Springhill Care Group Limited

Birch Green Care Home

Inspection report

Ivydale
Birch Green
Skelmersdale
WN8 6RS
Tel: 01695 50916

Date of inspection visit: 16/06/2015 & 19/06/2015
Date of publication: 02/11/2015

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

Birch Green Care Home is situated in Skelmersdale. It provides accommodation for up to 74 people who require help with personal or nursing care needs. There is a dedicated unit for those living with dementia. A passenger lift is available for easy access to the first floor. All bedrooms are of single occupancy and some have en-suite facilities. Bathrooms and toilets are located throughout the home. Ample parking is provided and public transport links are nearby. Local amenities include a supermarket, shopping centre, pubs and cafes.

This comprehensive inspection was unannounced and was conducted over two days.

On the first day of our inspection the registered manager was not on duty. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. We were joined shortly after our arrival by the Managing Director and the Director of Quality and Compliance, who represented the organisation, Springhill Care Group Limited.

Summary of findings

We found recruitment practices to be robust. Induction records for new staff were maintained. Agency staff also received a simplified induction programme before they started work. A wide range of training was provided and staff were knowledgeable about the needs of those in their care.

Assessments of people's needs had not always been fully completed and relevant information was sometimes missing. However, we found the planning of people's care and support to be person centred, providing staff with clear guidance about the needs of those who lived at the home and how these needs were to be best met. Risk assessments had been conducted, which were in general satisfactory. However, one we saw provided conflicting information for staff about an individual having swallowing difficulties and being at risk of choking.

People were helped to maintain their independence and although staff approached them and interacted with them in a gentle and friendly way, their privacy and dignity were not consistently respected.

We found that people's dignity was not consistently promoted and their privacy was not always respected. However, we observed staff members approaching people in a kind, gentle and friendly manner and people were supported to maintain their independence as much as possible. People looked comfortable in the presence of staff members.

The staff team were confident in reporting any concerns about a person's safety and legal requirements had been followed in relation to the Mental capacity Act 20015 (MCA) and Deprivation of Liberty Safeguards (DoLS). We have made a recommendation around this.

Accident records were appropriately maintained and these were kept in line with data protection guidelines. A contingency plan provided staff with guidance about what they needed to do in the event of an environmental emergency, such as power failure or severe weather conditions. Systems and equipment within the home had been serviced to ensure they were safe and fit for use.

We found that Medication Administration Records (MARs) had been appropriately signed when medications had been administered and any reasons for omission had been recorded. However, the overall management of medications could have been better. One person had not received two of their medicines for several days because the home had failed to order them in sufficient time. Receipts of medications into the home had not always been recorded and hand written entries on MAR charts had not always been signed, witnessed and countersigned in order to reduce the possibility of any transcription errors. On the first day of our inspection we noted one person's medications were retained in a basket in her bedroom, which was easily accessible by other people. However, when we visited several days later this safety concern had been appropriately addressed.

Clinical waste was being disposed of appropriately. The layout of the home was well designed. Progress was being made towards adapting the environment on the first floor to be more suitable for those who lived with dementia. However, there were areas which needed attention in order to promote infection control practices and to make the environment consistently safe for people who lived at Birch Green.

Food served was tasty, nutritious and plentiful. The dining tables were pleasantly laid. However, the management of meals in one dining room was disorganised, but well organised in the other. A range of in-house activities were provided and outings to local places of interest were arranged, as well as visits from external entertainers.

We found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for safe care and treatment, dignity and respect, good governance, person centred care and notifications of other incidents.

You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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

This service was not consistently safe.

Medicines were not always well managed and therefore people could be at risk of unsafe medication practices.

Risk assessments had been conducted, which in general were satisfactory, although one we saw did provide some conflicting information from other records seen for the same person. There were areas which needed attention in order to promote infection control practices and to make the environment consistently safe for people who lived at Birch Green.

At the time of this inspection, recruitment practices were robust, which helped to ensure only suitable staff were appointed to work with this vulnerable client group.

Staff were confident in responding appropriately to any concerns or allegations of abuse. People who lived at the home were protected by the emergency plans implemented at Birch Green.

Is the service effective?

Good

This service was effective.

We noted people were able to move around the home, as they pleased, without any undue restrictions being placed on their freedom. People's rights were protected, in accordance with the Mental Capacity Act 2005. People were not being unlawfully deprived of their liberty because legal requirements and best practice guidelines were followed.

New staff completed an induction programme when they started to work at the home. Records showed the staff team completed a range of mandatory training modules and this was confirmed by staff members we spoke with. Supervision sessions enabled members of the workforce to discuss their personal development and training needs with their line manager.

Progress was being made towards providing suitable surroundings for those who lived with dementia, so that these people could experience a more meaningful and tenacious life style.

Systems were in place to support people to select their choice of menu and people's dietary preferences had been taken into consideration.

Is the service caring?

Requires improvement

This service was not consistently caring.

People's privacy and dignity was not consistently respected. However, people were supported to remain as independent as possible whilst living at the home and they told us that staff were kind and caring towards them.

Summary of findings

People were supported to access advocacy services, should they wish to do so. An advocate is an independent person, who will act on behalf of those needing support to make decisions.

