West Berkshire Council

Birchwood Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Birchwood Care Home is a residential care home providing personal and nursing care to 49 people aged 65 and over at the time of the inspection. The service can support up to 60 people. Some people at the care home are living with dementia, physical disabilities or sensory impairments.

The care home is located in a residential area. There are five separate units, set across three floors. Each person has their own bedroom and en-suite bathroom facilities. There are communal areas such as lounge rooms and dining rooms. There is a large garden to the rear and side of the building.

People's experience of using this service and what we found
Leadership, management and governance systems were poor and did not demonstrate the service was well led, people were safe, or their care and support needs were being consistently met. Systems in place to oversee the service and ensure compliance with the fundamental standards were not always effective. They did not enable the manager and provider to identify when their legal responsibilities were not being met. The health, safety and welfare of people using the service were not always managed effectively and required records were not always kept or available. Risks to people were not always regularly reviewed to enable staff to provide safe care.

Medicines were not managed safely. People were placed at risk of harm due to a lack of information for staff about how to manage people's medicines. Audits of people's medicines were not completed consistently and not used effectively to address errors and omissions. Suitably qualified staff were not always deployed to administer people's medicines safely. Incidents and accidents were not analysed to prevent recurrences and keep people safe.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was rated good (published 4 June 2021). At this inspection the service deteriorated to requires improvement.

Why we inspected
The inspection was prompted in part due to concerns received about medicines, infection control, and the management of the service. We decided to inspect and examine those risks.

This report only covers our findings in relation to the key questions of Safe and Well-Led. 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. We have found evidence that the provider needs to make improvements.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Birchwood Care Home on our website at www.cqc.org.uk.

Enforcement and recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, staffing and good governance. Please see the action we have told the provider to take at the end of this report.

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.

Follow up
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 alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well led findings below.

Birchwood Care Home

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 included checking the provider was meeting COVID-19 vaccination requirements. 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 one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service did not have a manager registered with the Care Quality Commission. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The home manager had submitted their application to us to become the registered manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we held and had received about the service since the last inspection. We contacted the local authority safeguarding team. We looked at online reviews and relevant social media

posts. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection-
We spoke with five people who used the service and seven relatives about their experience of the care provided. We spoke with the home manager, clinical lead, a registered nurse, three care workers, one cleaner and the maintenance officer. We also spoke with a visiting healthcare professional. We received written feedback from the local authority. We reviewed a range of records. This included five people's care records and multiple medicines administration records. We looked at six staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested and received quality assurance records and were provided with additional evidence for consideration.

Requires Improvement

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 good. At this inspection the rating has changed to 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.

Using medicines safely

- Medicines were not managed safely.
- Protocols for staff to give medicines on a PRN ('when required') basis did not contain sufficient information for staff to administer these safely. In one person's record the PRN protocols for staff to administer an antipsychotic and a sedative medicine did not contain the maximum dose in 24 hours. In addition, the 'special instructions or additional information' sections had not been completed. In another person's PRN protocol for a sedative the 'special instructions or additional information' and maximum dose in 24 hours sections had not been completed. In a third person's PRN protocol for a sedative the 'maximum dose in 24 hours', 'special instructions and additional information; and 'other medicines to be aware of' had not been completed. This placed people at risk of harm as staff did not have full and complete guidance to support people to take 'when required' medicines safely. None of these omissions had been identified in the provider's audits.
- The provider's medicines audits were either not completed or not used effectively to identify errors and omissions and action necessary improvements.
- Audits completed for one of the home's units in November and December 2021, identified the home had been running out of people's medicines due to staff ordering medicines in the middle of a cycle. There was no evidence to show this issue had been rectified. In addition the November 2021 audit showed two staff had not signed people's MARs to confirm they had administered medicines. There was no evidence actions had been taken to address this issue.
- An audit for another unit in December 2021 identified errors in three people's MARs. However, there was no evidence of actions taken to address the errors and prevent them recurring. The audit completed for a different unit in January 2022 identified errors in eight people's MARs. There was no evidence actions had been taken to mitigate the risk to people and prevent recurrences.

The registered person did not ensure the proper and safe management of medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people's safety were assessed and documented in their care plans using evidence based tools. However, reviews of risk assessments had not always been completed. In one person's care plan risk assessments for choking, falls, skin damage and oral health had not been reviewed since March 2021. In another person's care plan their risk of skin damage and fire safety plan including safe evacuation methods, had not been reviewed since March 2021. This put people at risk of harm as staff did not use up to date risk

assessments to help keep people safe.

We recommend the provider ensures all risk assessments are kept up to date and regular reviews of risk assessments are scheduled and completed.

● There was a lack of evidence to show appropriate contingency plans were in place to manage outbreaks of illness within the home. We requested evidence of contingency planning for situations such as outbreaks of flu or COVID-19 from the home manager. No evidence was provided.
● The home's maintenance records were up to date and showed all necessary audits were completed and where issues were identified remedial actions had been taken.

Systems and processes to safeguard people from the risk of abuse
● Staff training records for safeguarding were not up to date.
● We requested the staff training records for mandatory training including safeguarding. We pointed out the staff training matrix showed 39 out of 90 staff had not completed their level one safeguarding training. The home manager told us the training record she had given us to review was out of date and stated staff had completed the provider's required safeguarding training. We requested the up to date training record. This was not provided.

We recommend the provider ensures they keep clear and up to date records of staff training in safeguarding.

