Alliance Care (Dales Homes) Limited

Birkin Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected the service on 28 December 2018. The inspection was unannounced. Birkin Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

Birkin Lodge is registered to provide accommodation, nursing and personal care for 50 older people. There were 33 people living in the service at the time of our inspection visit.

The service was run by a company who was the registered provider. The former registered manager had left their post shortly before the inspection. The registered provider had appointed a new manager who was in post and who was in the process of applying to the Care Quality Commission to become the 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.

We carried out an unannounced comprehensive inspection of this service on 20 September 2018 and 24 September 2018. After that inspection we received concerns in relation to the way people were supported to avoid preventable accidents so that they consistently received safe care and treatment. As a result we undertook a focused inspection to look into these concerns. We looked at our domains 'safe' and 'well led'. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk.

We found that there were two breaches of the regulations. The first breach was because there were shortfalls in the arrangements that had been made to provide people with safe care and treatment. Suitable provision had not been made to prevent avoidable accidents and to learn lessons when things had gone wrong. There were also shortfalls in the management of medicines. Furthermore, there were two oversights that had reduced the level of fire safety protection in the service. In addition to this, robust steps had not been taken to prevent and control infection. The second breach was because the right systems and processes had not been used to monitor and improve the service by addressing the shortfalls described above. You can see what action we have told the registered provider to take at the end of the full version of this report.

We also raised another concern with the manager in relation to which we have made a recommendation. This was because there was a shortfall in the deployment of staff.

Our other findings were as follows: Background checks on two new care staff had not been completed in the right way to ensure that they were suitable to be employed in the service. People were safeguarded from

situations in which they may be at risk of experiencing abuse. Nurses and care staff had not been fully supported to ensure that regulatory requirements were met. However, they had been enabled to speak out if they had concerns about the wellbeing of a person living in the service. The registered provider had submitted notifications to the Care Quality Commission about important events that occurred in the service in line with our guidelines. The manager was actively working in partnership with other agencies to support the development of joined-up care. The registered provider had conspicuously displayed the quality rating we gave the service at our last comprehensive inspection both in the service and on their website.

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 consistently safe.

Sufficient provision had not been made in relation to one person's care to enable lessons to quickly be learned when things had gone wrong so that they were kept safe.

Parts of the care provided for a person who lived with dementia and for a person who had reduced mobility had not been planned and/or delivered in the right way.

Medicines were not consistently managed in line with national guidelines.

There were two shortfalls in the level of fire safety protection.

People were not fully protected by the prevention and control of infection.

There were shortfalls in the deployment and recruitment of care staff.

People were safeguarded from the risk of abuse.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Suitable steps had not been taken to maintain and improve the quality of the service.

There was no registered manager.

Nurses and care staff had not been fully supported to manage risks and to enable regulatory requirements to be met.

Notifications had been submitted to inform the Care Quality Commission about incidents that occurred in the service.

The registered provider had displayed in the service and on their website the latest Care Quality Commission rating for the service.

The service worked in partnership with other agencies to promote the delivery of joined-up care	

Birkin Lodge

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to an investigation by the local safeguarding authority and as a result this inspection did not examine the circumstances of the incident. However, the information shared with the Care Quality Commission about the incident indicated potential concerns about the management of risk to people's health and safety. This inspection examined those risks.

We undertook an unannounced focused inspection of Birkin Lodge on 28 December 2018. We inspected the service against two of the five questions we ask about services: is the service safe and well led. No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

The inspection was undertaken by two inspectors. During our inspection visit we spoke with six people who lived in the service and with two relatives. We also spoke with a nurse, three care staff, the head chef, the deputy manager and the manager. We observed care that was provided in communal areas and looked at the care records for five people. We also looked at records that related to how the service was managed including the management of medicines, health and safety, staffing and quality assurance.

In addition, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us.

Requires Improvement

Is the service safe?

Our findings

We undertook this unannounced focused inspection of Birkin Lodge on 28 December 2018 to respond to concerning information we received since our last comprehensive inspection on 20 September 2018 and 24 September 2018. This information indicated that suitable provision had not been made to help people avoid preventable accidents so that they consistently received safe care and treatment.

Records showed that on three occasions since 6 August 2018 a person had left the building on their own when it was not safe for them to do so. The person lived with dementia and was not able to manage everyday risks such as negotiating road traffic. The manager told us that robust steps had been taken to prevent the same thing from happening again. This included nurses and care staff following a plan to carefully establish the person's location at all times. However, in practice nurses and care staff had not been given sufficient written guidance about this matter. Two care staff told us that they had adopted informal ways to address this matter. Summarising this response, one care staff said, "Yes, we try to keep an eye on (the person) but it's not an organised approach and it's only if you happen to be in the same room. If I'm on the top floor doing something I've no idea what's going on the lounge where the person sits. Often we end up searching around the corridors for the person." Although we saw the person being accompanied by nurses and care staff, the arrangements in place increased the risk that they would not consistently receive the care they needed to keep safe.