Is the service responsive?

Requires improvement

This service was not consistently responsive.

People's needs were assessed before a placement at the home was arranged. However, these records were found to lack person centred information and relevant details were often missing. This did not enable the staff team to be confident they were able to meet the needs of all those who went to live at Birch Green.

Care plans we saw were well written, person centred documents. These provided staff with clear guidance about the needs of people and how these needs were to be best met.

A variety of leisure activities were provided at the home and outings were arranged regularly.

People we spoke with told us they would know how to make a complaint should they need to do so and staff were confident in knowing how to deal with any concerns raised.

Is the service well-led?

Requires improvement

This service was not consistently well-led.

Confidential records of people who used the service and of the staff team were not kept securely. Therefore anyone could access this information.

Records showed that surveys had been conducted and a variety of meetings had been held for those who lived at the home and their relatives. A wide range of audits had been conducted and external professional bodies periodically assessed the standard of service provided.

Systems for assessing and monitoring the quality of service had been implemented and evidence was available to demonstrate the home worked in partnership with other relevant personnel, such as medical practitioners and community professionals. However, systems in place for monitoring the quality of service provided had not always identified areas in need of improvement and therefore shortfalls had not consistently been addressed.

Birch Green Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We also looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

This unannounced inspection was carried out on 16 June 2015 and 19 June 2015 by two Adult Social Care inspectors from the Care Quality Commission, who were accompanied by a specialist dementia care advisor and an expert by experience. An Expert by Experience is a person who has experience of the type of service being inspected. Their role is to find out what it is like to use the service. This was achieved through discussions with those who lived at Birch Green, their relatives and staff members, as well as observation of the day-to-day activity.

At the time of our inspection of this location there were 64 people who lived at Birch Green. We 'pathway tracked' the care and treatment of six of them. This enabled us to determine if people who lived at the home received the support they needed in a person centred way. We were able to speak with eight people and seven of their relatives, as well as eight members of staff.

We toured the premises, viewing a randomly selected number of bedrooms and all communal areas. We observed people dining and we also looked at a wide range of records, including the care files of eight people who used the service and the personnel records of four staff members.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We 'pathway tracked' the care of six people who lived at the home. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed. Other records we saw included a variety of policies and procedures, training records, medication records and quality monitoring systems.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us and we asked local commissioners for their views about the service provided. We also requested feedback from 16 community professionals, such as medical practitioners, community nurses, mental health teams and an optician. We received six responses, which provided us with positive information.

Requires improvement

Is the service safe?

Our findings

People we spoke with who lived at the home told us they felt safe. Their comments included, “Yes, I feel very safe. There is always someone walking about or coming into my room with cups of tea”; “I suppose I do feel safe” and “They (the staff) ask me where I am going when I go out. How long I will be gone and what time I will be coming back. That makes me feel safe.” However, one person told us, “If they talk to me in a nasty way I retaliate” and another commented, “Most of the staff are kind but some can be sharp.”

We asked people about staffing levels. Comments from those who lived at the home and their relatives included, “The manager has brought more staff in. I think there is enough staff”; “If you are needy you get help, but if you are ok they (the staff) just leave you to it. You have to wait a very long time sometimes to get someone to help you especially at bedtime”; “One of the staff told me not to use the buzzer unless it was an emergency”; "Last night my mother rang my sister at 11.30pm to come in and change her and her bed because she was lying in a wet bed. We fed this information back to the provider on the first day of our inspection and discussed it further during our second visit to Birch Green. We were advised that the manager had investigated the concerns we had raised and there was no evidence to demonstrate this incident occurred on the night in question. However, records showed the incident occurred six months previously and this was thoroughly investigated at that time. We know that they unplug her buzzer. We have come to visit and seen it unplugged." The provider told us that they were not aware of any occasion when this had occurred nor had a relative brought this to their attention'.

We looked at staff rotas and talked with people about staffing levels. We established that the numbers of staff deployed at the home were calculated in accordance with the dependency levels and needs of those who lived at Birch Green. However, some examples were given of people’s needs not being met in accordance with their wishes. One person told us that she often went to her bedroom at six in the evening and got up at ten in the morning, because there was no-one to support her at different times. Records we saw confirmed this information as being accurate. The provider told us that this was discussed with the individual, who confirmed that she returned to her bedroom at around 6.30pm, because there was no-one sitting in the foyer and she did not wish to go to sit in the lounge with the other residents. She would rather watch television in her room or go to bed if she was tired. One person who lived at the home told us that a member of staff had told her to, “Do it in your pad” when they (the staff) did not have time to take her to the toilet.

