St Dominic's Limited

Birdscroft Nursing Home

Inspection report

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

Summary of findings

Overall summary

Birdscroft provides accommodation and nursing care for up to 28 people, some of whom have dementia. Rooms are arranged over two floors and there is a passenger lift. Communal facilities include a large lounge and dining area, a small quiet lounge, and a secluded rear garden which is accessed via a ramp with rails. There is parking to the front of the property. At the time of our inspection 24 people lived here.

There was not 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 current home manager had been in post for two months and had submitted his application to become the registered manager to CQC.

The inspection took place on 28 November 2016 and was unannounced. At our last inspection in February 2015 we identified three breaches in the regulations, and areas of the home that required improvement. The registered manager and provider gave us an action plan on how they would address these issues. At this inspection we found that some, but not all of the areas of concern had been addressed.

The lack of good leadership after the departure of the registered manager had an impact across four of the five key areas we looked at. It affected the safety of the home as medicines where not managed safely; how effective the home was at meeting people's needs; how responsive staff were; and how well the home was led. We have identified three breaches in the regulations. This is the same amount compared to our last inspection showing the lack of leadership was failing the people who live here. You can see what action we have asked the provider to take at the back of the full version of this report.

Staff did not manage the medicines in a safe way. Safe systems of work were not followed so people could not be assured they had the right medicines at the right time. Staff had made decisions to alter the format of medicines by crushing them. This was done without consulting a GP or pharmacist to check if this could affect the effectiveness of the medicine.

The provider did not have effective systems in place to monitor the quality of care and support that people received. Quality assurance records were completed to check on important aspects of the management of the home; however these had not identified the issues found during this inspection. The home manager had not ensured that accurate records relating to the care and treatment of people and the overall management of the service were maintained. This was an area of improvement we had highlighted at our previous inspection.

People were not always supported to have access to healthcare professionals to maintain good health. The management of pressure wound care was variable, with concerns being raised about the accuracy of, and lack of records to manage peoples nursing needs. These concerns were also identified a week after the inspection by a visiting tissue viability nurse, showing the management had not acted quickly to improve the

support people received.

People received the care and support they needed, however the care plans did not always reflect peoples current needs. Care plans were based around the individual preferences of people as well as their medical needs. People and relatives were involved in reviews of care, but these reviews did not always result in a change of the support plan to reflect current needs. People were at risk of not getting care they really needed as staff who may not be familiar with people (such as agency staff) would not have access to correct information.

The staff were kind and caring and treated people with dignity and respect. However the failures across the home demonstrated there was a lack of care and attention to following safe systems of work, and to meet the requirements of the health and social care act. There was positive feedback about the home and caring nature of staff from people who live here, and their relatives.

There were sufficient numbers of staff who were appropriately trained to meet the needs of the people. The manager regularly reviewed staffing levels to ensure they met the needs of people. Staff understood their duty should they suspect abuse was taking place, including the agencies that needed to be notified, such as the local authority safeguarding team or the police.

In the event of an emergency people were protected because there were clear procedures in place to evacuate the building. Each person had a plan which detailed the support they needed to get safely out of the building in an emergency.

The provider had carried out appropriate recruitment checks before staff commenced employment, to ensure they were safe to work with people who may be at risk.

Staff received a comprehensive induction and on-going training, to ensure they could meet and understand the care needs of the people they supported. Staff received regular support in the form of annual appraisals and formal supervision to ensure they gave a good standard of safe care and support.

Where people did not have the capacity to understand or consent to a decision the provider had followed the requirements of the Mental Capacity Act (2005). An appropriate assessment of people's ability to make decisions for themselves had been completed. Where people's liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS) to ensure the person's rights were protected.

People had enough to eat and drink, and received support from staff where a need had been identified. People's individual dietary requirements where met.

People had access to a wide range of activities that met their needs. Activities were varied and based on people's interests.

People knew how to make a complaint. When complaints had been received these had been dealt with quickly and to the satisfaction of the person who made the complaint. Staff knew how to respond to a complaint should one be received. People and relatives were encouraged to give feedback about the home, via surveys and regular meetings. The manager and provider listened and took action where required.

