Birds Hill Nursing Home Limited

Birds Hill 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

The inspection was unannounced and was carried out on 17 and 18 May 2017.

Birds Hill Nursing Home is a nursing and care home for up to 72 older people some of whom may be living with dementia and or have nursing needs in Poole. There were 57 people living at the home which is divided in to three separate living units over three floors. One of the living units, Nightingale was specifically for people living with dementia, Merlin was for older people some of whom may have nursing needs and or be living with dementia and Starling was for people with high level and complex nursing needs and or were living with dementia.

The provider was registered in May 2016. The previous registered manager/provider remained in post and was registered as manager until November 2016. The provider and new management team has been fully responsible for the operation of the home from then. The registered manager has been registered since December 2016. 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.

Some risks to people's safety were not consistently assessed and managed to minimise potential harm. This was because staff did not have access to the correct information about the risks to people and how to manage some risks.

Some people's medicines were not consistently and safely managed or administered. This was because staff did not have clear instructions when they needed to give some people 'as needed' medicines. Some people had medicines that needed to be crushed and administered in food and drink but pharmacy advice had not been sought to check this was safe. The shortfalls in the people's risk and medicines management were a breach of the regulations.

Some people's needs were not reassessed when their circumstances changed and care plans were not updated or did not include all the information staff needed to be able to care for people. Some care plans included contradictory information. People's needs had changed but their care plans had not been updated to reflect their current needs. However, staff were able to describe how they met people's needs and staff delivered the care people needed despite the shortfalls in the assessments and care plans in place.

There were shortfalls and inaccuracies in the record keeping for people. This meant there was not an accurate individual record for each person. The shortfalls in people's record keeping and the assessing and planning for people's care needs were breaches of the regulations.

Staff were beginning to fully understand, work to and adhere to the principles of the Mental Capacity Act 2005. People were not subject to any unnecessary restrictions. There continued to be shortfalls in the

correct recording of people's consent, mental capacity assessments and decisions made in people's best interests. This had been identified by the registered provider as an ongoing area for improvement. We have made recommendation about this.

People and relatives told us they and their family members were safe. People's independence and wellbeing had been enhanced by improvements made to the environment of the home. The provider had invested in new equipment, furniture, the refurbishment of the building and used their knowledge of best practice to make the environment suited to the needs of people, including those living with dementia.

People and relatives spoke highly of the caring qualities of staff. Staff were kind, caring and responsive to people's needs. People's individual care needs were met by staff who knew them well and were familiar with the care they needed. People had access to the healthcare they needed. People were occupied during the inspection and actively engaged with staff.

New staff received a six day induction, core training and some specialist training so they had the skills and knowledge to meet people's needs. Existing staff were also receiving the same core training and new updates from the provider. Staff told us they felt very well supported by the new management team and provider. Staff employed were recruited safely.

The home was well-led and there was a positive, caring, open and improving culture. People, relatives and staff were kept informed of developments at the home and were consulted regarding how the home was run. There were regular meetings for people, relatives and staff. Staff felt well supported by and listened to by the management team.

The provider's quality assurance system was being introduced. The provider and registered manager audited, observed practices, consulted and reported back on various aspects of the running of the home. The findings of the quality assurance system fed in to the overall improvement plan. The plan in place had identified the shortfalls found at this inspection and included realistic targets for the improvement of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Improvements were needed to make sure people were consistently kept safe. This was because the management of medicines was not consistently safe and risks to people were not consistently assessed, planned for or managed.

Staff were recruited safely and there were enough staff to meet people's needs.

Staff knew how to report any allegations of abuse.

Is the service effective?

Good

The service was effective.

Staff received the training and support they needed.

Staff had an understanding of The Mental Capacity Act 2005. There was a plan in place to ensure decisions were in people's best interests and these were recorded accurately.

People were offered a variety of choice of food and drink. People who had specialist dietary needs had these met.

People accessed the services of healthcare professionals as appropriate.

Is the service caring?

Good

The service was caring.

Care and support was provided with kindness by staff, who treated people with respect and dignity.

Staff understood how to provide care in a dignified manner and respected people's right to privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive to people.

Overall, people received the care they needed. However, most

people's care plans were not updated and did not include all the information about their care and support needs. This meant staff did not have up to date information about how to care for people.

Activities were based on people's individual interests and abilities.

People and relatives were listened to and their comments and complaints acted upon.

Is the service well-led?

