

# Maria Mallaband 17 Limited

# Birch Heath Lodge

## Inspection report

Birch Heath Lane  
Christleton  
Chester  
Cheshire  
CH3 7AP

Tel: 01244434321

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

### About the service

Birch Heath Lodge is a residential care home providing personal and nursing care to 30 people aged 65 and over at the time of the inspection. The service can support up to 38 people. Accommodation is provided across two buildings with shared garden and communal facilities.

### People's experience of using this service and what we found

Processes in place to effectively monitor risk and provide appropriate support were not robust which put people at risk of harm. We discussed our concerns with staff and the manager during the inspection who acted immediately to investigate the concerns raised and reduce the risk.

Systems in place were not always robust to demonstrate that physical health was being monitored by the management team and required support provided to people was taking place. We raised this to the manager who took step to address the concerns raised during the inspection.

We received mix responses from people and relatives regarding staffing levels. The provider was able to demonstrate a dependency tool which assessed the amount of staff needed. During the inspection we saw people having support when they requested it, however people informed us they needed to be patient at times. We discussed this with the manager and have made a recommendation about monitoring how staff are deployed across the service in line with people's dependency.

Although processes were in place to assess people under the principles of the Mental Capacity Act (MCA) we found that the service was not always working in line with this. We spoke to the manager regarding our concerns and recommended they reviewed information held on people.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service were not always followed to supported this practice.

Safe recruitment processes were followed. Staff received on-going training and development to support them in their roles.

Staff spoke positively about the management team and felt supported to develop in their roles .

People who lived in the service overall spoke positively about the staff in the service and the support they received.

The manager was open and proactive during the inspection regarding identified concerns and proactive to address risk.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

#### Rating at last inspection and update

The last rating for this service was requires improvement (published 27 February 2021) and there was a breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations. The service remains requires improvement. This service has been rated requires improvement for the last 2 consecutive inspections.

#### Why we inspected

This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement based on the findings of this inspection.

#### Enforcement and Recommendations and update

At our last inspection we identified a breach of Good governance. At this inspection we found the provider was still in breach of this regulation

We identified a further breach that systems were not robust enough to demonstrate people were supported safely and that risk was managed.

We recommended the provider reviews how staff are deployed in the service in line with people's needs.

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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Birch Heath Lodge on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

#### Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

**Requires Improvement** ●

# Birch Heath Lodge

## Detailed findings

### Background to this inspection

#### The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

#### Inspection team

This inspection was carried out by 2 inspectors.

#### Service and service type

Birch Heath Lodge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Birch Heath Lodge is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

#### Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for 4 months and had submitted an application to register. We are currently assessing this application.

#### Notice of inspection

This inspection was unannounced.

### What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

### During the inspection

We spoke with 8 people who used the service and 5 relatives about their experience of the care provided. We observed interactions between staff and people living at Birch Heath Lodge. We spoke with 8 members of staff in various roles.

We reviewed a range of records. We reviewed 6 people's care records and other records relating to people's care and support. We looked at 8 staff files in relation to recruitment. A variety of records relating to the management of the service was reviewed, including policies and procedures.

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement.: This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

### Assessing risk, safety monitoring and management

- Systems to monitor risk and provide effective support were not robust. We found gaps in records for people's repositioning, to reduce risk of developing pressure sores in bed. There were also, inconsistencies in fluid records which staff completed to ensure people remain hydrated.
- Wound management was not managed effectively. Staff were not following identified actions to monitor and prevent further harm.
- Care plans were not always current. For one person, plans reflected support required prior to living at the service. Information was not updated promptly as people's needs changed.

Systems were not robust enough to demonstrate people were supported safely and that risk was managed, placing people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns with the manager who responded immediately during the inspection to investigate the concerns raised. Actions were also taken to improve the accurate completion of care monitoring records. We found on the second day of the inspection recording had improved.

- Appropriate systems were in place to ensure health and safety, including fire safety was maintained. This included safe use of equipment. Audits were in place to ensure that systems remained robust.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the provider was not always working within the principles of the MCA. Decision making for people was not always clearly evidenced.
- For example, one person's care plan stated they did not have capacity to make decisions around their

care and support, however a conflicting document stated they could make the decisions relating to their care.