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 safe.

People's medicines were not managed in a safe way, and they did not always have their medicines when they needed them.

People felt safe living at the home. Appropriate checks were completed to ensure staff were suitable to work at the home. There were enough staff to meet the needs of the people.

The provider had identified risks to people's health and safety with them, and put guidelines for staff in place to minimise the risk.

Is the service effective?

Requires Improvement

The service was not effective

People did not always have clear plans in place to detail what care and support they needed for their health to improve. Specialist health care professionals were not always consulted when request had been made, nor followed up when a need had been identified. People had access to health care professionals for routine check-ups, or if they felt unwell.

Staff said they felt supported by the manager, and had access to training to enable them to support the people that lived there.

People's rights under the Mental Capacity Act were met. Assessments of people's capacity to understand important decisions had been recorded in line with the Act. Where people's freedom was restricted to keep them safe the requirements of the Deprivation of Liberty Safeguards were met.

People had enough to eat and drink and had specialist diets where a need had been identified.

Is the service caring?

Good

The service was caring.

Staff were caring and friendly. We saw good interactions by staff

that showed respect and care.

Staff knew the people they cared for as individuals.

People could have visits from friends and family whenever they wanted.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans were not always person centred and did not always give detail about the current support needs of people. People were involved in their care plans, and their reviews.

People had access to a range of activities that matched their interests, and physical and mental health needs.

There was a clear complaints procedure in place. Complaints were used as a tool to improve the service for people.

Is the service well-led?

Inadequate

The service was not well- led. Concerns raised at the last inspection were found again at this inspection.

Quality assurance checks had not identified where the service was failing to meet the requirements of the Health and Social Care Act. They were not effective to drive improvement throughout the home.

Records management was inconsistent, resulting in a risk that people would to receive the care and support they needed.

The manager understood their responsibilities with regards to the regulations, notifications of incidents and accidents were sent to us when they should be.

People and staff were involved in improving the service. Staff felt supported and able to discuss any issues with the manager. Feedback was sought from people via surveys and regular meetings.

Birdscroft Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 28 November 2016 and was unannounced. The inspection was carried out by two inspectors and a specialist nurse advisor (SPA).

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

The provider had completed a Provider Information Return (PIR). This 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. This information was reviewed to see if we would need to focus on any particular areas at the home.

To find out about people's experience of living at the home we spoke with eight people and two relatives. We observed how staff cared for people, and worked together as a team. We spoke with eight staff which included the registered manager and a representative from the provider. We reviewed care and other records within the home. These included nine care plans and associated records, nine medicine administration records, three staff recruitment files, and the records of quality assurance checks carried out by the staff.

We also contacted Healthwatch England, and commissioners of the service to see if they had any information to share about the home. After the inspection we received feedback from the local authority safeguarding board and the tissue viability nurse.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Birdscroft, however we identified concerns which had put people at risk of unsafe care and support.

At our previous inspection in February 2015 we identified two breaches in the regulations. These were around the lack of safe systems for assessing and managing risks to people, and safe recruitment of staff. We had also identified that management of medicines needed to improve. The registered manager (in post at the time) and provider gave us an action plan on how they would address these issues. At this inspection we found that these two areas had improved, however we found a new breach around the management of medicines.

Medicines were not well managed because people did not always get their medicines as prescribed. Feedback from people was positive about their medicines. Comments such as "I get my medicines on time," and "Staff tell me what the medicine is" were made, however there were seven instances during November 2016 where medicines had been recorded as being given, but the tablets were still in the blister pack when we checked. Additionally medicines in blister packs were not always dispensed in date/time order, further increasing the risk of medicine errors being made. Internal medicines audits, completed by the same staff that gave the medicine, had failed to identify these issues. These matters were bought o the attention of the manager, who had been unaware of any issues with the management of medicines in the home. A memo was immediately issued by the manager to clinical staff alerting them to the errors and the actions they needed to take to put things right.