Good

The home was well led by the management team and provider.

People, relatives and staff felt listened to and supported. The culture was more open and learning from incidents and events were seen as a positive.

Improvements and significant progress had been made on meeting the shortfalls identified following the provider starting to operate the home. There was a comprehensive improvement plan in place.

Birds Hill 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 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 comprehensive inspection took place on 17 and 18 May 2017 and was unannounced. There were two inspectors and an expert- by-experience, whose expertise was in older people, in the inspection team on the first day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. There were two inspectors on the second day

We met and spoke with most of the 56 people living at Birds Hill Nursing Home. Because some people were living with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with five visitors and relatives and two visiting health professionals. We also spoke with the registered manager, deputy manager, clinical lead, director of care, director and 11 staff. The staff spoken with included nursing staff, care givers, care team leaders, activities staff and facilities manager.

We looked at four people's care, health and support records and care monitoring records in detail and samples of monitoring records such as food and fluid monitoring and mattress checks. We looked at seven people's medication administration records and documents about how the service was managed. These included three staff recruitment files and the staff training records, audits, meeting minutes, maintenance records and quality assurance records.

Following the inspection we received telephone feedback from two relatives, and two relatives left feedback via the CQC website.

Before our inspection, we reviewed all the information we held about the service. This included the information about incidents the registered manager notified us of.

We contacted commissioners prior to the inspection and sought the views of professionals involved in the

service following the inspection. We received feedback from the local safeguarding team, one GP and two commissioners.

Following the inspection, the registered manager and director of care sent us the information we requested about, thank you letters, staff training, the activities programme, the provider's improvement and action plans.

Requires Improvement

Is the service safe?

Our findings

Risks to some people and the service were not consistently managed to make sure people were protected and their wishes supported and respected. This was because the guidance and risk management plans in place for staff to follow had not yet been reviewed.

One person's risk management plans did not reflect the care they were receiving. For example, they had a skin integrity risk management plan in place which identified the use of some specialist equipment. Although this person's needs had changed their risk assessments had not been updated. Staff were able to explain how they cared for the person and confirmed that they were not following the inaccurate risk management plan. This person was also nutritionally at risk, however, this had not been assessed. Staff were keeping daily records of the individual's food and fluids but this had not fully protected the person. This was because the fluid monitoring records did not include an individualised fluid target so that staff knew that the person had drunk enough to keep them well. We drew this to the attention of the registered manager who took immediate action and each person had an individual fluid target by the second day of inspection.

On the first day of the inspection we saw that one person's diagnosis meant they became frightened during personal care support and physically aggressive towards the staff supporting them. Staff explained to us how they supported them in these circumstances including the use of safe holding. Staff also recorded when they had used safe holding with the person. Their care plan advised that safe holding techniques should be used with two or three members of staff. However, the care plan did not provide staff with guidance on what safe holding meant for this person or what they should try to do to avoid the need to use safe holding. This meant there was a risk that this person's personal care support would not be safe, or the least restrictive intervention. We discussed this with the director of care. They showed us the guidance for staff which had been stored away from the person's records. They also updated this person's risk management plan immediately and informed staff of the updated risk management plan in place.

These shortfalls in people's risk management amounted to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For other people robust risk management plans were in place. For example, one person was at risk of falls whilst in bed. Their plan included consideration of their safety including the equipment they needed. At the time of the inspection staff were assessing people who had bed rails in place. This was because they had identified that 40 of the 57 people living at the home had bed rails in use without proper assessment. The director confirmed to us following the inspection that individual risk assessments had determined that 13 people required bed rails to make they were safe in bed. This showed that the systems in place for making sure people's safety was maintained using the least restrictive option. One person had a risk assessment for a bed rail that determined it should not be used. We checked this person's bed and found the bed rail was not in use.

The new care plans for people included detailed assessments and risk management plans and there was a summary of the risk to people on their care passport (Their care passport is a person centred summary of all their needs).

Medicines management was not consistently safe. Most people had 'as needed' PRN medicine plans in place. However, some of these plans were not accurate or clear and some did not fully describe the circumstances when these medicines should be administered or did not detail the times between doses and the maximum dose in 24 hours. We were unable to establish from one person's bowel monitoring records whether they had received their 'as needed' PRN bowel management medicines as prescribed. Another person's 'as needed' PRN plan for their epilepsy rescue medicine did not include a specific time to administer the medicine. The plan detailed the medicine was to be administered when the person had been having a seizure for 10 to 15 minutes. No further detail was included in the person's care plan. The registered manager took immediate action to clarify the plan and to inform staff.