The views of people who lived at the home and those who worked at Birch Green varied in relation to staffing levels. Some residents, relatives and staff members told us they were happy with the current staffing levels and we were told that staff had time to sit with people & chat during the day. However, others told us they felt there were not enough staff deployed at certain times of the day. One member of staff said, “From 8pm it is really bad. We now have residents who have high dependency. On one unit alone we have 17 people who need two carers to attend to their needs. It is just as bad or even worse in the morning trying to get all the residents up, washed and dressed, doing medications and changing people who are very soiled or distressed. When people ring for assistance we have to tell them they will have to wait and we will get to them as quickly as we can. We can’t get into the dining room to serve breakfast till 9.30am. It’s not fair on the residents they have not had a hot drink since the previous evening about 9pm.” Another commented, “If the night staff are running late it has a bad knock on effect on the day staff, who have to take over some of the night staff duties. Through the day we have to accompany residents on hospital appointments and if a member of staff does not turn in we are really stretched. We could do with another member of staff especially from 8pm and first thing in the morning.” The provider told us that this comment suggests this is a daily occurrence, which she says isn’t the case. The provider added that residents may require an escort to hospital on average four times per month. Should a resident require escorting to a hospital appointment, the family would be contacted in the first instance and asked if they would like to accompany the resident to the hospital. Should they be unable to do so, we would arrange for the person to be supported. This is normally by the activity team, rather than the care team. In the event that we need a member of the care team to support a resident to hospital then the staffing levels would be reviewed and additional staff brought in if necessary.

On the first day of our inspection we observed staff members rushing about the home between their duties,

Is the service safe?

without much time for sitting and chatting with people. We saw one of the senior staff almost running to get her work completed in a timely fashion. However, staff did not rush people when supporting them with their activities of daily living. The provider supplied us with evidence that the staffing levels were calculated using a model that takes the dependency scores of each resident within the service and populates a spread sheet which indicates the staffing levels required to meet the needs of people in their care.

Environmental risk assessments had also been conducted and periodically reviewed. These covered areas, such as the handling of laundry detergents, carpet cleaning, passenger lift safety and hot equipment. The recent fire risk assessment identified that a new fire alarm system was needed and at the time of our visit this had been Installed. However, although people we spoke with told us they felt safe living at the home we observed aspects of the environment that were not safe. For example: We saw building materials, such as sand, cement and long strips of wood propped up against a wall. One unlocked room contained a hot water tank and another contained an assortment of disused wheelchairs, toilet seats and various other unused items. In one person's bedroom there was a cracked and broken bedside lampshade. We also saw an open garden gate, which led to an area of the garden that was being repaved, where a wheelbarrow filled with rubble, other building materials and tools had been left unattended. These areas presented potential risks for those who lived at the home.

We found the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because the premises were not always used in a safe way. This was in breach of regulation 12(1)(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our tour of the premises we found the environment to be, in general, pleasant smelling. However, one bedroom we visited was malodourous. A cleaning schedule and an infection control policy were in place and we noted that clinical waste was being disposed of in accordance with current legislation and good practice guidelines.

Some areas required improvement in order to better promote infection control. For example, we noted that two hoists were dirty and in need of a thorough clean. The carpet in the dining room was very dirty especially the part of the carpet that led into the kitchen. Some bedroom carpets were marked and dirty. Windowsills, wardrobes and carpets in people's rooms were dirty.

Toothbrushes and toothpaste were pushed behind taps. Due to the lack of a towel rail in one bedroom, damp towels were draped over the back of an armchair. Two of the bathrooms and two of the bedrooms we visited had no sanitizer or soap for washing hands.

A member of staff serving food had a dirty overall on, false nails that had debris underneath them and long flowing hair that she constantly adjusted. We observed this member of staff butter some crackers for one person. She also served food to other people during the lunch service. These observations did not promote good infection control practices.

A Health & Safety procedure was prominently displayed within the home and Personal Protective Equipment (PPE) was available for anyone entering the serving area of the dining room. However, white coats were dirty and gloves were not in use when staff were handling food.

We saw that residents had equipment to help them to be independent. However, some of it needed a good clean and sanitise. We visited one person in her bedroom. We noticed that the commode did not have a seat and that the smell of urine was very strong. The commode was very old and very dirty.

We found the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because infection control practices adopted by the home were not robust. This was in breach of regulation 12(1)(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medication policies and procedures were in place at the home. The Medication Administration Records (MARs) we saw were signed correctly when medicines were administered. However, the receipt of medicines for one person had not been recorded and hand written entries had not been consistently signed, witnessed and countersigned to avoid any transcription errors.

Records showed that one person had not received one prescribed medicine for three days and another medicine for one week. In discussion with the registered nurse it was established that the reason for this omission was because

Requires improvement

Is the service safe?

the medications were 'out of stock.' It was clear that these medicines had not been ordered in a timely fashion and therefore had run out of supply. Therefore, people could not always be assured they would receive their medicines as prescribed.

We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not well managed. This was in breach of regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Controlled drugs were being stored appropriately and the corresponding register was correctly maintained. We checked the balance of a number of randomly selected medicines and these were found to be correct.

The treatment room was very warm, despite the recent installation of a new fan. This temperature could have potentially rendered medications ineffective. We were later advised by the registered manager that a new standard fan had been purchased, which had reduced the temperature of this room.

Risk assessments were evident in the care files we looked at and these had been reviewed and updated each month. They covered areas such as, risk of falls, pressure ulcers, and management of medications, malnutrition and choking. However, some information provided was contradictory to that recorded on the pre-admission assessment. For example, the pre-admission assessment for one person indicated they were at risk of choking and had swallowing difficulties, but their risk assessment stated they did not have a history of choking or any swallowing difficulties. This provided the staff team with conflicting and confusing information. However, the planning of this individual's care in relation to nutrition was well written and clear guidance for staff was provided. Therefore, we recommend the registered manager ensures that all documentation accurately corresponds with the needs of those who use the service.