People did not always have their medicines given safely. One person was described by the nursing staff as, "often refuses their medicine." The staff member giving medicines on the day of the inspection said, "I crushed medication for one person when she refused medication, and also use chocolate." This person lacked capacity to understand this decision and there was no authorisation for covert medication (This is where the medicine is hidden and people did not know they were taking it). Staff were not aware they were giving medicine covertly. The manager was not aware that staff were using a covert method of administration. There was no record of any decision to administer medicine covertly. The pharmacist had not been consulted for advice regarding crushing tablets and if it was safe to do so.

The failure to manage medicines in a safe way a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The ordering, storage, and disposal of medicines were safe. Medicines were stored in locked cabinets to keep them safe when not in use. Medicines were also well arranged so could be accessed quickly. The medicine room was clean, and medicines that required storage at particular temperatures were kept at safe temperatures, for example medicines that required cool storage were kept in the refrigerator. Both minimum and maximum temperatures were recorded daily to demonstrate safe temperatures had been kept. Arrangements were in place and followed by staff to dispose of unused medicine and sharps (items such as needles).

For people who took medicines for diabetes (both insulin dependent or oral medicine) their blood glucose was monitored regularly at the frequency specified in their care plans. There was guidance for staff about the action to take in case of high and low blood sugar. There was emergency glucose gel available, and glucose monitoring equipment was calibrated regularly, to ensure it gave accurate results.

People were protected from the risk of abuse. One person said, ""I feel very safe." Staff had received safeguarding training and could tell us about the various forms of abuse and what they would do if they suspected or saw that it was taking place. This included taking action and making a referral to a relevant agency, such as the local Adult Services Safeguarding Team or police.

There were sufficient staff deployed to keep people safe and support their health and welfare needs. One person said, "Staff come quickly when I press the buzzer." Another person said, "They are there for me when I need help." A relative said, "Yes there are enough staff." People said that staff were available when they needed them and responded promptly to their needs. During the inspection call bells were answered promptly by care staff, and at quiet times during the day staff had time to sit and talk or interact with people.

Staffing levels were calculated on the needs of the people who lived at the home. The provider used a dependency tool to assess the care needs of people who lived at the home. People's needs had been reviewed on a monthly basis to check if there had been any changes that may impact staffing levels. Staffing rotas showed the amount of staff on shift over the past eight weeks matched with the calculated support needs of the people that lived here.

Staff were recruited safely. Appropriate checks were carried out to help ensure only suitable staff were employed to work at the home. The management checked that they were of good character, which included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People were kept safe because the risk of harm from their health and support needs had been assessed. The manager carried out reviews of accidents to reduce the risk of them happening again. People were not restricted from doing things because it was too 'risky'. People with limited mobility, were not prevented from moving around and were actively supported by staff who ensured their safety by following guidance in risk assessments such as safe moving and handling practices. Throughout the day people were able to move freely around the home. Staff encouraged people to maintain their mobility by only offering support if the person required this or was at risk from falling.

The risk to people of developing pressure wounds had been assessed, and action had been taken to minimise this risk. Risk assessments had identified the use of air mattresses to reduce the risk of a pressure sore. The pressures of these mattresses were set according to people's body weight, to give the best protection according to the manufacturer's instructions. The pressures were checked and recorded by staff twice daily to ensure their effectiveness. There were no gaps in the recording of these checks.

People who were at risk of falling out of bed were kept safe. There were falls risk assessments and bed rails risk assessment in place, which gave guidance to staff on how to use them in a safe manner. Bedrails were used in a safe way. They were fitted securely and had bumpers to prevent entrapment. Staff checked these daily to ensure they were in good, safe, working order. Records of these checks were recorded and there were no gaps in recording. Rails were removed from beds where people did not require them.

Risk assessments had been regularly reviewed to ensure that they continued to reflect people's needs.

Assessments had been carried out in areas such as nutrition and hydration, mobility, and behaviour management. Measures such as specialist equipment to help people mobilise around the home had been put in place to reduce these risks. People who required help mobilising used a hoist and had their own slings. This reduced the risk of accidents as the sling was the correct size for each person, and held them securely and safely when in use. In addition individual slings also reduced the risk of cross infection because other people did not use them. People were assisted by staff in a safe way, that matched the guidance in risk assessments.