● People told us they felt safe whilst being supported by staff.
● Staff told us they had completed safeguarding training and felt confident they would recognise and act on any signs of abuse or harm to keep people safe.

Staffing and recruitment
● The provider had not ensured sufficient numbers of suitably qualified staff were deployed to meet people's needs. On one occasion the provider had failed to ensure people were given medicines by a suitably qualified member of staff. As a result, an unqualified staff member administered medicines to eight people.
● There was no clear system in place to determine the numbers of staff required to meet people's needs safely. The manager and clinical lead told us staffing levels remained the same even if the needs and numbers of people living in the home changed. They stated they based their staffing deployment on previous assessments of people's needs and these were not routinely reviewed. The manager told us additional staff were deployed if people required one to one support.
● Allocation sheets were in place to record the numbers of staff on each unit for each shift, however these were not completed consistently.

The registered person had not ensured suitably qualified staff were effectively deployed. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Robust processes and systems were in place to ensure only suitable staff were employed.
● Recruitment files contained all records required by the regulation and associated schedule. This included full employment history, proof of identity, proof of conduct in prior care roles and criminal history checks.

Preventing and controlling infection

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections.

● We were somewhat assured that the provider was meeting shielding and social distancing rules.

● We were somewhat assured that the provider was admitting people safely to the service.

● We were somewhat assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were somewhat 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.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Learning lessons when things go wrong
● The provider used an incident reporting system to document accidents and incidents such as falls. The home manager told us accidents and incidents are recorded individually and there was no analysis of themes and trends.
● The home manager stated they reviewed each incident and asked the staff member who reported it which actions had been completed to address the incident and prevent recurrences. We reviewed the incident records for the six months prior to the inspection. Manager reviews for 50 incidents were outstanding, dating back to August 2021. For these incidents there was no evidence of learning from staff to prevent recurrences and keep people safe.

The registered person failed to evaluate and improve their practice in respect of the processing of information related to accidents and incidents. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; continuous learning and improving care;

- There were shortfalls in leadership and governance and oversight of the service was not adequate.
- Audits were not used effectively to review quality and safety in the service. The home manager told us they maintained a number of audits to maintain an oversight of the service, however, during the inspection visit they were unable to locate these audits.
- The home manager delegated auditing for different areas of service delivery to appropriate staff, such as the clinical lead, nurses and housekeepers. However, there was no evidence to show the manager was reviewing these audits for accuracy and to check errors and omissions had been addressed. For example, the home manager was not aware of the outstanding reviews of risk assessments in people's care plans.
- In addition the head housekeeper's audit from December 2021 showed a dining room floor had not been mopped on the 3rd or 4th of December. No action had been taken to address this by housekeeping staff and the home manager was not aware of this. The head housekeeper explained that audits were not always completed, for example, if she had to postpone audits due to insufficient cleaning staff being deployed.
- Systems did not enable the home manager and provider to identify where they were not meeting their legal obligations and the fundamental standards.
- Effective processes to monitor care delivery were not used. Staff were not deployed effectively to provide safe care which met people's needs.
- There was a lack of evidence to show staff reflected on practice to make improvements to the service to provide person centred care.
- The home manager told us there were a significant number of improvements which needed to be made to the service. They told us they were implementing improvements from an action plan put in place by the local authority but were unable to describe how they had implemented any changes in the service.

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;

- Staff were committed to promoting people's health and wellbeing. However, there was a lack of evidence the manager promoted a positive, person-centred culture to achieve good outcomes for people.
- Staff told us there had been an extended period when managers were not in the home on a regular basis due to the previous registered manager resigning and due to the home manager being absent in October and December 2021.
- There was a lack of evidence to show staff were supported to develop their practice. Staff training records

we requested were out of date. When we requested the up to date training records from the home manager, these were not provided.

- Staff told us they had not always received regular supervisions.
- People, staff and the public were not involved in how the service was run.
- There was no evidence people's views had been sought to drive improvements. The home manager told us they had not gathered the views of people who used the service since the last inspection.
- Although staff surveys had been completed, there was no evidence of how staff feedback was used to influence service developments.
- Staff meetings were used by the home manager as an opportunity to communicate messages with staff and highlight improvements needed. There was no evidence to show staff were encouraged to give feedback or to influence how the service was run.
- There was no evidence to show the home manager encouraged and supported staff to reflect on practice to make improvements to the service to provide individualised care.

The registered person had not established an effective system to enable them to ensure compliance with their legal obligations and the regulations. The registered person had not assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users. The registered person had not sought and acted on feedback from people using the service and other stakeholders about the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. The registered person had not evaluated and improved their practice. These areas are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- When notifiable safety incidents occurred, the home manager notified the 'relevant person', made a written apology and conducted relevant investigations, in line with their regulatory responsibilities and the associated legislation. However, there was a backlog of incidents that the manager had not yet reviewed some of which may require further investigation.

Working in partnership with others

- Staff worked in partnership with professionals from outside agencies to provide individualised support to people.
- People's care and support documents contained evidence of appointments with and reviews from healthcare professionals.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met. The registered person did not ensure the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met The registered person had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met The registered person had not established an effective system to enable them to ensure compliance with their legal obligations and the regulations. The registered person had not assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users. The registered person had not sought and acted on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. The registered person had not evaluated and improved their practice. Regulation 17 (1)(2)(a)(b)(e)(f)

The enforcement action we took:

We served a warning notice on the provider.