Malvirt Limited

Birchwood Care Services

Inspection report

Birchwood House
Stockland Green Road
Speldhurst
Kent
TN3 0TU

Tel: 01892863710
Website: www.birchwoodcare.co.uk

Date of inspection visit:
17 November 2022
28 November 2022

Date of publication:
17 January 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Birchwood Care Services is a domiciliary agency providing the regulated activity of personal care. Not everyone who used the service received personal care. The Care Quality Commission (CQC) only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of the inspection 17 people were using the service

People's experience of using this service and what we found
People were not consistently supported by staff who knew them well. People's calls were late or had been cancelled at short notice, relying on people's families to support their loved ones. The service was using agency care staff as a contingency; however, calls were still late. Following the inspection, action was taken to hand back several care packages to the local authority commissioning team reducing the number of people supported to 13.

Risks to people's health, safety and welfare were not adequately assessed. There was a lack of information for staff about how to provide the right support.

The provider had not promoted a positive culture that was person-centred, open, inclusive and empowering and achieved good outcomes for people.

There was a lack of oversight, scrutiny and governance by the manager and nominated individual. Checks and audits were not effective and / or not completed to monitor the quality and safety of the service. People and staff had provided feedback to the manager; however, no action had been taken to analyse this or take any action.

People were supported by staff who had been recruited safely. Staff completed training to keep their knowledge up to date. Staff met with the manager for one to one supervision, however this had only begun since the manager started in September 2022.

We could not be assured people were supported to have their medicines as prescribed. Due to the lateness and / or short notice cancellation of calls, there was a risk people may not receive their medicines on time.

People were supported to have maximum 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 supported this practice.

Staff wore personal protective equipment, such as face masks, in line with current guidance. Staff told us they had plenty of stock when they needed it.

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 good (published 20 December 2017).

Why we inspected
This inspection was prompted by a review of the information we held about this service. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to the service being short staffed, resulting in late and / or cancelled care calls; risks to people's safety not being consistently assessed, monitored and reviewed, and poor oversight and leadership. CQC served warning notices on the provider in relation to safe care and treatment, staffing and good governance.

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 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.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

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 Services

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.

Inspection team
The inspection was carried out by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

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 (CQC) 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. There had not been a registered manager since September 2021. A manager had been overseeing the day to day running of the service since September 2022 and they were applying to become the registered manager.

Notice of inspection
This inspection was unannounced. Inspection activity started on 17 November 2022 and ended on 28 November 2022. We visited the location's office on 17 November 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. 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 four people about their experience of the care provided. We spoke with four staff, the care co-ordinator, the manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included four people's care plans and associated risk assessments and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including audits, policies and procedures were also reviewed. Following the inspection, we spoke with the local authority commissioners.

Inadequate

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 Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment; Learning lessons when things go wrong

- People were not always supported by a consistent staff team. The service was short staffed and reliant on agency carers. People's calls were late, and many calls had been cancelled at short notice. People were not consistently informed if their care call was going to be late and this caused them anxiety. Following the inspection, office staff were instructed to make sure people were contacted. This was confirmed by one person we spoke with who commented, "The last two days they have rung to let me know they were running late."
- The manager told us they had handed back four care packages to the local authority commissioners in October 2022 to reduce the risk of further need to cancel care calls. However, calls continued to be cancelled and families asked to provide support. The Care Quality Commission (CQC) were informed, following the inspection, a further four care packages had been handed back to ensure all future care calls could covered and people's needs met.
- Records showed staff did not always stay the amount of time they were contracted to. For example, on 14 November 2022 records showed a person was due a 45 minute care call, however staff were only at the person's home for 23 minutes. The same person had a 30 minute call later that day and staff were only in the home for 16 minutes. The manager was speaking with the individual staff responsible for short calls and was following the provider's disciplinary process.
- People's views were mixed. People said, "The staff are absolutely wonderful, but the timing of the calls is not always good. I am meant to have a call between 08:00 and 09:00 and one day they did not come until 13:00", "My calls have been late. They should be with me at 09:00 and today an agency person turned up at 10:30. On the whole they are getting better. I have asked the office staff to let me know if they are running late" and, "Call times may vary, but that is OK with me. They let me know if they are running late."
- Staff told us, "We had to give some clients back [to the local authority] because we were short staffed. There is usually enough travel time to go between calls. We let people down when the timing isn't good", "I try and stick to call time; I hate to short-change people. Sometimes at the weekend I go over my time. I let the office know if I am running late", and "Most of the calls are 30 minutes. I occasionally leave early if there is nothing else the person wants. If I can, I will try and sit and have a chat with them."