People's care and support would not be compromised in the event of an emergency. Information on what to do in an emergency, such as fire, was clearly displayed around the home. People's individual support needs in the event of an emergency had been identified and recorded by staff in personalised fire evacuation plans. Emergency exits and the corridors leading to them were all clear of obstructions so that people would be able to exit the building quickly and safely. Fire safety equipment and alarms were regularly checked to ensure they would activate and be effective in the event of a fire.

The home was well maintained. Assessments had been completed to identify and manage any risks of harm to people around the home. Areas covered included infection control, and fire safety. People were cared for in a clean and safe environment. People told us that their rooms were cleaned regularly and that they were pleased with the standard of cleaning. Regular safety checks had been carried out on equipment such as hoists and slings, nurse call bells, pressure mattress settings to ensure they were in good working order.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in February 2015 we identified one area that required improvement. This were around the lack of support for staff. The registered manager (in post at the time) and provider gave us an action plan on how they would address these issues. At this inspection we found that improvements had been made. However new concerns had been found.

People received inconsistent support to keep them healthy. Appropriate healthcare professionals, such as a tissue viability nurse (TVN) were not always involved to ensure effective care was given to people. The care and treatment of the wounds for people who had pressure sores was variable. One person with a grade three pressure sore had no wound care plan in place to guide staff. In addition monitoring of the wound had not been completed so staff were unable to demonstrate that the wound had improved, or that the care they had given had been effective. Documents kept by staff recorded that a TVN had been requested but, at the time of our inspection they had not visited and staff had not followed this up. We received feedback from the TVN after they visited which highlighted that documentation to record the wound-care for this person was poor, although there was no indication that the care given had not been effective at treating the wound. Another person had a grade two pressure sore and had received appropriate support from a TVN, and clear care plans were in place to give guidance to staff on the care the person required. Documentation such as photos and measurements of the wound showed the person's health had improved and the wound was getting better.

People had access to a range of other medical professionals including, a chiropodist, doctor, and an optician. One person said, "Staff arrange for me to see a GP. Also a chiropodist and optician come in to see me if I ask for them." However, one person told us they had asked for a referral to a physiotherapist because they wanted to walk again, but a referral had not been made by staff. The manager told us he would arrange this. He was unable to explain why this had not already been done. Where people's health needs had changed some appropriate referrals had been made to specialists to help them get better, for example speech and language therapists if people's eating habits changed.

People were supported by staff who had received training to enable them to care for people; however areas for improvement had been identified. The induction process for new staff was not robust to ensure they would have the skills to support people effectively. For example the manager had not always checked on the competency of staff before they gave support. One registered nurse who was new to working in the home was doing the medicine round without the manager or other appropriately trained person checking that they were familiar with the homes procedures. This resulted in them not following safe medicine processes, and not knowing how to report issues with staff who had completed the medicines round prior to them taking over.

Staff received ongoing training to ensure they were kept up to date with current best practice. One person said, "Staff use the hoist with me very safely, they are very good." Staff training included safeguarding adults, first aid, health and safety, food hygiene, infection control, end of life care, dementia awareness, moving and handling, and behaviour management. The effectiveness of the training was displayed during the inspection

where staff demonstrated the correct use of equipment such as walking aids, mobility hoists, foot-rests for wheelchair use, and pressure cushions when supporting people.

Staff were effectively supported. Staff told us that they felt supported in their work. Staff had regular one to one meetings (sometimes called supervisions) with the home manager, or their line manager, as well as annual appraisals. This enabled them to discuss any training needs and get feedback about how well they were doing their job and supporting people.

The Mental Capacity Act 2005 (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.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had complied with the requirements of the Mental Capacity Act 2005 (MCA). Some people were unable to understand why they had to stay at the home. Where people could not make decisions for themselves the processes to ensure decisions were made in their bests interests were effectively followed. Relatives involved in decisions had Lasting Power of Attorney, and best interest decisions had been clearly documented when these had been made. Care staff had a basic understanding of the Mental Capacity Act (2005) and were seen to work within the legal framework of the act when supporting people, such as seeking and gaining consent before giving care. Staff sought people's permission before providing care, and took time to explain choices that were available to help the person understand. Nursing staff had a good understanding of the MCA.

