing and Residential 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook a focused inspection of Birch Court Nursing and Residential Home on 5 and 6 August 2015. We carried out this inspection in response to concerns raised by a member of the public about the standard of care provided on the Waterside unit of the home. Whilst we visited all parts of the home during our inspection we focused our inspection on the Waterside unit. We

inspected the service against one of the five questions we ask about services: is the service effective? This was because the concerns raised by the member of the public highlighted a risk that the provider may not meeting legal requirements in relation to that question. We asked are people receiving effective care, which is based on best practice, from staff who have the knowledge and skills they need to carry out their roles and responsibilities?

The inspection was undertaken by one adult social care inspector.

During the inspection we spoke with seven people who used the service together with three relatives. We talked with four members of care staff as well as the clinical services manager, three unit managers, two registered managers from sister homes operated by the provider and the quality assurance manager for Bupa Care Homes (CFHCare) Limited (the registered provider). We looked at care records relating to 17 people who lived at the home. We looked around the building including, communal areas of the home and bedrooms of the people who used the service.

Before our inspection we reviewed the information we held about the home. We shared information with the local authority under adult safeguarding procedures and we liaised with a Care Quality Monitoring Officer and a Safeguarding Strategy Manager employed by Warrington Borough Council.

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Is the service effective?

Our findings

People appeared relaxed in the home's environment and those who were able to speak to us and share their views told us that they were well cared for and their needs were met. Relatives told us that care staff were kind and caring and overall they were satisfied with the standard of care provided. One of the relatives spoken with described an incident where their loved one had been subjected to inappropriate and unauthorised restrictions on their freedom of movement.

The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken.

The Care Quality Commission (CQC) is required by law to monitor the operation of DoLS. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated DoLS, with the clinical services manager and the house manager on the Waterside unit. The house manager told us that none of the 29 people currently accommodated on Waterside unit had capacity to make decisions and would not be allowed to leave the home unsupervised as this would put them at risk of harm. This meant that all the people living on the unit would need the protection of a deprivation of liberty safeguard to ensure that the decisions to limit their freedom of movement were made in their best interests.

The house manager told us that DoLs applications had been made for some of the people living on the unit but was unable to tell us which person had an application made on their behalf or those who had a DoLS approved. We were concerned as to how such a lack of basic information on the part of a person who was in charge of the unit could impact on the wellbeing of people who lived on the unit as it was likely in such circumstances that people could be subjected to unauthorised deprivation of liberty.

During the inspection we spoke with a relative of one of the people living at the home about DoLS. They told us that other family members had been prevented from taking their loved one on a day trip the weekend before our inspection. The house manager told us that this had come about because of a misunderstanding of how the person's deprivation of liberty safeguards were applied and a lack of information in the person's care plan.

The home's clinical services manager maintained a checklist referred to as a "DoLS tracker". This showed that applications for DoLS had been made for 12 of the 29 people currently accommodated on the Waterside unit and that authorisations had been granted for 7 of them. This showed that there were no applications made for 17 of the people living on the unit, who according to the house manager were not free to leave the home unsupervised and were under continuous supervision and control. In the eyes of the law this meant that these people were being deprived of their liberty. If a person is deprived of their liberty, this must be specially authorised in accordance with the requirements of the Mental Capacity Act. For care homes, the process of achieving such authorisation is the Deprivation of Liberty Safeguards. This meant that people's human rights were not being protected because they were deprived of their liberty without the protection of DoLS.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In providing care and treatment of service users the registered provider did not act in accordance with the Mental Capacity Act 2005.

The DoLS tracker maintained by the Clinical Services Manager showed that the home had DoLS applications approved for 10 people living at the home in total in 2015. However, the Commission's records showed that we had only received notification relating to 9 of these people. This showed that the provider had failed to notify the Commission that DoLS applications had been approved for a further person accommodated at the home.

This was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009. The registered person must notify the Commission without delay of any DoLS application being approved.

The house manager told us that two people living on the unit presented with difficult behaviour which presented a risk of physical abuse and assault to other people who lived on the Waterside Unit and staff. This behaviour was described as "behaviour that challenged". We looked at the care records for one of these people and found that the risks presented by their behaviour had not been thoroughly

and effectively assessed. Known triggers had not been identified and there was no plan of care as to how staff should respond to the manifestations of the behaviour in a way that would ensure the safety and well-being of the person and others. Arrangements had not been made to ensure that any episodes of difficult or aggressive behaviour were recorded effectively. This is essential in order to enable care staff and clinically trained staff to learn from experience and develop effective methods of responding to, deescalating or redirecting manifestations of behaviour in the least restrictive way.

We looked at this person's medication administration records and found that their doctor had prescribed a medicine to be used on an as and when required basis for extreme agitation, maximum four times a day. The medication administration record and the person's daily records showed that they had been given the medication consistently four times a day for the last 23 days even when there was no evidence of any extreme agitation or aggression. On the contrary records showed that the person was administered the medication on several days when they were described as "pleasant in mood and manner" throughout the day. This meant there was a risk that the medicine was being given unnecessarily and not in line with the prescribers directions'.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person must ensure the proper and safe management of medicines.

Care staff told us that they did not read care plans but had developed methods of responding to challenging behaviour and generally took people to a quiet place. A member of public told us that people who shout out a lot are then put in the 'quiet' room. The house manager on Waterside told us that the home used a quiet room which had originally been used as an office. We found that this quiet room was fitted with a coded lock. Whilst the coded lock was designed to prevent access to the room the type of handle fitted on the inside and its location at chest height meant that most of the people living on the unit would find it difficult if not impossible to operate should they wish to leave the room once inside.