The provider failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to meet people's needs. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the nominated individual informed CQC they would not be taking on any further care packages until there were sufficient numbers of trained and competent staff.
- People were supported by staff who had been safely recruited. Reasons for gaps in employment were

explored and recorded to make sure a full employment history was obtained. Disclosure and Barring Service (DBS) criminal record checks were completed to ensure new staff were safe to work with people and at least two references had been obtained before staff began their induction. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Staff completed training to keep their knowledge up to date with best practice. Staff told us, "The training is good" and, "I have recently updated my moving and handling and first aid training. I have catheter care training this week."

Assessing risk, safety monitoring and management;
● Risks to people's health, safety and welfare had not been consistently assessed, monitored and reviewed.
● There was a lack of guidance for staff to follow when people needed specialist equipment, such as equipment to help people during sitting and standing transfers. Whilst staff were able to tell us how they used this safely, there was no guidance for new staff or agency staff about how to safely use the equipment. One staff said, "We don't have anyone we support who is hoisted, just use a Sara Stedy [A transfer aid]. With one of my clients I have worked closely with the occupational therapist and physio therapist and the client is doing really well now."
● Some people had bed rails in place. The potential risk of entrapment had been identified. However, the guidance for staff noted, 'Care worker to ensure bed rails are in the correct position' and 'Care worker to ensure bed guards are in the correct position'. There was no information about what denoted 'correct position'. Not all staff had completed safe use of bed rails training. This meant there was a potential risk of the equipment being used in an unsafe manner.
● Care plans lacked important information about people's health conditions. Care plans varied in the level of person-centred detail. For example, when a person had heart or lung problems, there was no information to support staff on how to spot any signs which may be a deterioration in their health.

Using medicines safely
● There was a risk people may not be supported to have their medicines as prescribed as many care calls were late or cancelled. Some people were prompted to take their medicines which meant there was a risk they may not take their medicines without being reminded.
● There had not been any checks or audits completed to ensure people's medicines were managed safely.
● Staff completed medicines administration training. However, staff competency had not been assessed to ensure they followed best practice.

The provider failed to assess the risks to people's health and safety and to do all that was reasonably practicable to mitigate any such risks. The provider failed to ensure there was proper and safe management of medicines. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's home environments were risk assessed. There was guidance for staff about how to enter the property, for example, using a key safe. People told us they felt safe having staff letting themselves into their homes.
● People told us, "I have never felt unsafe" and, "All in all I am happy, safe and get what I need with Birchwood." Staff said, "People are safe. For example, I support a person who uses a 'stroller'. I always make sure the stroller is nearby when I finish the call and that helps keep them safe. I make sure people stay as independent as possible."
● The service used an electronic system to record any medicines administration.
● When people had prescribed creams to help keep their skin healthy, there were no topical body maps to

guide staff to where the creams should be applied. We discussed this with the care co-ordinator who began to add these to the electronic system during the inspection.
● Staff told us, "I have been trained to do medicines. I only support one person with their medicines, and it is all in a Dosette box" and, "A lot of people self-medicate. I have one person who I just remind about their medicines."