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 are called the Deprivation of Liberty Safeguards (DoLS). Some people's freedom had been restricted to keep them safe. Where people lacked capacity to understand why they needed to be kept safe the manager had made the necessary DoLS applications to the relevant authorities to ensure that their liberty was being deprived in the least restrictive way possible.

People had enough to eat and drink to keep them healthy and had good quality, quantity and choice of food and drinks available to them. One person said, "The food's lovely. They give you a choice." Another person said, "They ask you what you want in the morning. There is always an omelette or sandwich if I don't like the option." Ample tea and coffee was served throughout the day and staff were seen to offer encouragement to people to remind them to drink plenty of fluids

People were protected from poor nutrition as they were regularly assessed and monitored by staff to ensure they were eating enough to stay healthy. A calculation was completed to assess each person's risk of malnutrition (This is called a MUST assessment). Nutritional care plans were developed from this. People's weight was monitored and recorded to identify any changes that might indicate a need for additional support. People at risk of malnutrition had food supplements, for example high protein drinks to help maintain their weight. If people had any dietary issues they were referred to the dietician or SALT team. There was a choking policy in place and staff had undertaken first aid training to include choking.

People's special dietary needs and choices were met. Various dietary requirements were catered for, such as soft diets, and vegetarian diets. Where people had a pureed lunch each food item was kept separate on the plate so people could taste the individual components of the meal, and have different taste experiences.

People were given choices about meals and choice of drinks.

People received effective support when they needed specialist support to eat. Where people could not eat food via their mouth, nursing staff were knowledgeable and demonstrated skilful management of percutaneous endoscopic gastrostomy (PEG) equipment. This is an endoscopic medical procedure in which a tube (PEG tube) is passed into a person's stomach through the abdominal wall. Care plans gave clear guidance to nursing staff about the person's food regime, and cleaning and maintenance routines to prevent blockage and to prevent infection.

Good

Is the service caring?

Our findings

We had positive feedback about the caring nature of staff from people and their relatives. We also saw many positive interactions during the inspection.

People told us that the staff were kind and caring. One person said, "Staff are very kind." A relative said, "My family member is well cared for. Staff are lovely." Staff had a positive and caring attitude to the work they did. One staff member said, "I love doing what I do and look forward to coming to work."

The atmosphere in the home was calm and relaxed and staff spoke to people in a caring and respectful manner. One person said, "I have a laugh and a joke with them (staff)." People said they were pleased with the standard of care at Birdscroft because staff were kind, listened to what they wanted, which made them happy to live there.

People were supported by staff that knew them as individuals. One person said, "Staff know me and my relative." Staff's knowledge of people's communication methods was good. They were able to advise on how best to talk with people, so we could get their feedback about the home. When they talked with people staff got close to them so that they could hear each other. During conversations staff spoke to people calmly and maintained eye contact. Throughout our inspection staff had positive, warm and professional interactions with people.

Staff were caring with people. One person said, "Staff take their time with me." When giving a drink to a person, the staff took time to allow the person to finish one sip before presenting the cup to the person again. There was a lot of smiles and laughter, a happy atmosphere. When staff supported a person to drink, they used phrases such as "well done," and "excellent, you are doing well" to show the persons achievement to maintain their independence had been recognised and celebrated. Other observations of kindness included staff holding people's hands when talking to them. This was something that we could see comforted people. During the medicine round people were treated kindly by the nurse and not rushed when the nurse gave their medicine to them.

Staff treated people with dignity and respect. One person said, "Everyone is very friendly. Staff are polite." Staff were very caring and attentive throughout the inspection, and involved people in their support. Many respectful actions towards people by staff were observed during the inspection, such as knocking on doors before entering, and calling people by their preferred names.

People were given information about their care and support in a manner they could understand. One person said, "Staff understand me, I can't fault them." However one person said, "Staff speak in their own language in front of me." Although we did not encounter this during our inspection it is something the manager said they would look into. Information was available to people around the home. It covered areas such as local events, in house activities. Items such as clocks and calendars where correct, so people had a clear view of the time and date to help orientate themselves. Seasonal decorations around the home also helped to orientate people to the time of year.