One person had been prescribed a night time sedative medicine. The instructions for staff were not clear. This meant there was a risk that the person could be over medicated. The registered manager was aware of this and was taking action. Staff told us about the action they had immediately taken to understand when the medicine should be used and how much should be administered.

Some people had medicines that needed to be crushed and administered in food and drink. Administering medicines in food or drink can significantly alter their therapeutic properties and effects, and pharmacist advice is necessary. We drew this to the attention of the director of care. They and a member of staff told us that they were aware of this issue and showed us the action they were taking to make sure that pharmacy advice was sought when altering the properties of prescribed medicines.

Medicines were stored safely and the administration of people's medicines and topical creams was recorded accurately.

The temperature records for the medicines' fridge on Nightingale living unit showed the maximum temperature had been consistently above the safe range since the beginning of May 2017. The records did not show what action had been taken as directed by the recording template. The deputy manager agreed to immediately follow up the high fridge temperature with the pharmacy that provided the fridges.

The shortfalls in people's medicines were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us they felt safe. One person told us, "Yes the carers make me feel safe". We also received feedback from the local authority safeguarding team that the provider appropriately reported and investigated any safeguarding concerns.

There was information displayed about how people, relatives and staff could report any allegations of abuse. The staff had all received safeguarding training. All of the staff we spoke with were confident in recognising the types of potential abuse and how to report any allegations. They spoke highly of the training they received in relation to safeguarding and the responses of managers when they reported any allegations or concerns. Staff told us that since the change in provider there was a positive focus on keeping people safe.

The registered manager and director of care had reported allegations of abuse as required to the local authority safeguarding team and CQC. The director of care confirmed the safeguarding concerns they had

identified and raised with the local authority safeguarding team when they became the new providers. They shared the reports of investigations and actions they had taken in response to make sure people were protected from abuse.

There were enough staff on duty to make sure people's needs were met. One person told us, "When I ring my bell they always come quickly" and another individual said, "Yes staff are always around when I need them". Observations showed call bells did not ring for long periods of time and staff responded to people's requests for assistance.

The service followed appropriate recruitment process before new staff began working at the home. Staff files showed photographic identification, a minimum of two references, full employment history, nursing registrations and a Disclosure and Barring Service check (DBS). A DBS check helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with certain groups of people.

Accidents and incidents were reported, and investigated. Audits of accidents and incidents were completed and the director care explained to us they were implementing the provider's audits and trend analysis system from May 2017.

During the inspection the fire alarm sounded. There was a quick, effective and safe evacuation of the home with key staff understanding and calmly carrying out their roles. People and staff were moved to areas of safety as needed.

The provider had a facilities manager who managed the maintenance workers, housekeeping and catering teams across the group of homes. There were robust systems in place to ensure the premises were maintained safely. This included a bi-monthly audit to make sure all maintenance and servicing was up to date. Regular checks were completed for fire safety equipment and fire panels, electrical testing, lighting systems, gas safety and hoisting equipment. Legionella testing was regularly completed. Legionella is a waterborne bacteria that can be harmful to people's health.

The provider had purchased new adjustable beds and mattresses when they started operating the service. This was because the previous beds and mattresses placed people at risk of infection, injury or skin damage.

Good

Is the service effective?

Our findings

Staff had received a range of training to develop the skills and knowledge they needed to meet people's individual needs. There had been a focus on safeguarding and Mental Capacity Act 2005 (MCA) training. This was because the provider had recognised these were key areas of risk to people.

Some staff had completed a four day dementia course, in addition to dementia awareness from nationally recognised trainers. This training focused on understanding and validating people's feelings and emotions. This was also planned for the remainder of the staff team. In addition staff received training in understanding end of life care, person centred care, safe holding techniques, and mental health awareness. Staff also received training specific to their roles. For example, nursing staff were being trained in falls prevention, epilepsy, nutritional risk assessing and catheterisation.

When staff first came to work at the home, regardless of what their role was, they undertook a six day induction training programme. Existing staff at the home were also completing this induction programme. This covered all essential core training.