The manager also said that both of the external doors previously used by the person to leave the service had been more robustly secured. Although we found that one door had been fitted with a keypad lock, the other door was not locked at all. In addition to this, the alarm fitted to the door was not working. This was because the key used to activate the alarm was broken and could not be used. We raised our concerns with the manager about these shortfalls. They assured us that the alarm would immediately be repaired. They also said that nurses and care staff would be given more detailed guidance about how to check that the person was safe and comfortable within the building.

A further shortfall related to the care provided for another person who lived with dementia. We noted that the person when distressed often expressed themselves in ways that placed themselves and others around them at risk of harm. This included occasions when the person did not recognise and did not accept that they needed assistance to manage everyday tasks. This had sometimes resulted in the person not being fully dressed when in communal areas, not being clean and speaking in a loud way. It had also resulted in the person becoming involved in altercations both with members of staff and with other people living in the service.

The manager told us that nurses and care staff followed a consistent plan to reassure the person when they were becoming upset. This involved quietly speaking with the person to explain how they were going to provide assistance and inviting them to retire to the privacy of their bedroom. However, we found that nurses and care staff had not been given any written guidance about this matter. In the absence of this, they had adopted different and inconsistent approaches to meeting the person's needs.

We saw an example of this when the person was in a communal area and was wearing two pairs of trousers at the same time one of which had fallen down to their feet. One care staff told us that it was best to give the person the time they needed to take off the second pair of trousers. However, when they did this the person became increasingly upset. This was because they did not know how to remove the trousers and then were frustrated by the trousers restricting their ability to walk. A second care staff adopted a different approach and invited the person to sit in an armchair in one of the lounges so that they could be distracted by having a cup of tea. This approach was also unsuccessful in meeting the person's needs because they soon started to move their legs in an animated way in an attempt to remove the trousers and free their ankles. At this point we asked a member of care staff to accompany the person to their bedroom to remove the second pair of trousers. After this was done we saw that the person became more relaxed and settled.

We found that risks to people's health and safety had not always been managed in the right way. We examined the written guidance nurses and care staff had been given when assisting a person to change their position. This guidance was contained in the person's care plan and related risk assessment. The person had significantly reduced mobility and needed to be assisted using a special hoist. The information did not give a comprehensive account of the steps nurses and care staff were expected to follow such as ensuring that the slings attached to the hoist's lifting mechanism were appropriately secured. Although during the inspection visit we saw hoists being used correctly, the shortfall had increased the risk that people would not always be assisted in a safe way.

People were not fully protected against the risk of fire. Although the service was fitted with a modern system to detect and contain fire, suitable steps had not been taken to address two shortfalls identified in the registered providers' own fire risk assessment. One of the shortfalls involved a wooden fire exit door that was rotten in places and which consequently was likely to be stiff to operate in damp weather. The other was a linen cupboard that had not been properly fitted with sealed doors that are necessary to contain a fire from spreading.

There were shortfalls in the management of medicines. We examined the records kept of the medicines dispensed to a person during December 2018. On five occasions an entry had not been made in the records to indicate whether or not a medicine had been dispensed in line with the doctor's instructions.

A further oversight concerned a medicine that was being administered covertly in a person's food. There was no written or other evidence to show that this arrangement had been authorised by a doctor or pharmacist. This is necessary because some medicines may lose some of their therapeutic effect when administered in this way. Although care records showed that the shortfalls described above had not resulted in the people concerned experiencing actual harm, the mistakes had increased the risk that they would not be suitably supported to take medicines in a safe way.

In addition to these oversights, robust arrangements had not been made to prevent and control the risk of infection. Although most areas of the service were clean, the carpet in one bedroom was not clean and had a very stale odour. In another bedroom the carpet was badly stained and this was also the case in the ground floor hallway. In one of the two lifts the floor, sides and doors were stained and dirty. We examined one of the communal toilets and found that the one of the wash-hand basin taps was extensively stained with lime-scale. Furthermore, the pull cord used to operate the light was not covered with a cleanable cover and was dirty. All of these shortfalls increased the risk that people would acquire avoidable infections.

We raised all these concerns with the manager who assured us that steps would immediately be taken to address each of the shortfalls.

Failure to provide safe care and treatment was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Robust arrangements had not been made to ensure that sufficient numbers of care staff were always on duty. The registered provider had used a written 'dependency tool' to calculate the number of nurses and care staff who needed to be on duty to promptly provide people with the care they needed. We noted that the tool did not specifically take into account the layout of the service that resulted in care staff having to provide care to people whose bedrooms were located on three different floors. We looked at the record of the care staff who had been on duty on six days during December 2018. The record showed that on two days sufficient care staff had not been deployed to meet the minimum number that the registered provider considered to be necessary.