Staff took time to explain things to people before they gave care or support. People told us that they were asked about their care and that staff did listen to them. A relative said, "I was given mums care plan and a questionnaire to fill out." People's bedrooms were personalised with furniture from home, ornaments and personal photographs.

Family members were able to keep in regular contact and visit whenever they liked. One relative said, "Staff always keep me informed (about how their family member was)." Relatives said they could visit whenever they wished and that they were made welcome by staff. One relative told us, "The staff always ask how I am. We are always made to feel welcome." People's needs with respect to their religion or cultural beliefs were met. Staff understood those needs and people had access to services so they could practice their faith, for example by religious leaders from the local community visiting the home.

Requires Improvement

Is the service responsive?

Our findings

People received care and support that matched with their preferences or need; however records of care for staff to follow were not always fully completed, or up to date to reflect people's current needs. The completion of care records was inconsistent across the home. For example one person had a 'breathing care plan' which stated 'I am nursed in bed at all times, which puts me at high risk of a chest infection.' This person was seen sitting in the lounge for a number of hours during the inspection. Their care and support plan did not match their current needs (which had decreased as their health had improved) even though the record had been reviewed by staff in November 2016. Specific support needs such as skin integrity, moving and handling and eating had been identified for other people. Staff had given support as needed, such as by the use of pressure cushions, correct use of hoists, and giving food in the correct consistence, but the care records were inconsistent on whether guidance for staff had been given. Staff relied on memory as to the care people needed. There was a risk that people would not get responsive care if their needs had changed, and when agency staff where used.

People's needs had been assessed before they moved into the service to ensure that their needs could be met. Assessments contained information about people's care and support needs. Areas covered included eating and drinking, sight, hearing, speech, communication, and their mobility.

People and relatives were involved in their care and support planning if they wished. One person said, "I have a care plan, but I am not interested in it." People said staff always asked if they were happy with their care and said that when they made a suggestion the staff responded to their ideas. People's choices and preferences were documented and those needs were seen to be met. For example people's preferences for hot and cold drinks was carried by the kitchen staff when they distributed drinks during the day, and they were seen to give people the drinks they wanted, in their preferred mug, or cup. Some files gave a clear overview of the person, their life, preferences and support needs, but as with other records the completion of these was inconsistent. It was clear staff had read and understood the information where it was present as they were able to tell us about the people they cared for, and the information they gave matched with that recorded in the care records, to with what people had told us.

People had access to a range of activities many of which focussed and promoted peoples well-being, physical and mental health. One person said, "I do foot exercises daily. A person comes in fortnightly to do chair exercises." Another person said, "The activities person keeps us busy with skittles, and darts. I also like watching films." People told us, and we saw, that there was range of activities they could take part in if they wished. The service employed an activities co-ordinator who worked in the home full time. During the day they did a number of activities with people, some of which was one to one, and some group work. During the inspection there was a constant choice of activities for people to take part in. This included a discussion on the daily news, which helped keep people orientated with reality and up to date on current affairs. There were also quiet areas around the home for people to go to if they wanted some peace and quiet from the positive hustle and bustle provided by the activities coordinator and staff. Activities were fully inclusive and programmes had been introduced to ensure that people in bed or who preferred not to take part in group activities were enabled to participate.

People were supported by staff that listened to and responded to complaints or comments. One person said, "The manager comes to talk with me, to see if there are any problems." People told us they would feel comfortable making a complaint if they needed to and were confident that any concerns they raised would be addressed. Relatives said they would feel comfortable making a complaint. They had been given a copy of the home's complaints policy (which was also clearly displayed in the reception area) when their family member moved into the home. They understood how to complain if they felt the needed to. The policy included clear guidelines on how the registered manager should respond and when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Care Quality Commission.