Plans of care followed on from a risk management framework and potential risks were incorporated into the care planning process with clear strategies of action being evident to reduce the possibility of harm.

Policies and procedures were in place in relation to safeguarding vulnerable adults and whistle-blowing. Records showed staff had completed training in this area. A system was in place for recording and monitoring any safeguarding concerns, so that the manager could easily identify any themes or recurring patterns. Staff we spoke with knew what action they needed to take, should they be concerned about the safety of someone in their care.

Staff members whom we spoke with told us they would know how to respond to an allegation or incident that might constitute abuse. One said, "I would go to a senior or if the senior was the perpetrator I would go to management and if need be, call the police and whistle blow to CQC." Another told us, "I would implement the whistle-blowing policy."

During our inspection we looked at the personnel records of four staff members. Prospective employees had completed detailed application forms, including health questionnaires and had provided acceptable forms of identification. We found that recruitment practices for new staff were robust. The background assessments undertaken included the receipt of two written references and Disclosure and Barring Service (DBS) checks, which would identify if the individual had any criminal convictions or had ever been barred from working with vulnerable people. The recruitment procedures followed helped to ensure prospective employees were suitable to work with the group of people who lived at Birch Green.

Staff personnel records showed that interviews were conducted for prospective employees and a record of the activity was retained in staff files. New staff were provided with job descriptions relevant to their specific role, terms and conditions of employment and an employee handbook. Together, these documents provided staff with clear guidance about their roles and what was expected of them whilst working at Birch Green.

Accident records were appropriately recorded and these were kept in line with data protection guidelines. This helped to ensure people's personal details were maintained in a confidential manner. The records of one person showed they had sustained numerous unexplained bruises and skin tears over the past six months. We discussed the care of this person with the registered manager of the home, who told us that medical practitioners were involved and that controls had been put in place to help to reduce the possibility of injury.

Records were available to demonstrate that systems and equipment had, in general been serviced, in accordance

Requires improvement

Is the service safe?

with manufacturers' recommendations and a wide range of internal checks had been conducted, to ensure they were fit for use and protected people from harm. However, the hoist slings had not been checked for over a year. These should be assessed for damage every six months.

A business continuity management plan was in place, which provided staff with guidance about action they needed to take in the event of an environmental emergency, such as a flood, power failure or severe weather conditions. The provider told us that additional maintenance resources were planned. The provider has since confirmed that these commenced shortly after our inspection.

A procedure was in place outlining action staff needed to take in the event of fire. This was clearly displayed in the reception area of the home, so that everyone could access the information.

Individual Personal Emergency Evacuation Plans (PEEPs) had been developed, which were coded by a 'traffic light' system and showed how people should be assisted from the building in the case of evacuation being necessary. This information was located in a position for easy access by the emergency services, who would not be familiar with those who lived at Birch Green.

We recommend that the provider assesses the deployment of staff to ensure people's needs are appropriately met.

Good

Is the service effective?

Our findings

We asked people about staff training and these were the responses we received: “They (the staff) seem to know what they are doing. They do get training. There is a training session going on today” and “I think it is good. The carers are all good. They do what they are supposed to do.”

However, One person expressed concerns about the ability of the staff to meet their relative’s more complex needs. On the day of our first visit to Birch Green we established that there was a training sessions in progress in relation to the management of challenging behaviour.

During the course of our inspection we toured the premises, viewing all communal areas and a randomly selected number of bedrooms. The building comprised of two floors. A passenger lift was available for access to the first floor. We noted a refurbishment programme was in place and at the time of our inspection, decoration of some areas was in progress. We noted that one of the communal baths was out of order. However, we were told by the management team that arrangements had been made for its repair the following week.

One person who lived at the home told us, “It’s not perfect. They are always trying to make it into a good looking place” and a relative commented, “The lounge has been decorated and we have had new furniture.” We saw that some people had a key to their bedroom door and a locked drawer for private items. We saw a member of staff ask one person if they would unlock their door, so she could put some clean clothes on their bed. This helped to safeguard people’s personal belongings. One person told us that her lock had broken on her drawer some weeks ago and it had not been repaired, but no explanation had been given to the individual as to why the work had not been done. We recommend this issue be addressed.

We found the building to be well designed to meet some people’s needs. Corridors were straight and wide to aid visibility and accessibility. Hand rails were fitted to walls to help with mobility. However signage could have been better. Not all bedroom doors had numbers and names attached. We did not see any evidence of dementia friendly adaptations on corridors or in communal areas. However, the registered manager was fully aware of research conducted to support people to experience a meaningful and tenacious life style, by providing surroundings most suitable for those who lived with dementia. Progress was being made to adapt the environment on the dementia care unit for the people who lived there, which would help to provide opportunities to stimulate exercise, relieve boredom and give people the chance to explore their surroundings, as well as enabling people to orientate themselves to their environment.