Systems and processes to safeguard people from the risk of abuse
● Staff were trained about safeguarding people and were able to tell us how to identify and respond to allegations of abuse.
● However, the provider's failure to provide sufficient numbers of staff, to ensure people received their support in a safe and timely way, represented neglect, a form of abuse.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● People were supported by staff who understood the importance of infection prevention and control measures. Staff completed regular training about infection control.
● People told us staff wore personal protective equipment (PPE) when they were supported.
● Staff told us they had plenty of PPE and could collect more stock whenever they needed it. One member of staff commented, "I always have face masks, aprons and gloves and there is plenty of stock if I need to top mine up."
● The office was clean and spacious which allowed social distancing when required.

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). When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

● At the time of the inspection, there was nobody with a Court of Protection.
● People told us staff gained their consent before supporting them with their care.
● Staff understood, when a person was not able to make complex decisions themselves, that discussions were needed with relevant people, such as relatives and health care professionals, to ensure decisions were made in people's best interests.

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 Good. 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 widespread shortfalls in the day to day running of the service, leading to multiple breaches of regulation. There was a lack of oversight and scrutiny of the service by the manager and nominated individual. There had been a lack of consistent leadership at the service to support staff.
- The service had not had a registered manager leading the service since September 2021. There had been several changes in manager. The manager, overseeing the day to day running of the service, started in September 2022. They had begun the process of applying to register with the Care Quality Commission (CQC) and had just received their Disclosure and Barring Service check results to progress this application.
- The manager had not completed any staff competency assessments or audits of care plans or medicines management since they started at the service. Following the inspection, the manager informed CQC they would be completing medicines competency assessments at the end of November 2022.
- The manager had not completed any analysis of the missed or cancelled calls. People had raised concerns with the office about their calls being late. These had not been consistently recorded. Following the inspection, the manager told CQC they had introduced a tracker to ensure any necessary remedial action was taken.
- People's and staff feedback about the quality of the service being delivered had not been acted on in a timely way. People had contacted the service about their dissatisfaction around the time of their care call. Staff had completed surveys and noted their concerns about the timeliness of calls.

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

- The provider had not promoted a positive culture that was person-centred, open, inclusive and empowering and achieved good outcomes for people. This was detrimental to people's health, safety and well-being.
- People did not all feel the service had been well-led. The provider failed to ensure feedback people and staff provided was acted on in a timely way. Some people felt things were improving under the manager, who began working at the service in September 2022. People told us "It is now much better with better co-ordination", "They are trying very hard. I think it will keep improving now the communication is getting better" and, "I have three regular carers who are superb. The management is a shambles."
- The manager had identified staff had not been receiving regular one to one supervision and had implemented these meetings. Staff said, "I have had supervision meetings and we have had team

meetings."

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

● The manager told us they understood their responsibilities in relation to duty of candour. This is a set of specific legal requirements that services must follow when things go wrong with care and treatment. However, this openness had not been followed in practice. People had been frequently let down with their care calls being cancelled at short notice.

The provider failed to ensure systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of the services provided. The provider failed to act on feedback about the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the nominated individual informed CQC that the manager was no longer working at the service and an interim manager would be in place for eight weeks until a new manager was recruited.

Working in partnership with others

● Staff worked with people's health care professionals, such as occupational therapists and community nurses. People told us staff supported them when needed to seek medical advice.

● Referrals had been made to health care professionals when required to ensure people received the support they needed.

● Staff told us, "If someone needs support with making appointments, I contact the office and they help to get in touch with the right people."

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
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to provide sufficient numbers of staff, to ensure people received their support in a safe and timely way, and this represented neglect, a form of abuse.

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess the risks to people's health and safety and to do all that was reasonably practicable to mitigate any such risks. The provider failed to ensure there was proper and safe management of medicines.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of the services provided. The provider failed to act on feedback about the services provided.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to meet people's needs.

The enforcement action we took:

Warning Notice