Serendib Limited

The Birches

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We undertook this unannounced, focussed inspection on 25 September 2018. The inspection was prompted, in part, by information shared with the Care Quality Commission which indicated potential concerns regarding the health, safety and wellbeing of people using the service. This inspection examined these concerns and potential risks to people's safety. We inspected the service against two of the five questions we ask about services: 'Is the service Safe?' and 'Is the service Well Led?' This was because the information shared was relevant to these two key questions and the service was not meeting some legal requirements in these areas.

The Birches is a residential home which provides care to older people including some people who are living with dementia. The Birches is registered to provide care for up to 19 people. At the time of our inspection there were 11 people using the service.

The Birches is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Our last comprehensive inspection of this service was carried out on 21 November 2017. Two breaches of the legal requirements were found and we issued a warning notice. We rated the service as Requires Improvement. We asked the provider to submit an action plan but they did not submit one. You can read the report from our last comprehensive inspection by selecting 'all reports' link for The Birches on our website at www.cqc.org.uk.

We undertook a focussed inspection on 27 March 2018 to check that the provider met the legal requirements. We found two continued breaches of the legal requirements. We issued a Notice of Proposal to impose positive conditions on the provider, placed the service in special measures and rated the service as Inadequate. We asked the provider to submit an action plan but they did not submit one.

Services in special measures are kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

At this inspection, we found the provider had not made significant improvements and the rating remained Inadequate.

People's safety was being compromised in a number of areas. People were not protected from the risks of the spread of infection in the service. The provider had not ensured sufficient numbers of suitably competent, skilled and knowledgeable staff were available to keep people safe and meet their needs. The provider had not followed safe recruitment procedures for all staff working in the service.

Risks associated with the premises had not been effectively assessed or monitored. The provider had not taken action to address priority concerns from fire and electrical reports, which placed people and staff at risk in the event of a fire. Maintenance was not provided in a timely manner to ensure the premises were safe and fit for their intended purpose.

Risks associated with people's health conditions and care were not consistently reviewed and care plans did not reflect people's current needs. Risk assessments lacked accurate, detailed information regarding the measures staff needed to take to keep people safe. Falls and incidents were not analysed or monitored to prevent the risk of further harm for people.

Safe systems were not consistently in place to ensure people received their medicines as prescribed. there were insufficient numbers of staff employed who had completed the necessary training to administer medicines. Medicine errors were not identified or reported in a timely manner.

The service was not well led. The provider had not adequately monitored the service to ensure it was safe and they had not identified the areas of concern that we found during our inspection. The provider had not made adequate arrangements to ensure effective leadership and governance or oversee the day-to-day running of the service in the absence of a manager.

The provider had not made the significant improvements required since our last inspection to meet the requirements of the regulations and to keep people safe from harm.

We found continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were at risk of harm as the provider had not ensured the premises were safe and well maintained.

People were not always protected from risks associated with their care or health conditions.

People did not always receive their medicines safely or as prescribed.

Staff were not always safely recruited and the provider did not ensure sufficient numbers of qualified, experienced staff were deployed to keep people safe.

People were not protected from the risk of infection.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not taken action to remedy the breaches of regulations and improve the quality of the service to ensure people received safe care.

Records and systems were not sufficient or accurate enough to demonstrate that the service was well-led.

The Birches

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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This focussed inspection visit took place on 25 September 2018 and was unannounced. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our focussed inspection of May 2018 had been made.

We inspected the service against two of the five key questions we ask about services; is the service 'safe' and is the service 'well-led'. This was because the provider was not meeting some legal requirements.

The inspection team consisted of two inspectors.

Before the inspection, we reviewed information we held about the service, which included notifications they had sent to us. A notification is information about significant events or incidents within the service that the provider is required to send us by law. We also spoke with commissioners from the local authority, responsible for funding some of the people using the service, to obtain their views about the care provided at the service. We used this information to plan this inspection.

During the inspection we spoke with three relatives of people using the service, two visiting health and social care professionals, the cook and three care staff. We also spoke with the registered provider by telephone. We reviewed care records and associated risk assessments for two people. We reviewed records relating to the day to day management of the service, including staffing, medicines and quality assurance.

Inadequate

Is the service safe?

Our findings

At our last inspection of March 2018, we found that improvements were needed to ensure the proper and safe management of medicines, to ensure staff followed safe infection control procedures and to ensure the premises are safe to use for their intended purpose and are used in a safe way. These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found some improvements had been made but further improvements were required to meet the requirements of the regulations and to keep people safe from harm.

Improvements made included the fitting of hand sanitizer units and colour coded apron dispensers throughout the service. This supported staff to prevent the risk of cross infection, by using the appropriate personal protective equipment when supporting people with tasks. However, some of the areas of the premises were not clean. A bathroom had an 'out of order' sign on the door. The room was dirty, with extensive black mould around the bath and smelt of damp. The room was being used to store people's equipment, such as a hoist and walking frame, presenting a potential risk of cross-infection. The last recorded cleaning of the room was dated August 2018. There was another shower room and bathroom available for people to use on the ground floor. The bathroom did not have a lock on and was being used as a storage area for other items such as a walking frame. The toilet seat did not have a lid fitted.

