Birds Hill Nursing Home Limited

Birds Hill Nursing Home

Inspection report

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16 November 2018

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Ratings

Overall rating for this service	Requires Improvement

Is the service effective?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This focussed inspection took place on 15 and 16 November 2018 and was unannounced. This shorter inspection was carried out due to concerns that were raised with us. A comprehensive inspection was undertaken in June 2018 and we rated the service as good overall, with no breaches of legal requirements.

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

Birds Hill Nursing Home is a nursing and care home in Poole for up to 72 older people some of whom may be living with dementia and or have nursing needs. There were 62 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 people living with dementia.

There was a registered manager, which is a requirement of the service's registration. 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 received concerns and allegations in relation to whether people's health care needs were being effectively met and how well-led the home was. We reviewed this information and planned to carry out an inspection focusing on the questions, Is the service effective? and Is the service well led? During the inspection, we also identified that one person's concerns and complaints were not fully responded to, so we also focused on the key question Is the service responsive?

Some people's needs were not fully assessed and planned for and/or changes in their health were not responded to appropriately to make sure all their healthcare needs were met in a timely way. This had placed some people at risk of avoidable harm and was a breach of the regulations.

Most staff had the support and training they needed. Staff were well trained. The implementation of clinical and professional support for nursing staff was an area for improvement.

Overall people's rights were protected and staff understood and acted in accordance with the Mental Capacity Act 2005 (MCA). However for those people who were supported by one member of staff at all times and who were not able to consent to this, the decision had not been considered under the MCA. This was an area for improvement and the registered manager agreed to address the shortfalls.

People's independence and wellbeing was enhanced by the design and environment of the home. People had been involved in choosing the décor and furniture throughout the building.

People were supported to eat and drink enough to obtain a balanced diet. People's dietary needs and preferences were met.

People received very personalised care and support they needed and in the ways they preferred. Staff took the time to get to know people and their life and social histories so they could truly understand their experiences.

Overall, people and relative's complaints were taken seriously and used as an opportunity for learning and improvement. However, one person's concerns had not been recorded or fully addressed. The director of care took immediate action to address the person's complaint.

There was a programme of quality checks and audits to monitor and improve the quality and safety of the service. However, these had not always been proactive and effective in identifying concerns and there was not sufficient oversight of the suitability of agency staff. This was a breach of the regulations. The registered provider took immediate action in response to the shortfalls identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service effective?

Requires Improvement

The service was not fully effective and required improvement.

Some people's health care needs were not fully assessed, planned for responded to.

Staff received the training and support they needed. The clinical and professional support for nursing staff was an area for improvement.

Staff had a good understanding of The Mental Capacity Act 2005.

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

Is the service responsive?

Good

The service was good.

People's care plans were personalised and staff knew people well. People had the opportunity to be occupied and there was a wide range of activities to keep them stimulated.

People and their relatives knew how to complain. Overall people's complaints were listened to and used as an opportunity to improve.

People's end of life wishes and plans were in place.

Is the service well-led?

Requires Improvement

The service was well led but required further improvements.

There were quality assurance and monitoring systems in place but they had not been fully effective.

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

The inspection was prompted in part by allegations that two people using the service potentially did not receive the health care attention they needed and because there was an increase in safeguarding allegations about people's health care. These incidents were subject to further investigation by both the local authority safeguarding team and CQC, as a result this inspection did not examine the circumstances of the incidents.

However, the information shared with CQC about the incidents indicated potential concerns about the management of people's health care needs and how well the service was led. This inspection examined those areas.

This inspection took place on 15 and 16 November 2018 and the first day was unannounced. There was one inspector and a specialist advisor whose expertise was nursing care for older people on the first day of the inspection. There was one inspector on the second day of the inspection.

We met and spoke with eight people. 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 two visitors and relatives. We also spoke with the registered manager, director of care, managing directors and five staff. The staff spoken with included nursing staff, deputy managers and care givers.

We looked at eight people's care, health and support records and care monitoring records in detail and samples of monitoring records such as food and fluid monitoring, MCA assessments, best interests' decisions and deprivations of liberty records.

We looked at four people's medication administration records and documents about how the service was

managed. These included agency staff recruitment files and the staff training records, audits, meeting minutes, and quality assurance records.

We contacted and received feedback from commissioners and the local authority safeguarding team prior to the inspection.

Requires Improvement

Is the service effective?

