

Melton Health Care Limited

Birch Abbey

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The inspection took place on 10 & 11 April 2018 and was unannounced. The last inspection of the service was 6 & 7 January and 14 April 2016 and the rating for the service following this inspection was Good.

Birch Abbey is a '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.

Birch Abbey is a care home providing personal and nursing care. It can accommodate up to 60 older people. At the time of the inspection 58 people were living at the home. The service specialises in caring for people with dementia.

A registered manager was in post. 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.'

At this inspection we found a breach of regulation. People's plan of care lacked information around care and support. This meant there was a risk staff did not have the information they needed to meet people's care and support needs effectively and in accordance with individual need and preference. Governance arrangements to assess and monitor standards in the care home were not always effective to ensure the service was managed safely. Record management needed to improve as some information was difficult to locate.

The environment was maintained and subject to service contracts and safety checks of obvious hazards. Not all of these were current though the registered manager took immediate action to rectify this.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made. Sixteen people were being supported on a Deprivation of Liberty (DoLS) authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests.

Staff understood the concept of safeguarding knew how to report any concerns. Records indicated that safeguarding referrals to the local authority had been made appropriately.

Medicines were administered safely to people. Staff received medicine training and had been deemed competent for their administration.

Risks to people safety and wellbeing were recorded to enable staff to support people safely whilst

promoting their independence. Staff recorded actions to maintain people' safety.

Accidents and incidents were recorded and analysed to look for patterns and trends.

People at the home were supported by the staff and external health and social care professionals to maintain their health and wellbeing.

Staff were deployed in sufficient numbers to keep people safe and meet their needs.

The registered manager obtained required checks before an employee's commencement in post to ensure staff were suitable to work with vulnerable adults.

Staff received training and support to care for people in accordance with their individual needs. This included more specialised training to support people with dementia.

Our observations showed good interaction by the staff with people they supported. Staff were attentive, kind and respectful in their approach.

Staff were aware of their responsibility to treat people equally and respect their diversity and human rights.

Relatives told us the staff respected their family member's rights to privacy and dignity and staff looked after people well.

Our discussions with staff confirmed they had a good knowledge and understanding of the people they cared for. We saw care being provided in accordance with individual need.

People's dietary needs were managed with reference to individual preferences and choice. Pictorial menus were available for people to help choose their meal.

A new social activities programme was in place to help people engage with hobbies they enjoyed and to provide some structure and normality for their day.

Staff were positive about the management and leadership of the home. Staff told us they were able to share their views openly.

A complaints' procedure was in place and relatives we spoke with were aware of how to raise a concern.

Birch Abbey had a clean environment and we observed good adherence to the control of infection.

Relatives and visitors were welcomed at the home and kept up to date about their family member.

There was a system in place to get feedback from people and/or their relatives so that the service could be developed with respect to their needs and wishes. These included meetings and satisfaction surveys.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with our statutory notifications. The ratings from the previous inspection were on display in accordance with requirements.

You can see what action we took at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe

Staff were checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Risks associated with people's care and environmental hazards were assessed and actions put in place to mitigate risk.

Medicines were managed safely and consistently monitored.

There were enough staff on duty to help ensure people's care needs were met.

Staff understood the concept of abuse and how to report an actual or potential incident.

Is the service effective?

Good ●

The service was effective

People were supported by staff and external professionals to keep them in good health.

Staff were supported through induction, supervision, appraisal and a comprehensive training programme.

When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made.

Is the service caring?

Good ●

The service was caring

People and their relatives told us the staff were kind, respectful and displayed good communication with them and their family member.

People and their relatives were listened to and felt involved in making decisions about their care.

Staff knew how people liked to be cared for and supported.

Is the service responsive?

The service was not always responsive

People's plan of care lacked information around care and support. This meant there was a risk staff did not have the information they needed to meet people's care and support needs effectively and in accordance with individual need and preference.

A new activities programme had been introduced which was meaningful and provided good engagement for people.

A process for managing complaints was in place and relatives knew how to complain. Complaints received had been responded to.

Staff had a good understanding of how to provide compassionate end of life care.

Requires Improvement ●

Is the service well-led?

The service was not always well led

The service's governance arrangements to assess and monitor standards were not always effective to ensure a safe well managed service. Record management was found to be disorganised and a number of records difficult to locate.