Staff told us they felt very well supported by the new management team. The supervision records reflected this and showed staff were supported to think about reflective practice, their responsibilities and people's changing needs. One member of staff had received positive feedback from colleagues and this had been fed back to them during supervision. Where staff required emotional support records showed a compassionate and genuine regard for their welfare. Some staff had an appraisal and there was a plan in place for the remainder of the staff team.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005. The 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 spoke with the lead staff member for the MCA. They explained to us how people who had capacity made their own decisions and said that recent MCA training made sure that staff respected people's decisions and acted upon them. They commented staff had, "Come a long way, there has been a lot of training around dementia and choice. The willingness to listen to residents is really there". They also said, "We are not there yet but we will get there and we have a plan". What they told us reflected our findings. One person had capacity and records showed they had consented to photography for care purposes and social media. They had also requested the use of bed rails and provided written consent. The detail of their requests was reflected in their records which provided staff with instructions on how the person wanted the bed rails used.

Where people lacked capacity to make specific decisions there was a mixed picture of adhering to the principles of the MCA. This was because the provider had needed to retrain and support staff extensively to

understand the act and their responsibility to protect people's rights.

For some people the provider had ensured that individualised mental capacity assessments had been undertaken and any consequent best interests decisions involved the person and other interested people such as family or involved professionals. These had taken into account the person's wishes and reflected a least restrictive, most proportionate approach. For example, one person was at risk of falling when in bed. Staff had chatted with the individual, listening to them and weighed up whether they understood the decision that needed to be made. A number of options had been considered with a risk versus benefits approach. The solution decided upon demonstrated the staff were using the principles of the MCA.

However, other people's plans still reflected the guidance received by staff from the previous provider. This meant that their rights were not protected and decisions made about them did not reflect either the best interests statutory checklist or the principles of the act. Records showed that people had not been supported in a meaningful way to assess their capacity to make a specific decision, and the decision made did not explore the person and their relative's wishes and was not a least restrictive, most proportionate approach. The MCA lead and provider were aware of this and were at the time of the inspection working hard to protect people's human rights, including their rights to make or be involved in decision's made about them.

In addition, staff had sought consent inappropriately from some family members where they did not have a legal power (such as a lasting power of attorney or Court of Protection deputyship) to make decisions on the individual's behalf. This meant there was a risk people's rights would not be protected and decisions made in their best interests because staff were not fully adhering to the MCA. We drew this to the provider's attention during the inspection and they took immediate action to review this.

We recommend the provider continues to review their adherence to the MCA for people living at Birds Hill Nursing Home and ensure that mental capacity assessments and best interests decisions reflect the principles of the Mental Capacity Act 2005.

People can only be deprived of their liberty so that they can 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager understood when DoLS applications would be required and had made appropriate applications. Some people had conditions attached to their DoLS authorisations. There was a system in place to ensure the registered manager made further applications when these were required and was assured that any conditions were adhered to.

There was an enthusiasm from staff about people's nutritional needs being met. For example, the new chef had completed a full review of the catering systems. They had identified a number of shortfalls that prevented people from having easy access to nutritious food and drink including being able to eat freshly prepared food and the things they enjoyed. They had taken immediate action. This included ensuring people had free access to snacks and drinks on each of the living units. Improvements to the cleanliness of the kitchen to make sure people's meals were prepared in a safe environment. Pureed foods were presented using shaped moulds so that they looked appetising. We reviewed the chef's analysis and changes made document and found people's mealtime experiences were much enhanced.

People confirmed this saying, "I have a tummy problem and sometimes I ask for something else to eat and I always get it" and, "I get plenty to eat and drink and there is always a choice" and, "I had difficulty one day with some hard fish and sent it back, the chef came to see me and said very sorry and if you don't complain how can I put it right, I thought that was a very good attitude".

People helped themselves to the snacks and drinks on the living units and or staff offered them to people throughout the inspection. People were offered visual and verbal choices of food and drinks. For example, people were shown two plates of food to choose from. Bright contrasting coloured crockery was used for some people living with dementia. This was good practice and research has shown that people living with dementia can see food more easily on coloured crockery and may subsequently eat more. Some people preferred to use neutral coloured china crockery and this choice was respected.

People and their relatives told us they were supported to access healthcare when they needed to. One relative told us, "They will call a Dr if he needs one" and a person commented, "Yes if I have a problem with my teeth the dentist would visit or if not a carer would take me". One person had a percutaneous endoscopic gastrostomy (PEG) feed. A PEG allows nutrition, fluids and/or medications to be put directly into the stomach via a tube. The records showed staff were monitoring the person's weight and that they had sought advice from the Speech and Language Therapy Team (SALT) team.