On the day of our inspection visit the service was fully staffed. However, we were concerned to note that even this deployment did not always result in people promptly receiving the care that they needed. On three occasions we heard the call bell sounding for more than double the three minutes that the deputy manager told us was the timescale within which call bells should be answered. All of the people who lived in the service with whom we spoke voiced reservations about the deployment of care staff. Summarising this view a person remarked, "Some days are particularly bad when they're short-staffed but other days are also problems as the care staff are having to run around between the three floors and quite simply they don't have enough staff to cover the building. They'll come in the end but it can be delayed." Two of the three care staff with whom we spoke told us they were concerned about the number of care staff usually on duty. One of them said, "Every day is a rush and sometimes it feels like treating residents as pot plants. You help them with getting up and dressed and have to rush off to the next person. The manager says that we're overstaffed but that can't be right as the calculation doesn't take into account the reality of providing care in such a spread out building.

We raised our concerns about the deployment of staff with the manager. They assured us that more robust arrangements would immediately be made to ensure that all shifts were filled.

In addition to this, we recommend that the registered provider review and revise the tool they use to calculate how many care staff need to be on duty. This is necessary to ensure that sufficient care staff are deployed to promptly provide people with assistance that meets their needs and expectations.

There were limited shortfalls in the checks that had been completed when recruiting two new care staff. These background checks are necessary to ensure that only suitable and trustworthy people are employed in the service. In both cases the registered provider had not obtained a full and continuous account of the applicants' previous periods of employment. This had reduced the registered provider's ability to determine what checks they needed to complete to establish the applicants' previous good conduct. However, references had been obtained in relation to the periods of employment that were known. In addition to this, the registered provider had in each case obtained a clearance from the Disclosure and Barring Service. These disclosures are necessary to show that the applicants had not been guilty of a relevant criminal offence or professional malpractice.

We raised our concerns with the manager who assured us that the service's recruitment procedure would immediately be strengthened to address the shortfall we had identified.

People told us they felt safe living in the service. One of them said, "I get on okay with the staff here and they're kind to me. I've no complaints." A person who lived with dementia and who had special communication needs smiled and waved in the direction of a passing member of staff when we used sign

assisted language to ask them about their experience of living in the service.

We found that people were suitably safeguarded from situations in which they may experience abuse. Records showed that nurses and care staff had received training and knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk. They told us they were confident that people were treated with kindness and they had not seen anyone being placed at risk of harm. The manager said and records confirmed that they had carefully considered each occasion when a person had sustained a minor injury such as a bruise. This was so that the causes of each injury could quickly be established and if necessary action taken to keep the person safe.

Requires Improvement

Is the service well-led?

Our findings

We asked five people who lived in the service how well the service was managed. All of them expressed reservations in connection with the deployment of care staff. One of them said, "Overall, it's pretty good I suppose. The meals are okay, the heating's on and the staff are kind. But the real problem is that the care staff are rushed and it doesn't make for a relaxed atmosphere. The owners need to look at staffing and get it sorted out."

The manager completed a number of quality checks that were designed to ensure that the service consistently provided people with safe and responsive care. However, we noted that these checks had not been sufficiently robust to quickly address the shortfalls we found during our inspection visit. These concerns included learning lessons when things had gone wrong, planning the delivery of care and dealing with trip hazards so that risks to people's health and safely could be resolved. They also included the systems and processes used to manage medicines, deliver fire safety protection and promote good standards of hygiene. In addition to this, there were oversights in the deployment and recruitment of care staff.

The manager said that people who lived in the service should be invited to contribute to 'residents' meetings' at least once in every three months. However, records showed that some of the planned meetings had not been held during 2018. Furthermore, there was no plan to address this shortfall in the near future. This oversight had reduced the opportunities people had been given to contribute suggestions to improve the service in the future.

Failure to assess, monitor and improve the quality and safety of the services was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager. However, the manager had only recently taken up their post. In addition, they had started the process of applying to the Care Quality Commission to register. 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.

Nurses and care staff had not been fully supported to manage risks and to enable regulatory requirements to be met. There was a nurse in charge of each shift and member of the senior management team was on call during out of office hours to give advice and assistance should it be needed. However, nurses and care staff had not been provided with all of the guidance they needed to effectively undertake their roles. This oversight had resulted in the shortfalls we have described above in the provision of safe and responsive care.

Nurses and care staff told us there was an explicit 'no tolerance approach' to any member of staff who did not treat people in the right way. As part of this they were confident that they could speak to the manager if

they had any concerns about people not receiving safe care. They told us they were confident that any concerns they raised would be taken seriously so that action could quickly be taken to keep people safe.

Services that provide health and social care to people are required to inform the Care Quality Commission of important events that happen in the service. This is necessary so that we can check that appropriate action has been taken. We noted that the registered provider had submitted notifications to us in the correct way.

It is a legal requirement that a registered provider's latest Care Quality Commission inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the registered provider had conspicuously displayed their rating both in the service and on their website.

The manager and the registered provider were working in partnership with other agencies. This included liaising with relevant healthcare specialists including speech and language therapists, occupational therapists, community psychiatric nurses and care managers (social workers) about the care people living in the service needed to receive.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to do all that was reasonably practical to manage risks to people's health and safety so that they received safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to assess, monitor and improve the quality and safety of the services provided.