The service was led by a management team who were approachable and respected by people, relatives and staff. Staff told us the culture of the service was open and transparent.

There was a system in place to get feedback from people and/or their relatives so that the service could be developed with respect to their needs and wishes. These included meetings and satisfaction surveys.

The Care Quality Commission (CQC) had been notified of reportable incidents in the home.

Requires Improvement ●

Birch Abbey

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 of Birch Abbey took place on 10 & 11 April 2018. The inspection was unannounced on the first day and announced on the second day.

On the first day of the inspection the inspection team comprised of an adult social care inspector, an assistant inspector and an 'expert by experience'. On the second day of the inspection two adult inspectors attended. An 'expert by experience' is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. This included notifications we had received from the provider such as incidents which had occurred in relation to the people who lived at the home. A notification is information about important events which the service is required to send to us by law. We also requested and received the Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Due to the nature of the service people were not always able to share their views about the service. To help us we therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the registered manager, two nurses (including the clinical lead), three care staff, and a chef, a member of the domestic team, an activities organiser and a regional manager of an external organisation who support the service. We also spoke with two people at the home and nine relatives. Following the inspection received feedback from two external health professional who had regular contact with the service.

During the inspection we spent time reviewing a number of records. These included the care records of four people who used the service, three staff personnel files, staff training matrix, medication administration

records (MARs), audits (checks), complaints, accidents and incidents and other records relating to the management of the service. Over the course of the two days we undertook general observations of the home. This included the general environment, décor and furnishings, bathrooms and bedrooms of some of the people who lived in the home. We also had lunch with people in the dining area/bistro.

Is the service safe?

Our findings

We asked relatives if they thought the service was safe. Relatives comments included, "My (family member) is always safe, I don't have any concerns at all, the staff are about and are watchful", "The security is good and the staff are helpful" and "It's the best place (family member) has been in. There's very strong security and there's always someone walking round". A person living at the home said there were enough staff on duty and they felt safe.

Risks to the environment were recorded to ensure it was safe and well maintained. Essential safety checks, for example, gas, electrical and fire safety were completed in accordance with the relevant schedule by suitably qualified external contractors. In respect of legionella compliance water sample checks for legionella and a service check of the sprinkler system for fire prevention were due in March 2017. The registered manager was aware however these had not been acted on as yet. The sprinkler system was serviced during the inspection and the registered manager made arrangements for the collection of the water samples for legionella compliance. The service completed its own health and safety checks where obvious hazards were identified. These included, checks on the emergency lighting, fire alarms and hot water temperatures. Not all were dated though the registered manager confirmed these had been completed. A check of the emergency lighting and fire alarms took place during the inspection to evidence compliance with fire safety. These were satisfactory.

Risks to people safety and wellbeing were recorded to enable staff to support people safely whilst promoting their independence. These included nutrition, falls, mobility, pressure area care and behaviours that may challenge. The risk assessments recorded appropriate preventative measures to help mitigate risks. Staff told us they were informed of risks and how to care for people in a safe manner. We observed staff providing people with care in a safe manner.

A record was kept of accidents and incidents which occurred at the service. The registered manager maintained oversight through the use of audits in order to analyse trends or patterns. We saw where actions were taken to mitigate risk, for example, referrals to the falls team and use of technology – sensor mats in people's rooms to alert staff if a person had a fall, specialist nursing beds and call bells. Lessons learnt from accidents and incidents were shared with staff to improve practice.

People had a plan of care which included a personal emergency evacuation plan (PEEP) for use in the event of any major incidents/emergencies. These were subject to review to ensure staff knew what level of support each person needed in the event of an emergency.

The PIR recorded how the service completed an audit tool for staffing levels based on people's dependencies. At the time of the inspection 58 people were living at Birch Abbey. We saw the current staffing was based on people's dependencies and was appropriate at this time. There were sufficient numbers of skilled staff to support people safely and in accordance with individual need; this included support over the lunch and tea time period. The registered manager was on duty with 14 care staff (including senior care staff), a cook, three domestic staff, laundry assistant, kitchen assistant, maintenance person, administrative

staff, activities organiser, two nurses and a clinical lead/deputy manager. At night people were supported by six care staff and a nurse.

We asked relatives if there were sufficient number of staff available to support people safely. In general people thought this was the case though some comments were made that staff were busy at meal times and could be 'pushed'. Some staff told us that staffing levels were affected at times by staff sickness which in turn affected how the staff team worked. They said however the registered manager sought agency cover for any gaps on the rota. Staff told us the registered manager and deputy manager took turns in being on call should they need to be contacted in an emergency.