The house manager on Waterside told us that when they started to work at the home in June 2015 they found that the staff group's morale was extremely low, they lacked support and confidence and training on important aspects of care including the management of challenging behaviour. We spoke with three of the care staff about the management of challenging behaviour. They told us that the subject had been discussed in brief as part of their induction training but they had not received instruction or training on the varying aspects of challenging behaviour, possible causes or techniques to manage the behaviour such as de-escalation and or re-direction. Staff told us that they would intervene physically if a person's behaviour presented an immediate risk of harm to themselves or others but they had not been trained in safe restraint.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Persons employed by the service provider must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties they are to perform.

The house manager told us that seven of the people who lived on the Waterside unit were being nursed in bed because of their frailty and complex nursing care needs. We found that four of these people did not have access to a nurse call alarm as these were either missing or the device was placed out if their reach. Staff told us that these people did not have capacity to use a nurse call alarm so they were not provided with one. We asked staff what arrangements were made to ensure the well-being of these people and we were told that staff undertook checks two hourly. We spoke with the house manager about this and looked at the care records for two of these people and could see that a record had been made of their inability to use the nurse call alarm but the risk this presented to these people had not been assessed and effective control measures had not been put in place.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not provided in a safe way for service users because risks of leaving them unattended had not been assessed and effective arrangements for their care had not been made to mitigate any associated risk.

The house manager on Waterside was unable to provide basic details about the needs of people who lived at the home. When asked if any of the people living on the unit had pressure ulcers the house manager advised there was

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Is the service effective?

just one person who had a grade three pressure ulcer. The Clinical Services Manager corrected this and told us that the person did not have a grade three pressure ulcer, it was a grade two.

Staff told us that another person living on the unit had a pressure ulcer on their sacrum and records confirmed this to be the case. The house manager told us that they were unaware that this second person still had a pressure ulcer, as they had thought it had healed. We were concerned that this lack of management oversight as to the needs of people living on the unit could result in people being at risk of their needs not being met.

One of the people we spoke to told us that they had a catheter but did not know why and said how uncomfortable this made them feel. We spoke with the house manager about this but they told us that they were unable to tell us why this person had a catheter, and they had wondered why themselves. We asked the house manager whether the issue had been clarified with this person's doctor or specialist catheter nurse and were told not. The local authority contracts officer and a specialist nurse from the local clinical commission group visited the home whilst we were there. They told us that they had found that this person had large open wounds on both their legs, believed to have been caused by their catheter. These wounds had not been dressed; there was no documentation in this person's care records as to how these wounds were being treated. Without effective assessment, care planning, dressings and treatment of these wounds this person's health and well-being was put at risk.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not appropriate to meet their needs and reflect their preferences.

A member of public had raised concerns that people living on the Waterside unit were not getting sufficient fluids. The people living on the unit were unable to tell us so we looked at the food and fluid records. At 6.20pm we found that the records for six people had not been entered since 6am and a further eight had not been entered since 9.30 that morning. Staff told us that they had given people drinks throughout the day but had not yet got around to writing up the records. If staff are to make effective use of records to help them assess whether people are getting sufficient fluids they need to write them up at the time the fluids are consumed. The monitoring and recording of food and fluid intake is vitally important when people have complex health and mental health needs or are unable to request food and fluids due to a lack of mental capacity. Failure to maintain effective records exacerbates the risks of dehydration and malnutrition and puts the health and wellbeing of people at risk.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not maintain an accurate complete and contemporaneous record of the care and treatment provided to each person.

The area manager told us that the registered manager had identified that staff required additional training on the management of behaviour that challenged and training courses had been arranged to take place on four separate dates in August 2015. Information provided by the provider's Area trainer confirmed that the course content included: Relevant legislation and good practice guidelines, Internal policies and documentation, Understanding what is Challenging Behaviour, Understanding the Triggers to Challenging Behaviour, Effective De-escalation Skills, Breakaway Techniques and Safe Holds and Escorts.

Care staff working on the Waterside Unit told us that they had never been so well supported until the house manager started work on the unit in June 2015. They told us that the house manager operated an open door policy, was approachable, fair and considerate.

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 9 HSCA (RA) Regulations 2014 Person-centred care Care and treatment was not appropriate to meet the needs of people who used the service and reflect their preferences. Regulation 9 (1) (b) and 9 (1) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent In providing care and treatment of service users the registered provider did not act in accordance with the Mental Capacity Act 2005. Regulation 11. - (1) and 1.-(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users because risks of leaving them unattended had not been assessed and effective arrangements for their care had not been made to mitigate any such risk. Regulation 12.-(1), 12.-(2) (a) and 12.-(b)

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

This section is primarily information for the provider

Action we have told the provider to take

Medication was not being effectively managed and as a result the health and welfare of a service user was put at risk.

Regulation 12.-(1), 12.-(2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not maintain an accurate complete and contemporaneous record of the care and treatment provided to each person. Regulation 17.-(2) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure that persons employed by the service had received such appropriate support, training, professional development, to enable them to carry out their duties they are to perform. Regulation 18.-(2).

Regulated activity	Regulation
	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person had not notified the Commission without delay of a DoLs application being approved. Regulation 18.-(2) (c).