We saw a garden of remembrance that relatives of residents who had passed away could visit if they chose to do so. We visited the Bistro where meetings were held and where people could take their relatives for a chat. On the first day of our inspection, the Bistro was closed to residents because staff training was being held there. One member of staff we spoke with said, “The Bistro is a complete white elephant. The residents hardly ever get the opportunity to use it.” The provider told us, ‘Since the opening of the Bistro in August 2014, a number of residents and relatives have enjoyed the benefit of the Bistro through selling refreshments and gifts. We have raised circa £4,500for the residents’ fund. Some residents do enjoy their meals in the Bistro, should they prefer to eat there, rather than the dining area.’

A dementia café had been developed. This was attractively decorated and served drinks and light refreshments. It was intended for the use of people who wanted to meet in a small group or have tea in privacy with their family. The space was also in use for staff training several days each week, which considerably reduced access for those who lived at the home and their relatives. The provider told us, "Whilst we do utilise the Bistro for training on occasions, it is not several days per week, as indicated. Our records show that the Bistro has been utilised on average of 19 occasions from 1st May 2015 to the 31st July 2015, an average of 1.5 occasions per week, during the 13 week period."

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people’s best interests. DoLS are part of this legislation, which ensure that where someone may be deprived of their liberty, the least restrictive option is taken.

Good

Is the service effective?

Policies and procedures were in place in relation to the MCA and DoLS. We observed that freedom of movement around the two units was evident, without restrictions being enforced.

Staff understood the concept of DoLS, but could not tell us which people might have received authorisation.

Mental capacity assessments had been conducted to ascertain if people lacked the capacity to make decisions about the care and support they wished to receive. The registered manager told us that 11 DoLS applications had been made on behalf of people who lived at the home and three had been approved. She said others were still waiting to be assessed, but that she followed these up periodically. We saw a note that one person should be given her medications by the nurses, which was in her best interests, but we saw no minutes of a best interest meeting taking place or evidence of consultation with her or her relatives who were frequent visitors.

Consent in various areas had been obtained from those who used the service or their relative, such as agreements for the taking of photographs for identification purposes and enabling the home to share information with those who needed it. People who lived at the home or their representative had been involved in the development of their plans of care. This helped to ensure they had been supported to make decisions about how they wished their care and treatment to be delivered.

Records showed that a wide range of community professionals were involved in the care and treatment of those who lived at Birch Green, such as community nurses, psychiatrists, GPs, dentists, opticians, and psychologists. This helped people to receive the health care they needed. We saw a medical practitioner and a district nurse visit on the first day of our inspection.

People thought that staff had the skills needed to support them. We established that a learning and development officer had been appointed, who was responsible for implementing induction programmes for new staff, organising staff training and auditing care records.

Records showed that staff members completed an in-depth training programme at the start of their employment, which covered modules, such as health and safety, infection control, moving and handling and safeguarding adults.

Agency staff who worked at the home also received a simplified, but relevant induction, which covered topics, such as information about the company and management team, rules and regulations, health and safety policies, fire procedures, infection control practices and relevant information about those who lived at the home. This enabled agency workers to obtain the information they needed, in order for them to do the job expected of them.

Staff members spoken with told us they received regular training. They felt enough training was provided to meet the needs of those who lived at the home. This information was confirmed by the records we saw, which showed that the staff team completed a wide range of annual mandatory training modules, such as moving and handling, health and safety, safeguarding vulnerable adults, fire awareness, first aid, infection control and food hygiene. A good percentage of the workforce had completed training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) this year.

Staff we spoke with told us they were able to attend training courses they thought would be beneficial to their personal development and to the needs of those who lived at Birch Green. Additional training courses included tracheostomy care, stroke management and dementia awareness, the latter of which was open for relatives and friends of those who lived at the home, which was considered to be good practice. A group of staff had commenced the Care Certificate, which is a national programme to ensure care staff are appropriately trained and some members of the workforce had completed fire marshals training. A moving and handling trainer had been appointed. This enabled staff to receive training in this area through both theory and practical sessions. One member of staff told us, “I have done a dementia diploma. It’s very frustrating we don’t have the time or the equipment to implement what we have learned.” The Activities Coordinator had received some specific training in relation to activities for people living with dementia.

Supervision records and annual appraisals were seen in staff files, as well as performance and development reviews. These allowed employees to discuss their work performance and training needs with their line managers at structured and regular intervals. One member of staff told us she had received supervision the previous week, but that it had been a year since the last session.

Good

Is the service effective?

Records showed that the home had recently been awarded a food hygiene rating of 5 by the local authority's Environmental Health Officer, which is equivalent of 'very good' and is the highest level available.

The menu was displayed outside the dining room. This meant that those who could not access this area did not have the opportunity to peruse the menu at their leisure. However, we overheard a member of staff asking people what they would like from the menu and care records we saw showed that people were to be supported to make choices from the daily menu. People's dietary preferences were documented within individual plans of care.

We observed lunch being served in both dining rooms. Eighteen people ate in one dining room, served by five members of staff. Tables were pleasantly laid with cutlery and crockery. Tea pots, milk and sugar were provided, so that people could help themselves. However, the food service was somewhat disorganised. Several staff plated up the meals. Tables were served in a haphazard manner. One member of staff shouted across the dining room to people asking what they wanted to eat. One of the inspection team dined with people in this area. The food sampled was tasty and plentiful. The management of meals in the other dining room was more organised, providing a more conducive dining experience for those who lived at the home.