Another person had become unwell on the first day of the inspection the clinical nursing lead told us what staff had done to support this person. This included telephone advice from 111 and an out of hours GP. The clinical nursing lead told us they were supporting their nursing staff colleagues to understand when they needed to seek external medical advice for people.

Records showed other people had been supported to access a range of healthcare professionals including their podiatrist, occupational and physiotherapists, audiologists, dentists and dieticians.

People's pain was assessed and well managed. The staff used two different types of pain assessments tools. Which tool used was dependent on people's ability to communicate their pain verbally or whether staff needed to look at people's facial expressions or body language to assess their pain.

During the inspection the home was undergoing major refurbishment. The facilities manager showed us the design plan for the home. New homely comfortable furniture was being delivered the day following the inspection. People had been involved and consulted about the new furnishings and décor. The environment was specifically designed and suitable for the needs of the people who lived on each living unit. For example, Nightingale unit accommodated people living with dementia and was designed and decorated taking into account into account national good practice such as that produced by the University of Stirling's Dementia Service Development Centre. There were contrasting coloured doors, contrasting coloured toilet seats, hand rails and easy to read signage for people living with dementia.

Good

Is the service caring?

Our findings

People and their family members spoke highly of the caring qualities of staff. One said, "Staff are very caring and always available even in the middle of the night" and another told us, "They do treat me with respect and are very caring". A relative said, "All the staff are lovely and polite, I couldn't ask for more. Any problems are dealt with instantly". Another family member commented, "It's absolutely fabulous. He has only been here since January but they know him so well and he has improved since he got here".

A GP fed back to us that the care people received was good and the staff are very caring. They said the staff know the people as individuals and staff meet people's needs well.

People said their family and friends were able to visit them at any time. One said, "All my visitors are made welcome and offered drinks if they want something".

Staff were caring and compassionate and treated people with respect and dignity. For example, it was one person's birthday. Staff had decorated their bedroom door with a happy birthday banner and we saw staff stopping to say hello and wish the person happy birthday. Later the whole staff team sang happy birthday to the person and gave them a specially decorated cake.

Another person was confused about what was happening in the lounge. Staff responded immediately checking out what was worrying the individual. They walked with the person so that the individual could reassure themselves about the safety of other people sitting in the lounge. They offered sensitive and respectful reassurance telling the person, "Look, everybody is safe". When the person became more settled they sat down and the staff member checked they were ok and showed them their drink saying, "You have got a juice here, would you like a cup of tea instead". Throughout the staff member was calm and reassuring whilst ensuring the person felt listened it and upholding their dignity.

People's independence was promoted and people were encouraged to move freely around the home. Staff told us that since the change of provider they encouraged and supported people to walk freely around their home. One staff member who was walking with a person told us the individual was much more settled and content now they were able to freely walk around rather than repeatedly told to sit down.

Most staff approached people in a respectful manner and were calm and positive in their approach. However, a small number of staff required further guidance on how best to support people in a way that was respectful and helpful. We drew this to the attention of the director of care and the registered manager. They were aware of these shortfalls and were committed to ensuring all staff understood that compassionate person centred care was paramount to people's happiness and wellbeing.

There was a chaplain who worked across the provider's four homes offering pastoral, religious and spiritual care to people. People's spiritual needs were acknowledged and catered for regardless of whether they were of a specific faith or had none. There was an interactive non-denominational Christian dementia friendly service held at the home each week. The chaplain had a network of different faith groups and contacted the

relevant group to visit and provide faith support to people living at the home.

People's bedrooms were very personalised and included possessions, pictures and photographs that were personal and important to them. People were orientated to their bedroom by signs on their bedroom doors. The signs were person centred. In addition to people's names there was information about people's likes, life history and things that were important to them. For example, '[the person] enjoys old movies and likes to read love stories', [the person] used to work for the army], [the person's] dream is to go to America'.

Requires Improvement

Is the service responsive?

Our findings

Staff knew people well and were able to tell us about the person as an individual and how they cared for the person. However this knowledge about people as individuals' was not reflected in most people's care plans.

The majority of people's care plans in place were not easy to follow and different sections gave contradictory information. For example, one person's care plan detailed that they had their medicines covertly. However, following discussion with staff their medicines were crushed and added to food because they had swallowing difficulties. This meant their care plan was inaccurate and the person did not need their medicines administered covertly.