Staff recruitment was robust. Staff records contained a minimum of two references, photographic identification and an application form. There were disclosure and barring service (DBS) checks on file. These checks helped to ensure employees were suitable to work with vulnerable people.

Medicines were administered safely to people by staff who were trained and deemed competent. Medicine trolleys were kept in locked clinical rooms; the doors to these rooms were locked at all times. Creams were stored in unlocked medicine cupboards in the clinical rooms. The registered manager made arrangements to have locks fitted to these cupboards to improve safe storage. People had a medicine administration record (MAR). The charts seen had been completed and on checking the stock balance of a number of medicines, including two controlled drugs, we found these to be accurate. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation. A small number of handwritten signatures were recorded by staff on the MARs for prescribed medicines. We discussed with the registered manager, best practice around recording two staff signatures to reduce the risk of errors when transcribing. The registered manager said they would action this.

The clinical room temperatures and medicine fridge temperatures were monitored and recorded daily; we saw that these were within safe ranges. If medicines are not stored at the correct temperature, it can affect how they work. Thickening powder was prescribed to thicken drinks. This is to aid people who may have swallowing difficulties to accept fluids and reduce the risk of choking. We found a lack of recording around the administration of a thickening powder. We brought this to the registered manager's attention and at the time of the inspection amendments were made to the records completed by the staff. We saw that topical preparations such as creams were recorded with good use of body maps to indicate the area the cream was to be applied. People had a plan of care which outlined their medicines and those to be given as needed, (PRN) medicines and guidelines for the use of PRN medicines were available. The administration of covert medicines was recorded and 'best interests' decisions were recorded for this type administration. Covert is the term used when 'medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them.'

We found the home clean with good adherence to the promotion of infection control. We observed staff using personal protective equipment, such as disposable gloves and aprons. Relatives told us the home was always kept clean and tidy.

We discussed with staff the principles of safeguarding people against potential harm or abuse. Staff demonstrated a good awareness the different types of abuse and how to report an alleged incident. There had been effective liaison with the local authority regarding safeguarding referrals made by the service. Staff told us they were familiar with the whistleblowing policy and would not hesitate to enforce this if necessary. Whistleblowing is where staff are able to raise concerns either inside or outside the organisation without fear of reprisals. This helps maintain a culture of transparency and protects people from the risk of harm.

Is the service effective?

Our findings

Relatives told us that staff were competent and had the skills and knowledge to support people effectively. Relatives' comments included, "Yes, staff are really good, my (family member) is very well cared for and is settled here" and "They're (staff) very caring and very efficient." Relatives also advised that their family member could see their doctor and appointments were made promptly.

Staff worked closely with external health and social professionals, for example, dietician, community psychiatric nurse, speech and language therapist, GPs and district nurse team. This helped to support people's health and wellbeing. Their advice and instructions were documented and followed by staff. External health professionals told us that appropriate referrals were made by the staff for their advice and that staff followed treatments plans. In accordance with people's assessed need, staff recorded people's dietary and fluid intake and completed turning charts (when people need to be moved in bed to prevent their skin from becoming red or broken). These charts help to monitor and provide an evaluation of care.

Staff received training and support which provided a good knowledge base to deliver effective care. Courses undertaken, included, infection control, moving and handling, fire safety, equality and diversity and food hygiene. Other training gave staff specialist knowledge in the service's care delivery, such as dementia awareness and the management of behaviours that may challenge. New staff had received an induction and shadowed a more experience member of staff for the first three days. The registered manager informed us that no staff were currently enrolled on the Care Certificate however this training would be provided in the future when required. The Care Certificate is the government's recommended blue print for induction standards. The registered manager enhanced staff learning with supervision and an annual appraisal. Supervision sessions between staff and their manager give the opportunity for both parties to discuss performance, issues or concerns along with developmental needs. Staff told us they felt supported in their job role and had access to ongoing training.