There had been one complaint received at the home in the last 12 months. This had been clearly recorded and responded to in accordance with the provider's complaints policy, and to the satisfaction of the person who had made the complaint. The manager and staff explained that complaints were welcomed and would be used as a tool to improve the service. Staff discussed any comments or complaints received at team meetings so they could learn from any mistakes that had been made.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in February 2015 we identified one breach in the regulations in this domain. This was around quality assurance checks not being in place to drive improvement. We also identified that records management required some improvement. The registered manager sent us an action plan about how they would put things right. These concerns had not been resolved, as we continued to find concerns with the effectiveness of quality assurance checks, and records were still not accurate to record that people had received the care they needed.

The issues we had identified across the home demonstrated a lack of care and attention by staff and management. Specific examples included the lack of effective management, the failure to manage medicines safely, failure to complete daily records and care records not identifying people's current needs,. This meant that people may not receive the care they needed, as staff did not have current correct and accurate information about how to care and support people.
Regular monthly and weekly checks on the quality of service were not effective at identifying areas for improvement around the home. Errors in medicine management had not been identified or managed to reduce the risk of them happening again. The internal checks had also failed to identify gaps in care records, gaps in daily care notes or that reviews of care had not been effective at recording changes in people's needs.

Records management was not good; resulting in lack of information about the care and support people needed, or had received. Wound care plans were not always in place where required. Records of fluids for people at risk of dehydration were not always completed. Staff were asked to record the fluid they gave people, but were not told about the targeted amount. At the end of the shift the results were not checked to ensure the correct amount had been given. . It was noted that records for people being offered drinks stopped at 6pm. The manager and staff told us people were offered and supported to have drinks at night, and this was a recording issue. People at risk of dehydration showed no signs that they had not received enough to drink, which corroborated the managers assurances. Repositioning charts, to record that a person had been turned to reduce the risk of developing a pressure wound were not completed fully, or did not reflect a person's current need. This could lead to ineffective care and support being given to people.

Failure to operate effective quality assurance processes and keep accurate, complete and contemporaneous records was a breach in regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies; This meant we could check that appropriate action had been taken.

Other audits were completed on all aspects of the home. These covered areas such as maintenance of the building, infection control, and health and safety. These audits generated improvement plans which recorded the action needed, by whom and by when. Actions highlighted were addressed in a timely fashion.

The manager and staff also responded well to external feedback about the service.

There was a positive culture within the home, between the people that lived here, the staff and the manager. The atmosphere was very welcoming and friendly. People felt relaxed and were happy to share thoughts about their life at Birdscroft with us. A relative said the staff were a, "Friendly team." Staff provided a positive experience for people living at Birdscroft, by being friendly and happy in their roles. One staff member said, "I love the manager, he respects and appreciates the staff." People and relatives described the home manager as always being available, and somebody who would help if necessary. One person said, "I know the manager, he is very approachable."

Staff felt supported and able to raise any concerns with the manager, or senior management within the provider. One staff member said, "The manager is easy going, relaxed and calm, just what we need." Staff understood what whistle blowing was and that this needed to be reported. They knew how to raise concerns they may have about their colleague's practices. Staff told us they had not needed to do this, but felt confident to do so. Staff told us the manager had an open door policy and they could approach the manager or provider at any time. Staff felt supported and able to raise any concerns with the manager, or the provider.

People and relatives were included in how the service was managed. People had access to regular house meetings where they could discuss items such as the food, activities and any issues they wanted to raise, and what activities they would like to take part in. Minutes of the meetings showed that people had the opportunity to raise any concerns, and were encouraged to tell the staff what needed to be done around the house, or in relation to their care and support needs.

The manager also ensured that various groups of people were consulted for feedback to see if the service had met people's needs. This was by the use of a questionnaire. All the responses from the last survey were positive about the home and staff. People who lived here and their families were involved in these questionnaires, which covered all aspects of care and support provided at the home.

The manager was visible around the home on the day of our inspection, supporting staff and talking with people to make sure they were happy. The manager had a good rapport with the people that lived here, staff and visitors and knew them as individuals.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that medicines were managed in a proper and safe way.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not adequately assessed, monitored and improved the quality and safety of the service.

The enforcement action we took:

We issued a warning notice