We saw staff cutting food up for people who needed assistance and we saw one care worker speaking kindly and sensitively to a person she was supporting to eat their lunch. The resident had limited speech, but we could see from the facial expressions that she was enjoying her meal. The person was allowed to eat at her own pace and was offered intermittent drinks. The carer first asked the resident then made her an ice cream cornet for desert.

We saw one person being nursed in bed. She did not like the two options on the menu for lunch, so the carer offered her toasted sandwiches, a variety of desserts, yoghurt and ice cream.

Comments about food provision included, "The food could be improved. Sunday roast is very good, but we get a lot of soup and sandwiches at tea time"; "It's (the food) sufficient. There is always plenty of it. We get a choice of two dishes at lunchtime. If you don't like either of them you get offered a sandwich" and "The food is reasonable."

We recommend that the guidance in the Mental Capacity Act 2005 code of practice be followed in relation to the recording of best interest decisions and how these have been made.

Requires improvement

Is the service caring?

Our findings

People who lived at the home said they were well cared for. Their comments included: "I think they (the staff) are all kind. They look after me very well"; "They are all lovely and very kind. They go to the shops for me" and "They always knock before coming in my room. I have the same carer that helps me with my shower. She is lovely. She stays with me and washes my back and tells me what she is doing at home and all about her little girl."

A visitor said, "My relative can't speak, but all the staff interact with him. He blows them kisses."

Another visitor told us that she was not happy with the care her relative was receiving and thought the staff and management did not try to understand her behaviour.

People told us that care workers were polite respectful and protected their privacy. We observed staff approach people in a kind, patient and sensitive way. Staff chatted with people whilst passing them or assisting them with activities of daily living.

We noted that privacy, dignity and independence were integral parts of the care planning process, particularly during the provision of intimate personal care and the promotion of people's abilities. However, we observed two occasions when people's privacy was not promoted. For example, we saw one member of staff attempting to help a female resident who was living with dementia to put her tights on in a communal area of the home, surrounded by other people. The member of staff was advised by a passing registered nurse to assist the individual to the bathroom, in order to assist her further. We also observed people being lined up in wheelchairs in the main reception area waiting for the toilet. Staff told us the reason for this was that they had better use of the hoist in that particular toilet. We also saw an entry in one person's daily record, which expressed frustration with one person who had been requesting urgent attention. It read, "I came off the phone and told her to calm down and stop acting like a spoilt child." These observations did not promote people's privacy and dignity.

We found that people were not always treated with dignity and respect and their privacy was not always protected. This was in breach of regulation 10(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Comments we received from the community professionals who responded to our request for their views about the service provided included, 'Staff are caring, professional, knowledgeable in their information about the residents they deal with'; 'The home is always clean and has a pleasant atmosphere for the residents' and 'I was involved with one patient during end of life care and I thought they (the staff) seemed professional and genuinely cared for the welfare of their patients. I have had telephone contact with them regarding another patient and they demonstrated sound clinical judgement as well as effective resource utilisation, which prevented delays in treatment of a patient who had become unwell on a Friday evening. I don't have anything negative to say about them.

We saw that a Statement of Purpose and a welcome pack were available for all interested parties. Together these outlined the visions and values of the organisation, the aims and objectives and services and facilities provided, including the complaints procedure. The welcome pack included a section entitled, 'Your Care Your Way', which encompassed the ethos of the home and explained how people's rights would be met. This helped prospective residents to make an informed choice about accepting a place at Birch Green.

The pre-admission needs assessments included a statement, which read, 'I have been fully consulted in the assessment and agree with the outcome.' These had not always been signed by the individual or their relative and therefore we were not able to determine if people had been consistently involved in the assessment of their needs. However, the records of one person showed that their relative had requested a monthly review of their care plan by telephone, although evidence was not available to demonstrate this was taking place.

People were well presented and looked comfortable in the presence of staff members. Interactions we observed between staff members and those who lived at the home were all pleasant, polite, friendly and unhurried. Staff expressed their genuine concern about individual people when talking with us. We observed appropriate moving and handling techniques. We observed that people who wanted to mobilise independently, but slowly, being allowed to do so.

Requires improvement

Is the service caring?

Records showed that five staff members were in the process of doing the 'Six Steps to End of Life' training and some staff had completed an advanced care planning module for those people who were nearing the end of their life.

People were supported to access advocacy services, should they wish to do so. An advocate is an independent person, who will act on behalf of those needing support to make decisions.

Requires improvement

Is the service responsive?

Our findings

Records showed that an assessment of people's needs had been conducted before a placement at the home was arranged. However, these had not always been signed by the assessor and they were not fully completed. Important information was often missing. For example, the section for mobility for one person was left blank, as were the areas for washing, bathing and dressing. This did not give a clear picture of the care and support people required and therefore did not enable the staff team to be confident they could meet people's needs.