Some people's medicines plans were not clear or inaccurate. For example, one person who was prescribed warfarin had an 'as needed' PRN place rather than a plan that detailed the medicine was a variable dose. However, the person had received the correct dosage of warfarin as detailed by the clinic following the person's International Normalised Ratio (INR) tests. INR is the measure of a person's blood clotting.

One person's care plan detailed they needed to be repositioned every two hours. Their repositioning records showed gaps where they had not been repositioned very two hours and they were inaccurate. This was because the person was positioned on their back but the records showed they were lying on their left side. Staff confirmed this person could not move independently.

People's plans were regularly reviewed. However, the review did not always accurately reflect the persons changing needs. One person's medicine records showed they had received pain relief medicines; however, the care plan review did not reflect this. Another person had a plan in place for their skin integrity. This had been reviewed. However, the person's pressure wound had healed but their care plan had not reflected this.

Other information about people was inaccurate. For example, the handover records showed two people who were unwell and having antibiotics. However, these people had recovered and finished their antibiotic medicines.

There was a communal record book on each unit where staff recorded people's bowel movements. This information was not consistently included in people's personal records so there was an accurate individual record. The registered manager told us they were not aware these records were in place. The use of these communal records had been the practice prior to the current registered manager and provider started providing the service at Birds Hill Nursing Home. The registered manager immediately took these communal records out of use.

Two health professionals told us that inaccurate record keeping and lack of detail as to why some specific decisions had been made, were making it difficult for them to fully assess one person's needs.

The shortfalls in people's record keeping and the assessing and planning for people's care needs were breaches of Regulations 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

The registered manager and provider were fully aware of the shortfalls in people's assessments and care plans. They had prioritised retraining staff so they were able to deliver safe, effective and responsive care to people. At the time of the inspection staff had rewritten some people's plans and these were person centred, comprehensive and focused on people's strengths. Following the inspection, to ensure people's care plans reflected care being given, nursing staff volunteered to work overtime to continue to put new person centred care plans in place. The director of care confirmed that any new people admitted into the home would have a full assessments and care plans completed to the provider's standard. The reassessment of people's needs and producing care plans was included in the provider's improvement plan.

There was a team of six staff responsible for providing activities based on people's interests. Staff told us they were getting to know people as individuals and developing personalised activity plans. Everyday staff would spend one to one time with people in their bedrooms and offer group activities. There was a monthly activities plan. This showed a range of activities including poem reading and writing, reminiscence, exotic fruits and ice-cream tasting, balloon tennis, cocktails and canapes, and old time singalongs. The activities lead had also made links with a local nursery so that nursery aged children could come and spend time with people each week. Each week a beautician and hairdresser visited. There were weekly trips out and the week of the inspection people went to Corfe Castle and Bournemouth football club. During the inspection people were supported to do the things they enjoyed. In a communal lounge we saw one person completing a word search whilst another person was reading their daily newspaper. Staff were sat with a third person looking at a book together.

Complaints information was displayed throughout the home. People told us they knew how to make a complaint and felt comfortable to do so. We received a range of comments including, "I would know how to complain and I would be comfortable about complaining, I would mention it to the Sister and ask her to refer it on", "I would feel comfortable about raising a complaint if I needed to", "If I had to complain I would just see who is on duty, I would feel comfy about complaining but never had to".

There was a positive, open, transparent culture about complaints and concerns. The registered manager told us and records showed us complaints and concerns were taken seriously and used as an opportunity to learn and improve the service. In addition the director of care also reviewed any complaints or concerns to ensure there was an impartial view. The registered manager and/or director of care wrote to people and or their representatives to apologise when there were any shortfalls that had impacted on the person.

Good

Is the service well-led?

Our findings

Observations and feedback from people, staff, and relatives showed us the service had an improving, positive and open culture. This was because the registered manager, management team and provider were changing the culture of the service to make sure that people were at the centre of the changes. People, relatives, people's representatives and staff were consulted and involved in all aspects of moving the home forward.

Relatives fed back via our website about how they had seen improvements in how well-led the service was. There were a further nine positive responses about the home from people or relatives that had been left on a national care home review website since March 2017. These nine responses included rating the management of the home as 'good' or 'excellent' and all of the respondents were 'extremely likely' to recommend Birds Hill Nursing Home.