People were supported with nutritious foods to help maintain a healthy and balanced diet. Pictorial menu boards had been sought to help people choose from the daily menu. We observed the lunchtime service and sampled the food served which was sausage roll, hash browns, carrots and peas with gravy. Alternatively people were offered soup and a sandwich. The menu offered plenty of choice and we saw staff showing people the prepared hot meals so they could choose which one they would prefer. Pureed foods were served individually on the plate to retain colour, texture and to appear more appetising. People did not however appear to have a choice when it came to pureed foods. We brought this to the registered manager's attention and they said they would review the menu choices for pureed foods.

The menu took into account people's dietary preferences and nutritional requirements which included, gluten free, vegetarian, lactose free and diabetic meals. A person living at the home told us there was plenty of choice and they were asked by staff what they would like to eat. Relatives confirmed the menu was varied. Fresh fruit was available and people were offered plenty of drinks and snacks throughout the day.

The provider had given consideration to making the environment suitable for people with dementia. The

adaptations helped orientate people to their surroundings to ensure their safety, independence, comfort and engagement with their surroundings. The home had hand rails, adapted bathrooms and wide corridors that were clutter free. The home was decorated with suitable colour schemes and appropriate flooring evident. A number of people were served their meals on coloured and pictorial signage was on all floors; these measures helped to orientate people. People had personalised their bedrooms and memory boards were displayed next to people's bedroom door. These enabled people and their relatives to place pictures or personal visual items to make the entrance to the rooms more personal, memorable and create links with the past. There was a television screen in the main entrance hall. This informed every one of the staff on duty and where they were working. A relative told us it was 'nice to know who was working'.

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). 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 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw mental capacity assessments had been completed and where people lacked capacity best interest decisions had been made how best to support them safely.

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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had recognised when someone was potentially being deprived of their liberty and made the necessary application to the supervisory body for an authorisation. We saw that the registered manager had applied for DoLS authorisations for those people who had restrictions imposed on them, such as people who were unable to manage their own medication and needed support with day to day activities; 16 authorisations were in place. Best interest decisions were recorded with the person and/or their representative however we discussed with the registered manager how these could be recorded in more detail so as to evidence assessments were linked to key individual decisions. The registered manager was working with an external health professionals in respect of this and accessing further mental capacity and DoLS training to increase their knowledge base. A relative told us they had been consulted around 'some important' decisions regarding their family member's care.

We saw examples of DNACPR (do not attempt cardio pulmonary resuscitation) decisions which had been made. We could see the decision had been made in people's best interest after consultation with the person where able and/or advocates (relatives).

It was clear from care records and discussions with relatives that their consent was sought in relation to care and treatment. The care records recorded relative meetings and the registered manager was in the process of obtaining relatives' written consent to evidence further inclusion. A relative told us, "The staff always talk to me about (family member); they ask me if I am okay with everything and explain things." Our observations showed that staff sought people's approval with day to day activities before supporting them.

Is the service caring?

Our findings

Relatives told us the staff were caring, polite and attentive to their family member's needs. Their comments included, "They're (staff) respectful and kind", "They (staff) always speak to (family member) respectfully and always let (family member) know what they're doing, "They communicate very well with (family member)", "They're (staff) very discreet, they won't even take (family member's) cardigan off in public " and "They (staff) always knock"- referring to entering the person's room. Relatives of people who required a hoist told us the transfer using this equipment was always carried out in a dignified way, not leaving anyone exposed. A person confirmed staff were polite and 'nice people'.

We spent time observing care at the home. There was a relaxed and friendly atmosphere and staff approach was kind, supportive and respectful; humour was also used appropriately. Staff told us it was a very busy home however it was evident that staff knew people and their relatives well. We saw positive cheerful interaction between the staff, relatives and people they supported. People's rights to privacy and dignity were respected. Staff addressed people by their preferred name and people appeared at ease and comfortable with staff when receiving personal care and when staff spent time with them talking about day to day activities. Staff knocked on people's doors before they entered their rooms and communal toilets and bathrooms. We observed a person who became agitated, the staff member was very responsive and spoke quietly and gently to the person, staying with them till they felt better and made them a cup of tea. The person concerned appeared reassured by the actions taken. For another person who needed support with their lunch and medicines, this was carried out in a very caring manner. The staff member stayed with the person until finished and then escorted them to an armchair of their choice.

Relatives told us they felt involved with their family member's care. A staff member told us how they arranged meetings with relatives and where possible the staff member who oversaw the care attended. Visitors were present at different times of the day and all were warmly welcomed by staff. Some relatives supported their family member with their lunch and staff told us relatives were offered a meal. Relatives told us staff communication was good and that any changes or concerns around their family member's health was promptly brought to their attention.