We found that the registered person had not ensured people's needs were always met, because the assessment process was not always sufficiently person centred. This was in breach of regulation 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the course of our inspection we looked at the care records of eight people who lived at Birch Green and 'pathway tracked' the care of six of them. We established that a 'key worker' system had been implemented. This allowed people to identify with a specific member of staff, so they developed a good relationship and became able to trust them and to discuss any concerns they may have. The key worker was also responsible for ensuring those in their care had everything they needed and to liaise with their relatives, as necessary, so that important information could be passed on to families, with the agreement of the person who used the service.

The care records we saw contained a lot of details and they were cumbersome for staff to access the information they required at any one time.

The plans of care we saw were well written, person centred documents. They had been reviewed regularly and any changes in circumstances had been recorded well. They provided the staff team with clear guidance about people's needs and how these needs were to be best met. They contained a good level of detail about people's preferences, wishes and social history. Records indicated that a model of person centred care had been developed across the organisation. The 'Springhill Model' was designed to cover areas, such as self-fulfilment, self-esteem, social and physical care needs, safety and security. One family member told us, "I read my relative's care plan. It gets updated about every six weeks or when necessary" and a person who lived at the home told us, "I think I have signed it (the care plan), but not for a very long while."

On entering the premises we noted an impressive central display within the reception area of the home, which boasted a wide range of craft items designed and created by people who lived at Birch Green, with support from the staff team. We were told this display was changed every month. We noted a wide range of activities were displayed of forthcoming internal events and trips out to the local community.

On the second day of our inspection the home had opened its doors for the National Care Homes open day 2015. This was a busy event attended by those who lived at the home, their families and friends, local school children and members of the public. Refreshments consisted of a barbecue, home-made cakes and beverages. A visit from Haigh Birds of Prey Centre was enjoyed by those who participated, when some people took the opportunity to interact with a barn owl. There was also music provided by the local Skelmersdale Community Singers and a raffle was organised by one of the people who lived at the home.

We found a lot of information about the social care people needed and their leisure interests. This was recorded in a lifestyle profile, which outlined how staff needed to support people with meaningful activities, which they enjoyed. The 'Map of Life' incorporated people's childhood memories, school life, employment history, family life and hobbies. This enabled the staff team to discuss people's interests with them and to talk about their life history.

We saw records of leisure activities, which had been provided. These showed who participated in the various events, what worked well and if it was enjoyed. In-house activities included various games, music sessions and dancing. On the day of our first visit, a general knowledge quiz was arranged during the afternoon for people who wished to participate. This seemed to be enjoyed by those who took part. External musicians visited the home to provide some entertainment and outings were also arranged from time to time, weather permitting. People we spoke with were satisfied with the level of entertainment provided and some confirmed they were able to choose if they participated or not. Preparations were being made for a summer fayre and open day, when a Beatles tribute act was opening the event in the home's own Cavern.

Requires improvement

Is the service responsive?

We saw some people going out into the garden and sitting in the sunshine talking to staff who were on their breaks. We saw one resident having a cigarette in the area reserved for smokers. The pastoral needs of people were met by Catholic Holy communion distributed every Sunday. Every month a Church of England service took place, to which all denominations were invited to participate.

The Lifestyle team provided quizzes, bingo, sing-alongs, arts & crafts, reminiscence activities, walks through the gardens and outings to a local garden centre, Southport & Chester Zoo. Tea dances and taster afternoons were arranged each month in the Dementia care unit and an entertainer visited twice each month.

We saw a display board with photographs of past celebrations. We were told that trips out were sometimes arranged. One person told us that the previous week, six residents had gone to Oswaldtwistle Mill and sometimes they went to the local cricket club for afternoon tea. People told us they enjoyed the quizzes, bingo and sing songs.

We viewed a number of bedrooms during our inspection. We found these to be personalised with objects and pictures displayed that were clearly personal and important to those who lived in these rooms. This promoted individuality and maintained people's interests. Each had a 'Memory Box' outside the bedroom door, which contained personal photographs and items of memorabilia.

A comment, suggestions and complaints policy was in place, which was clearly displayed in the reception area of the home and systems had been introduced for recording and monitoring any feedback in these areas. Each step of the complaints process was clear, which enabled a distinct audit trail to be followed. We tracked how one recent complaint had been handled. The information recorded was in accordance with that received by the Care Quality Commission and action taken was appropriate. We spoke with the person involved who told us they were totally satisfied with how their complaint had been managed. People we spoke with told us they would not hesitate to make a complaint, should they need to do so.

Two long standing members of staff we spoke with told us they would know how to handle any complaints and they explained the procedure to us.

We recommend that a one page profile of each person who lived at the home might be beneficial to enable staff to obtain information quickly.

Requires improvement

Is the service well-led?

Our findings

On the day of our inspection we were made very welcome. We asked for a range of records and documents to be provided. These were produced in a timely manner. However, we noted people's care files were retained on shelves across a variety of unlocked offices and were therefore easily accessible by anyone who wished to view them. These files contained confidential information and were not retained in a secure manner. We noted that offices were not locked when vacant of staff members.