Staff monitored the temperatures of fridge and freezers used to store foodstuffs but told us these fluctuated. Staff told us they visually monitored the food to make sure it had not de-frosted when the temperatures fluctuated, though these were not consistently recorded. One staff member told us, "The freezers were upstairs, they were broken. We needed a new one. The one we got was second hand and the fridge was dented. The temperatures yo-yo. I keep any eye on it to make sure the food is kept cold. It's not ideal." One of the freezers had a broken seal on it and there was no thermometer in place to check the temperature. There were areas of damp on the ceiling in a storage room where two fridges, a freezer and groceries were stored.

These practices increased the risk of infection to people and people being exposed to the risk of food poisoning.

People were not consistently protected by safe systems for managing their medicines.Improvements were needed to medicines management as medicines were not always safely administered. Medicines were stored in a clinical room which was poorly lit. Staff told us this made it difficult to read documents and identify medicines. The provider had not ensured there were sufficient numbers of suitably qualified and skilled staff to support people to take their medicines. At the time of our inspection, only two staff were employed who had completed the necessary training to administer medicines. This meant there were times when there were no qualified staff available to administer medicines. The local authority had intervened to provide suitably qualified staff at these times as an emergency measure and the provider had also used agency staff. However, these staff were not familiar with people's medicines. As a result, one person had not received their medicines as prescribed from agency staff as an essential medicine had not been

administered. This administration error had not been discovered until 24 hours' after the medicine should have been administered; having been identified by local authority staff who intervened to ensure the person's well-being had not been adversely affected.

Risks within the premises had not been effectively assessed and managed. We reviewed the provider's fire risk assessment, which had been completed by an external contractor on 30 May 2018. We noted that six items on the action plan were priority recommendations, with a timescale of 0-60 days for completion. These items had not been actioned. They included holes in the ceiling in the ground floor laundry and gaps in the ceiling head of the laundry room. This meant the area would not provide sufficient protection to people or staff in the event of a fire. Fire doors had been identified as not shutting correctly. We identified two fire doors from the main hallway to the dining room and to the lounge, which did not shut when the fire alarm sounded. Batteries for magnetic door closures on fire doors were not routinely replaced. This meant some fire doors, including those in communal corridors, remained closed, presenting a potential risk of falls or injury for people when they tried to navigate through them.

Maintenance records showed concerns with lack of hot water to rooms since May 2018. Staff had provided a list of rooms where there was little or no hot water, but told us this remained an issue. One staff member told us they filled a bowl of hot water from a sink and had routinely carried it to a person's room to assist them to wash as their room had had no hot water for some time. Another staff member told us, "We have to mess with the heating as it's not regulated and doesn't always work. The rain comes in and puts out the boiler." We checked hot water temperatures in two peole's rooms and the ground floor bathroom. Despite running the water for some time, water temperatures remained cold.

The clinical room was adjacent to a person's bedroom, with an adjoining door. We found an extension lead had been run under the door from the person's room to the clinical room and was being used to power the air conditioning unit and fridge. This had been identified as a hazard during an electrical assessment and staff told us they had asked for an electrical socket to be fitted in the clinical room, but the provider had failed to take any action. The provider had not ensured the premises were safe to use for their intended purpose and are used in a safe way.

The provider had not done all that is reasonably practicable to mitigate risks to people's health and safety. Risks to people's safety were not effectively managed. People's care plans included risk assessments which identified areas where they may experience potential harm, and the measures staff needed to take to keep people safe. However, risk assessments were not regularly reviewed or updated to ensure they reflected people's current needs. For example, one person had been assessed as being at risk of choking. Their care plan identified they needed a 'fork mashable diet with small amounts, thickener to be added to fluids.' The care plan was dated July 2017 and there was no record to demonstrate the care plan had been reviewed. A risk assessment had been written in August 2018 guiding staff to ensure the person had, 'small mouthfuls of mashed diet, with soft options such as sandwiches with soft filling and no crust. Sips of level 1 fluid.' The person had received an assessment from SALT (Speech and Language Team) in August 2018. The guidance and measures staff needed to take to reduce the risk of the person choking was detailed and explicit. This information had not been included in the person's care plan and had only been translated in part in their choking risk assessment. The information from the SALT was not in the person's care file, but was part of a pile of papers on the manager's desk. This meant the person was at risk of choking as staff were not provided with the detailed information and guidance they needed to reduce the risk.

Another person had been identified as being at high risk of falling. The person had experienced several unwitnessed falls and as a result, their falls risk assessment score was very high risk. This had resulted in a requirement for the falls risk assessment to be reviewed monthly, to include a review of contributory factors

such as medicines and health conditions. The care plan had not been reviewed since January 2018 despite the person continuing to experience falls. The person had recently experienced an unwitnessed fall and as a result had complained of shoulder pain. Staff had not sought medical guidance and recorded 'no visible injuries' on the accident form. Incidents and accidents had not been analysed or reviewed to reduce the risk of further harm for the person. .