People's rights and choices were considered. Some people wished to stay in their room whilst others sat in the lounges and dining area/bistro. Some people liked to stay in bed till late morning whilst others were up early. One person enjoyed reading a newspaper every morning with a cup of tea; staff told us how they facilitated this. People chose where they wished to sit at meal times; this included the main bistro, kitchen/dining areas on the various floors and the tea room. A staff member told us this was people's home and as such people make their own decisions.

Information was made available to people about advocacy services if they required support to have an independent voice. Records evidenced the input from services such as advocacy or other agencies acting on people's behalf. This was recorded in people's care documents.

In respect of confidentiality we saw that some personal care information had been left in the kitchen area of

the second floor. We brought this to the registered manager's attention and it was removed. Confidential information in other areas, such as, care documents were stored securely.

People's religious and spiritual needs were supported. For example, services were held at the home and people were able to choose whether or not to participate or attend their own church.

Is the service responsive?

Our findings

People's plan of care lacked information around regarding care and support based on individual need. This meant there was a risk staff did not have the information they needed to meet people's care and support needs effectively and in accordance with individual need and preference.

We looked at the records for four people. People's needs were assessed prior to their admission and used to establish risk and to develop care plans. For a person whose plan of care recorded the need to increase a person's weight by giving dessert and yogurt, there was no direction as to how often and what type of dessert the person liked. In respect of night support a person's plan of care recorded the need to 'establish normal sleep pattern and night routine' however there was no detail as to what this pattern/night routine entailed. We saw the night staff undertook night checks to ensure people's comfort and safety however a person's plan of care did not record this detail. For a person who could feel anger and frustration, the person's plan of care recorded, 'staff to promote therapeutic activities'. There was no detail as to how the signs of anger would manifest or what therapeutic activities the person liked and proved to be effective. Likewise where staff had recorded, 'staff to use diversional techniques' for a person. This included 'reassurance' however, there was no direction as to how best provide this and in what form. Care plans were reviewed monthly though these did not always provide a detailed summary of care over the given time period to help evaluate the care.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During the inspection we discussed our findings with the registered manager who advised they were aware of the work needed to improve people's plan of care and this was work in progress. Following the inspection the registered manager informed us they were undertaking care reviews for all existing care documents to make them more 'individual'. The registered manager gave us examples of how this was being achieved and also the introduction of a care plan called 'my overview'. The purpose being to provide a summary of care for staff who were unfamiliar with the person care needs.

Our discussions with staff confirmed they had a good knowledge and understanding of the care and support people needed. We observed staff providing care in accordance with individual need. For example, supporting people with personal care, meals and also how to support people who displayed agitation. A staff member said, "We know everyone so well and we know people's routine and what they like to do each day."

Evidence of people's likes, dislikes, hobbies and preferred foods were recorded though this information was limited. Information was also recorded in relation to people's faith, culture and other protected characteristics. A relative said the staff talked to them about their family member's care and what was important for them both, for example clothing, meals and day-to-day routine. Relatives we spoke with confirmed they attended care reviews.

In respect of ensuring people's preferences were respected the chef told us about menu changes. Foods such as, pizza and sweet and sour pork were being removed as these were unpopular and a new menu was being introduced. A relative provided an example of where a person requested a food they don't normally have. The staff checked with the relative if they were happy for them to go ahead and provide this request.

People were encouraged to part in social activities. A new activities organiser was in post five days a week and they were leading on a new activities programme with each individual and their relative. The hours available meant the activities organiser had only sufficient time to carry out a two hour session per floor twice a week; the registered manager appreciated that people would benefit from an increase in hours to promote more meaningful engagement and that this would be looked at as the activities programme developed. New activity boards were being ordered to display forthcoming events and activities were being planned around the themes of colours, animals, exercise, music, sports, food, flowers and nature and clothes. Nuts and bolts boards had also been ordered to promote some different activities particularly aimed for the male residents. Reading books were available for people in large print.

People living in the home had an activities room which was used as a hairdressing salon and also a themed tea room. This was pleasantly decorated and armchairs and tables were arranged so as to promote small friendly gatherings. We saw a number of people sitting in this room with their relatives. During our inspection a number of people were out with their relatives. There were no organised trips however the activities organiser told us this would be arranged when the weather was warmer. Some people were listening to music, watching television and also taking part in celebrating the Grand National.