Our findings

People's needs were assessed and care planning and delivery was based on people's individual needs. Each person had both an electronic care passport summary and paper care plan for staff to follow. At our last inspection, we identified that improvements were needed in fully assessing and planning people's health care needs. The registered persons produced an action plan in response to this. However, this plan had not been fully implemented and this had had a negative impact on how some people's health care needs were assessed, planned for and met. This included delays in seeking appropriate medical treatment, the identification of the deterioration of some people's health and staff not being able to provide health professionals with up to date assessments and documentation about some people's needs. Some people's care plans did not accurately reflect their needs. These shortfalls had placed some people at the risk of avoidable harm.

These shortfalls were a breach of regulation 12 of The Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2010. This was because the service had not fully assessed and mitigated the risks to ensure people's safe care and treatment.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. There were systems in place to make sure any applications needed were made and any conditions on authorisations were met. Following the last inspection staff now recorded when they had met a person's conditions in their electronic records.

Overall, people's rights were protected because the staff acted in accordance with the MCA. 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. There were a number of people who were supported by one member of staff at all times who were not able to give consent to this. However, this had not been considered under the MCA. This was an area for improvement and the registered manager agreed to address the shortfalls.

When staff first came to work at the home, regardless of what their role was, they undertook a seven day induction training programme. This covered all essential core training. New staff completed the care certificate. The Care Certificate is a national induction for people working in health and social care who did not already have relevant training.

Staff had training following their induction to develop the skills and knowledge they needed. All staff had refresher training covering core topics such as safeguarding, fire safety and moving and positioning people. This took place annually or every two or three years depending on the topic. Those who administered medicines had annual training and competency assessments in medicines administration. 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 had been provided with sepsis, tissue viability, stroke, diabetes and catheter care training since the inspection in June 2018. Nursing staff told us where they had not been able to attend training because of absence they were offered alternative dates. They said the registered persons were good with supporting nursing staff with relevant training.

People and a relative told us staff had the skills to meet people's needs. However, one person told us they did not have confidence in the skills and knowledge of the agency staff that worked at the home. We shared this information with director of care and the registered manager. Feedback from some healthcare professionals via safeguarding referrals raised concerns about some of the skills of staff and specifically their decision making when seeking medical attention . The provider acted in response to these concerns following the outcomes of the safeguarding investigations.

We reviewed the individual supervision records for four staff between September and October 2018 and the group supervision for nursing staff held in October 2018. Staff received regular individual and group supervisions. Nursing staff had not had any individual clinical and or nursing practice supervision since the last inspection. This had been part of the service's action plan. However, staff did not raise any concerns with us about the support provided by the management team. The clinical and nursing practice supervision of staff remains an area for improvement. The clinical commissioning group had offered nursing staff clinical supervision in the interim. The registered manager had a plan in place for how all staff were to receive regular supervision.

People's nutritional needs were met and those who were nutritionally at risk had their foods and fluids monitored to make sure they ate and drank enough. The electronic record system totalled people's daily fluid intake and flagged up and prompted staff when people had not drunk enough in any 12 hour period.

People helped themselves to the snacks and drinks on the living units and or staff offered them to people throughout the inspection. People who were living with dementia were offered visual and verbal choices of food and drinks.

People's specialist dietary needs were met and people were consulted about their preferences. There was always a choice of main meals including a vegetarian option.

Nightingale living unit had been designed to meet the needs of people living with dementia. The environment reflected current good practice in relation to dementia friendly environments. There were plenty of bright contrasting colours so people could easily find their way around. There were also lots of different interesting and reminiscence items, clothes and hats for people to use. People had been involved in choosing the décor and furniture throughout the building.

The development of a community café on the ground floor was near completion and this was for the use of people living and staying at the home and the public.

Good

Is the service responsive?

Our findings

At our last inspection, we rated the key question, Is the service responsive?, as outstanding. However, at this inspection the service had not been as responsive and did not consistently identify people's changing health needs. This is why we have changed the rating for this question from outstanding to good.

At the last inspection, the service was very person centred and focused on people's strengths and abilities. This had continued and was supported by our observation of the relationships between staff and people and how staff anticipated people's needs. The relatives spoke very highly of the personalised service their family members received. Staff continued to have an excellent understanding of how people communicated and be creative in using visual and environmental cues to assist people to understand things.

Each person had a personalised plan that detailed how they liked to spend their time and what they liked to do. There was an activities team and they and the care givers gave people the opportunities to be occupied and take part in group or individual activities. People also had easy access to things to pick up and do. For example, staff supported one person living with dementia to make their own hot drinks when they wanted one. Other people and their relatives worked with staff to make Christmas decorations. One person living with dementia had a twirly knitted object that was very tactile they could feel and move in their hand. They smiled and looked relaxed whilst they were doing this.