The provider had not ensured there were sufficient numbers of staff deployed to keep people safe. We reviewed staffing rotas from 10 September 2018 to the date of our inspection visit. The rotas were not an accurate record of staff who had worked in the service. For example, rotas showed three staff had been allocated to work the morning and three staff for the afternoon shifts for 15 and 16 September 2018. However, staff told us four of the six staff did not arrive for work as they had absence that had been approved by the acting manager. Rotas had not been updated to reflect this. This meant there were not enough staff working in the service on these dates to keep people safe. Staff told us they had, at the time, contacted the provider, who did not provide support but told them to contact the local authority. The local authority provided emergency staffing to work alongside permanent staff in the service to ensure people were safe and their needs met. This arrangement remained in place at the time of our inspection visit. On another occasion, the cook did not arrive for work as they had approved absence that had not been recorded on the staffing rotas. As a result, there were insufficient arrangements to provide a cooked meal for people and staff were supported by the local authority to provide people with take-away meals.

Staff had not always been safely recruited as the provider had not carried out the necessary checks to ensure staff were suitable to work with the people who used the service. Staff told us the provider had contacted staff who had left the service, and had arranged for them to return to work. Some staff had left the service over six months ago. The provider had not carried out any recruitment checks, such as references, or a check with the Disclosure and Barring Service to assure themselves ex-employees remained safe and suitable to provide care. When we spoke with the provider, they confirmed they had asked ex-employees to return to the service. They told us only one ex-employee was providing care and confirmed they had not carried out the necessary checks to ensure they remained suitable to work in the service. They told us other ex-employees were only sitting and spending time with people and were not providing personal care.

The provider had not ensured the staff providing care to people had the qualifications, competence, skills and experience to do so safely.

The above evidence demonstrates a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection in March 2018 we found systems to monitor, assess and improve the quality of the service were not effective to ensure the care provided was safe. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider had not made improvements to meet the requirements of the regulations.

The service did not have registered manager in post. A manager had been appointed but had left the service ten days before our inspection visit. The provider had not made appropriate arrangements to ensure the safe management of the service. Care staff had been left to oversee the day-to-day running of the service with little support from the provider. A staff member told us, "We have been given no information about who is running the home. We are just left to our own devices. We have no support [from the provider], staff support each other. The provider is on the phone a lot but does not visit very often. If I had any concerns, I would go the senior. I would not go to the owner (provider). I wouldn't dare ring up and ask for anything; he would shout and say he had no money." Another staff member told us that the provider had not implemented any interim management arrangements since the manager had left and did not listen to staff requests or help to solve problems. At the time of our inspection, the local authority was in the process of supporting people to move on to alternative placements and was supporting staff with these transitions and in the day-to-day management of the service to ensure people's needs were being met.

People and relatives did not feel their views had been listened to and had no confidence in the provider, or the previous manager. One relative told us, "The first thing the manager did when they came here was to move the office upstairs. They told us they needed more space, but in practice this meant people couldn't get to the office to see them. It took the manager over a week to introduce themselves, and I come here very regularly. I think it is disgusting how [Name of provider] plays with people's lives. We never see [provider]. The carers are really good and have looked after my relative." Another relative told us, "The care staff are very good here despite the leadership and governance. [Name of provider] lied to us; told us a load of rubbish. For example, we were told the home was having a full refurbishment. Some rooms did have a refurbishment but then work stopped, with no explanation. We asked for the gardens to be done as people can't access them in the current state. This was never done. Staff started to leave. At no stage has the provider told us the home was in trouble. The first we knew about it was the meeting with Derby City Council. At no time has the provider contacted us, other than to ask if [name of relative] is happy at the home. [Name of provider] never told us about the most recent CQC rating, which was a concern."

The manager had undertaken audits and checks on some areas of the service. These included medicines audits, checks on the environment, fire and kitchen. We reviewed audits undertaken on 10 August 2018. Where areas for improvement had been identified, for example the need to replace furniture and carpets, action points stated, 'discussed with provider' with no further explanation and the improvements had not been made. Audits and checks had not identified the issues of concern we had found during our inspection visit, including risks to people's health and safety. Audits did not include any review of care plans and

records or staffing. We found care plans were outdated and did not reflect people's current needs. Staff had not received any formal supervision since February 2018 and their competence and knowledge had not been assessed to ensure their training had been effective.

The provider had failed to establish and operate effective systems to assess, monitor and improve the quality and safety of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from the risk of infection. People were not consistently protected by safe systems for managing their medicines. The provider had not ensured the premises were safe to be used for their intended purpose and used in a safe way. The provider had not done all that was reasonably practicable to mitigate risks to people's health and safety. The provider had not ensured the staff providing care to people had the necessary qualifications, competence, skills and experience to do so safely.

The enforcement action we took:

Enforced cancellation of registration

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

The enforcement action we took:

Enforced cancellation of registration