People and their relatives were given a brochure about the home which included how to raise a complaint. We looked at the service's complaints' policy and procedure, details of which were displayed. We provided guidance for the registered manager regarding our role when dealing with complaints as this was not clear. Complaints were dealt with and responded to in accordance with the complaints' procedure. Relatives told us, "I've never found anything to complain about" and "I complained to the manager about something minor and it was resolved." The registered manager informed us that the complaints' procedure was available in large print should this be requested.

At the time of the inspection no one living at the home required end of life care. Staff however recorded information in respect of people's preferred place of care and were developing advance care plans and statement of wishes to support people and their families. There was ongoing engagement with a local hospice for training and staff support.

Is the service well-led?

Our findings

We found the service's governance arrangements to assess and monitor standards were not always effective to ensure a safe well managed service.

To help us determine the governance arrangements we looked at a systems and processes to monitor performance and to drive continuous improvement. In respect of the service's internal audits these had not picked up on the areas of concern we identified. For example, the lack of recorded individualised care and a lack of auditing and safety checks regarding the environment to ensure it was safe and well maintained. The management of records was not always secure and some environmental records were disorganised, therefore, information was difficult to locate.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager responsible for the oversight and day-to-day management of the home. The registered manager had previously worked at the service and became the registered manager in September 2017. The registered manager was supported by a nurse who held the role of clinical lead/deputy manager. The registered manager had a visible presence in the home. Their approach was caring and transparent and they demonstrated good communication with people, relatives and staff.

The registered manager was open and receptive to our findings and following the inspection informed of us the actions they had commenced to improve the service. This entailed formulating more detailed care plans, more robust safety checks for the environment and a more structured approach to record management. We were assured by the registered manager's prompt actions.

The PIR informed us about the service's governance. We looked at other audits to see how standards were monitored. For example, monthly audits were completed for medicines, incidents/accidents, weight analysis to monitor people's weight gain or loss, pressure ulcers, catering, finances, laundry and infection control. Required actions had been completed though these were not always 'signed off'. Where a medicine error had occurred appropriate actions had been taken to improve practice to minimise the risk of re-occurrence. The registered manager completed capability night visits. This was to observe and monitor care practice and to provide support and training for the staff.

We spent time talking with the registered manager who advised us they were committed to the further development of 'best practice' to support people with dementia. This included ongoing environmental improvements and the development of multisensory social activities. We saw a number of areas had been subject to decoration and the registered manager confirmed this work would continue throughout the home. End of life care training was being arranged for more staff which included accessing a course to support LGBT people. The registered manager was instigating a recognised framework for end of life care and they were looking to appoint a champion to lead on areas of practice such as dignity, end of life and infection control. The registered manager informed us they intended to place a 'welcome to my room'

poster in people's rooms to help people feel 'at home'.

The provider had policies and procedures which referenced legislation and required standards to inform and guide staff of their role. The provider employed the services of an external organisation to monitor standards and to highlight 'key operational risks' in the home. We were shown a copy of their report from March 2018 and accompanying action plan. The registered manager discussed actions taken to date and work pending.

The registered manager supported a culture that was open and transparent. Feedback from relatives regarding the registered manager's leadership was positive. Relatives told us the registered manager was friendly, approachable and they were able to see them at any time. A relative told us, "(Manager) is lovely, really good at listening and making sure things are run well." Family and friends meetings were held and the dates displayed. Areas for discussion included care reviews, social activities and laundry service. Satisfaction surveys were given to relatives in May 2017 and for staff June 2017. Feedback from the 11 relative surveys returned was positive. For example, 83% relatives said they were happy with the care and 80% happy with the management. A 'you said, we did' board was situated in the main entrance of the home to advise people and relatives of actions taken in response to the surveys and relative meetings.

The staff we spoke with said that they felt well-supported by the registered manager and the management of the home was organised. Staff told us they attended staff meetings which were informative and this provided a platform for them to share their views.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risk regarding Birch Abbey.

The ratings from the previous inspection were on display in accordance with requirements.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	<p>People's plan of care lacked information around regarding care and support based on individual need. This meant there was a risk staff did not have the information they needed to meet people's care and support needs effectively and in accordance with individual need and preference.</p> <p>The service's governance arrangements to assess and monitor standards were not always effective to ensure a safe well managed service.</p>