The staff had continued to work with people and their families to identify any dreams or wishes that they wanted to achieve or relive. They called this a 'diamond moment' and made effort to ensure they made this happen for people.

If people chose, they had a care plan which outlined their wishes and choices for the end of their life. When appropriate the service consulted with the person and their representatives about the development and review of this care plan. We reviewed the care plans and medicines records for one person receiving end of life care. There were some discrepancies with this person's prescription for their end of life medicines. They had received the appropriate medicines over a 24 hour period to ensure they were comfortable. However, the transcription of the correct prescription and full information about medicines administered had not been followed up with the GP when it was first highlighted by an agency nurse. The registered persons took immediate action and met with the GP to ensure the person's written prescription was correct.

The service continued to have good links with the community. For example, local nursery children visited twice a week to spend time and doing activities with people.

Complaints information was displayed throughout the home. Most people and relatives/visitors we spoke with did not raise any concerns or worries. Records showed us complaints and concerns had continued to be taken seriously and used as an opportunity to learn and improve the service. However, one person raised that their concerns and complaints had not been addressed by the registered manager. These concerns had not been recorded in line with the provider's policy. The person agreed for us to raise these concerns with the director of care for the provider, who took immediate action and met with the person. The director of

care responded in line with the provider's complaints procedure. The response to people's concerns was an area for improvement.

Requires Improvement

Is the service well-led?

Our findings

The provider acknowledged that following the last inspection there had been a change in the oversight at the home and that this had potentially contributed to the current shortfalls in the quality and safety of the service. The action plan implemented following the last inspection had not been fully implemented partly due to staffing retention and recruitment difficulties.

The local authority and clinical commissioning group contract monitoring team visited the week before our inspection and identified some shortfalls in the quality and safety of the service. The registered manager had taken action following their feedback.

Following the last inspection, the clinical nursing lead left the home. The nursing staff were consulted as to whether they wanted to replace the clinical lead or develop lead roles within the team . The nursing team chose to develop lead roles. However, this had not been successful and prior to this inspection the provider was actively recruiting a clinical nursing support lead for the home . In response to the concerns we identified in relation to clinical oversight at the home, the registered provider took immediate action and appointed additional nursing support through an agency and appointed a nationally recognised dementia care specialist to undertake clinical audits and provide nursing advice for the home.

There continued to be difficulties in recruiting suitably qualified staff with the right skills for the home. This meant that the service was reliant on agency staff and this included both care and nursing staff. There were shortfalls in the oversight of the suitability of agency staff at the home. For example, on the first day of the inspection agency staff profiles that detailed the staff's checks, qualifications and suitability to work with older people were not available for all of the agency staff on duty. There was no evidence of all agency nursing staff's current Nursing and Midwifery Council registration numbers, there were some agency staff who had not had a criminal record check (DBS) since 2012 and there was not any information as to when agency staff had completed any training. One agency staff had not responded appropriately to the provider's induction and this information and not been shared with or been reviewed by the management team. The registered manager took immediate action and determined they would not be using the agency member of staff again. In addition, the provider implemented new agency checks across all of their services and this included the checking of staff's identity and their latest DBS check prior to them working on any of the homes.

There were quality assurance and monitoring systems and systems for seeking the views of people, relatives and staff in place. Actions were taken in response to any shortfalls found in audits and or from feedback from people, relatives, staff, professionals and there continued to be a focus on improving the service. Staff told us there was positive focus on learning following any incidents and information was shared both within the service and across the provider's other three homes.

The registered persons were very responsive and took immediate actions in response to our feedback throughout the inspection. However, their quality assurance systems and the current levels of oversight had not proactively identified the shortfalls found by us, commissioners and health professionals. This had

impacted on the care and treatment, and the quality and safety of the service provided to some people living or staying at the home.

These shortfalls were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had confidence in the management team and registered manager and they could approach them with any concerns. They told us they felt listened to and managers took action in response to any feedback.

Registered persons are required to send CQC notifications about any allegations of abuse and other events. We use such information to monitor the service and ensure they respond appropriately to keep people safe. However, we had not received notifications for the recent allegations of abuse. The registered manager had not fully understood the need to send in the notifications when the local authority were investigating any allegations of abuse. They sent us the notifications immediately following the inspection.

The latest inspection rating was displayed on the provider's website and in the entrance of the home.

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 Some people's needs were not fully assessed and planned for and/or changes in their health were not responded to appropriately to make sure all their healthcare needs were met in a timely way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality assurance systems and the current levels of oversight had not proactively identified the shortfalls found.