Staff told us about how impressed they were with the systems developed by the provider. They said, "It's really good" and they were, "Looking forward to more changes". Another member of staff described they wanted to provide, "Safe" care. They were upset because they had realised that they had previously provided unsafe care, but felt supported and positive about the changes brought about by the provider. A third member of staff told us of the positive changes that had been implemented by the new registered manager and provider. They said this meant that although they had not known previously that people's rights were not protected and they did not receive personalised care, that people were now receiving "Better and safer care".

Staff told us the registered manager and provider listened to them. One told us about how a suggestion they had made to develop a checklist for people's health conditions had been acted upon. All the staff we spoke with told us all managers and directors were accessible and they could approach them about anything. They said they were always listened to and action was always taken in response.

Staff told us their views were actively sought and they had regular staff meetings where they received important updates and given clear guidance on their practices and roles. Staff were also supported to understand their roles and responsibilities by the communication systems in place. There were daily handovers between staff shifts and in addition there was a daily '10 at 10' meeting that involved managers, all nursing staff, the chef and facilities staff. At these meetings there was a daily review of all the people including any significant events. Staff were also emailed important information, changes in procedures and guidance.

The directors conducted annual and bi-monthly themed surveys with people and or their representatives. The results were analysed and any themes or comments were fed back to the registered manager, who took any action required. The director of care services monitored any action plans in place.

Feedback from commissioners showed an effective open relationship where advice and guidance was sought appropriately.

The provider has four homes in Poole and Bournemouth. Each home has a registered manager and the director of care services oversees the running of all four homes within the group, along with the managing director of the provider. The registered managers of all four homes met on a monthly basis and shared good practice ideas and any learning from incidents. The managers provided support and out of hours cover for each other's services.

The registered managers across the four homes had meetings so they can share good practice and any learning. The director of care services ensured any learning was shared and implemented across all of the four services. For example, in one of the provider's homes there was an incident where two staff had failed to keep adequate and accurate records about the care and support provided to one person. The training managers and director of care were able to use an anonymised version of the incident in staff training in record keeping and safeguarding. The registered managers were briefed on the case so they could share this information with their management team and staff during supervision sessions.

The registered manager and provider had changed the management team and staffing structure in the home. The management team now included, a deputy manager, a clinical nursing lead and a dementia lead who were supported by the nursing staff and care team leaders.

Staff knew how to whistle blow and had received training from the provider. Information was displayed about how staff could whistle blow. The director of care gave us examples of how staff had whistle blown and what action they and taken in responses. Staff told us there was now a 'no blame' culture and they were all encouraged to report any incidents, errors and concerns. Any complaints, safeguarding concerns and incidents were used by both the registered manager and provider as an opportunity for improvement.

The provider had a schedule for completing themed anonymous staff surveys. These themes had been identified following staff exit interviews and specific staffing issues that had been identified for each of the provider's four homes. This was so the provider could take action to address and shortfalls identified in staff survey responses.

The registered manager and provider works in partnership with other organisations to make sure they are following current practice and providing an improving and high quality service. The provider has been funded by a local partnership group to undertake some research in to 'effective leadership'.

The provider used 'secret shoppers' to regularly assess the experience of people and relatives who make contact with and come to look around the home.

The provider had developed a monthly action plan to assess, monitor and improve the safety and quality of the service. This action plan was being implemented in May 2017. This was in response to the ongoing shortfalls they had identified. The provider's findings reflected the findings of this inspection.

The director of care sent us the provider's improvement plan and this included all of the shortfalls and areas for improvement they had identified over the last six months. This included the shortfalls we identified during this inspection. All of the areas for improvement had a clear plan as to how the improvements were to be achieved, who was responsible, and who was reviewing the action plan and the timescales for completion. The plan focused on improving the quality and safety of care and support provided to people as a priority. The registered manager, director of care and provider were realistic as to the amount of work and time that would be needed to make the improvements.

The registered manager told us they were proud of the open culture that was now in place and that staff

now felt confident to speak up about any poor practice. This had meant staff were now passionate about their roles and making improvements in the care and support that people were receiving. The registered manager said the staff were less task focused and institutionalised in their approaches and this had made positive impact on people's lives and wellbeing.

People's records were stored securely and information posters acted as a reminder for staff to maintain people's confidentiality.

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 9 HSCA RA Regulations 2014 Person-centred care There were shortfalls in people's assessments and care plans and these did not reflect people's needs or the care and support they were receiving.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were shortfalls in people's medicines and risk management.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's records were not accurate, individual or contemporaneous.