- Another person required bed rails to remain safe. A best interest decision or consideration of the MCA in relation to this restriction was not evidenced.
- It was not clearly evidenced who was involved with decision making. Documentation did not always include involvement of an advocate, family members or external professionals to support decision making in relation to a person's capacity, if the person was deemed not to have this.
- Where applications had been completed, we found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met. Shortfalls in this area are discussed further in the well led section of this report.

### Staffing and recruitment

- Recruitment processes were robust. Checks were carried out to ensure suitable staff were employed. This also included checks on agency workers.
- Disclosure and Barring Service (DBS) checks were carried out by the employer during the recruitment process, this provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- Staff dependency tools demonstrated staffing was assessed against people's needs. However, we found mixed feedback from people. Comments included, "Some days there is enough staff, some days it seems short." and, "You can't expect them [staff] to come just like that."
- We also received mixed responses from relatives regarding staffing levels. One shared, "Staffing maybe a bit stretched at times."

We recommend that the manager reviews how staff are deployed across the service, in line with people's dependency levels and the layout of the building.

### Using medicines safely

- When we completed checks on medication, we observed that the date on one medication had expired.
- Medication stock control checks had not identified an incorrect count for a medication. This meant that a person had not received their prescribed medication.

We discussed our concerns with the deputy manager who responded immediately during the inspection to investigate and address the concerns raised.

- Although we found these concerns other medication was managed safely.
- Controlled drugs were appropriately managed and stored.

### Systems and processes to safeguard people from the risk of abuse

- People were protected from abuse. Allegations of abuse were reported appropriately to other agencies.
- Staff received training appropriate to their role, on-going refresher training was available. Competency checks were completed to ensure that skills were continually refreshed.
- People told us they felt safe living at the service. One person stated, "I feel safe, the staff are friendly, it's always a familiar face who comes to speak to you and offer you support."

### Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of



infection.

- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

Visiting to the service followed current guidance with no restrictions.

Learning lessons when things go wrong

- Systems were in place to record, monitor and review accidents and incidents when things went wrong.
- Regular staff meetings took place at the service. This gave staff a forum to review when things had gone wrong and to discuss lessons learnt. One staff member told us, "If there had been a fall, it would be shared about what happened, change to risk assessment, regular check or charts to complete."

# Is the service well-led?

## Our findings

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider had failed to ensure systems were in place to effectively monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Systems were not sufficiently robust to alert senior staff when care delivery was missed. We identified that essential support, including dressing changes on wounds and burns were not always completed.
- The service had identified within an internal audit that support for repositioning people for pressure area care was not always being completed. However, the service had failed to take steps to ensure this was addressed.
- Audit systems failed to alert staff when medication was missed, or medication dates had expired.
- Systems were not robust to ensure the provider was following the principles of the Mental Capacity Act (MCA).

Systems were either not in place or robust enough to demonstrate risks to people's physical health were effectively monitored. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Regular staff meetings took place in the service. One member of staff told us, "We have them regularly, if you can't attend you can join online through teams."
- We received conflicting feedback from people over regular meetings within the service. One told us, "[Meetings] we should have them, but we don't currently." While another said, "[Management] they do come around and talk."

We discussed feedback from people with the manager who was in the process of planning further engagement events with people and relatives throughout the year.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Relatives spoke positively overall about the care their loved ones received. One shared, "I think he is

looked after very well."

- People who use the service felt well supported. One told us, "A1, its great here." Another shared, "Staff are very good, not an issue for me, everything is ok I must say."
- Staff felt well supported by the management team. They told us, "I feel supported and have someone to go to. I speak to [The manager] often, easy to speak to if I need support."
- The service was actively working with external groups to introduce new activities and interests for the people. This included choir groups and a social prescriber working to reduce isolation and support mental health well-being with people.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The manager understood their requirements of duty of candour. Systems were in place to report and record when something went wrong.
- Relatives told us the service kept them informed. One shared, "They will always call if there's been an accident, they keep us fully updated."
- There was a system in place for monitoring and improving compliance. The manager was able to demonstrate improvements made in compliance since they had been in post. However, we need to see evidence that this is embedded and sustainable and leads to improvements in the quality of the service.

Working in partnership with others

- Information contained within care plans demonstrated the staff at Birch Heath Lodge worked in partnership with other agencies. One person told us, "If I'm feeling unwell, I can speak to staff who will help me. The doctor comes on a Monday if I need anything."

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Systems were not robust enough to demonstrate people were supported safety and that risk was managed, placing people at risk of harm.</p> <p>This was a breach of regulation 12 (1) (2) (a) (b) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>