We found that systems and processes had not been established in order to maintain securely records in respect of each service user, or such other records in relation to persons employed at the home. This was in breach of regulation 17(1)(2)(c)(d)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A quality management system had been introduced by the organisation. A matrix had been developed, which highlighted when various audits were next due. This helped to ensure a structured approach was adopted for the assessing and monitoring of the service provided. Regular internal audits covered areas, such as health and safety, staff personnel records, bed rails, medications, care planning and hospitality. The auditing system had been arranged under the five key questions used by the Care Quality Commission when conducting inspections. This was considered to be good practice. Records showed that a three day annual audit was conducted by a care consultant and director of quality and compliance. We were told that directors from the company visited the home twice every month and we saw their subsequent reports, plus reports following regular visits by the quality and safety representatives of the organisation. Action plans had been developed to address any shortfalls identified. However, the process could have been more robust. This would help to ensure improvements needed were always recognised. In light of the shortfalls we identified and breaches of the regulations we found the quality monitoring system at Birch Green was not always effective.

We found that the registered person had not ensured quality management systems had been effectively implemented to assess, monitor and improve the quality and safety of the services provided. This was in breach of regulation 17(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection we examined the information we held about this location, such as notifications, safeguarding referrals and serious injuries. We noted we had been told about some things we needed to know in accordance with The Care Quality Commission (Registration) Regulations 2009. However, the notifications we had received since April this year telling us about safeguarding issues did not match the number of safeguarding referrals made to the local authority in the same period of time.

We found that the registered person had not notified the Commission of all incidents of abuse or allegations of abuse in relation to a service user. This was in breach of regulation 18(1)(2)(e) of the Care Quality Commission (Registration) Regulations 2009.

The home had been accredited with external quality awards, which meant that independent professional organisations periodically audited Birch Green care home to determine the standard of services provided. We noted changes which had been introduced as a direct result of lessons learned. For example, a new system for laundering people's personal clothing had been developed, which we were told had made significant improvements. It was evident that some issues raised on the first day of our inspection had been rectified when we returned a few days later. For example, some exposed wiring had been attended to; key pads had been installed on doors of cupboards where toiletries and toxic chemicals were stored and the medications retained in the bedroom of one person had been locked away. This was pleasing to see. However, this demonstrated a reactive approach to quality management, rather than a proactive strategy system being implemented.

We saw the quality audit schedule for 2015 and this reflected when specific areas were to be assessed, which was considered to be good practice. However, these related to the previous Care Quality Commission outcome areas and should be updated to reflect current methodologies.

Records showed that focus group meetings for relatives were arranged and a family forum had been established. This enabled relatives to get together and discuss any topics of interest. Regular meetings were also held for different groups of the staff team. This enabled any relevant information to be disseminated across the workforce and allowed open discussions about any areas of concern or

Requires improvement

Is the service well-led?

any scopes of good practice. One relative we spoke with told us she was involved with the family forum which met every six weeks. She said they had asked for new bins and mugs instead of cups and these changes had been made. The forum also asked for charts in the bedrooms, so that relatives could read about the care and support being provided. These had also been implemented. This demonstrated that people were listened to and changes made in accordance with people's suggestions.

It was evident the home had established a wide range of links with the local community through volunteers from the Alzheimer's Society helping at Birch Green and from the development of a dementia friendly café opened for the local community, as well as for those who lived at the home and their friends and relatives. Volunteers from the local supermarket were also regular helpers at Birch Green and dementia friends were involved in helping with voluntary work too.

We established that annual independent surveys, entitled 'Your Care Rating' were conducted for those who lived at the home and their relatives. This meant that people were encouraged to submit their views about the service and facilities provided. A detailed report of the results was subsequently produced, which outlined the breakdown of responses received. Also on-going resident, relative and staff surveys were accessible through touch screen technology. Overall results of surveys had been collated and produced in bar charts for easy reference.

A wide range of written policies and procedures provided staff with clear guidance about current legislation and up to date good practice guidelines. These covered areas, such as safeguarding adults, whistle-blowing, privacy and dignity, health and safety, fire, discipline and grievance, complaints, the MCA, DoLS, infection control and advocacy.

All but one of the people we spoke with on the day of our visits knew who the manager was. They all thought that she had a very visible presence and some felt comfortable and happy to approach her with any concerns they may have had. We were told by the management team that they have been trying to employ a deputy manager for some months. We have subsequently been informed that a deputy manager has been appointed. This will help to support the registered manager of the home.

Some members of staff we spoke with told us that they did not feel well supported by the management team and that staff morale was very low. They thought that the manager could listen more to the needs of the staff. One relative said that she and her family had received a very 'frosty' and negative response from the manager. However, other people told us she was very approachable and would sort out any problems.

The manager of the home, Managing Director and Directors of the organisation attend the Springhill leadership in care programme. This is delivered by a fellow of Lancaster University and is aligned to the five key areas of the Care Quality Commission's inspection process, being accredited by the Institute of Leadership and Management.

The management team present at the feedback were very responsive to our comments and it was evident that they had already identified some areas in need of improvement.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used the service were not protected against the risks associated with the unsafe use and management of medicines. This was because appropriate arrangements had not been made for the obtaining, recording and safe administration of medicines. Regulation 12 (1)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because the premises were not always used in a safe way. Regulation 12(1)(2)(d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because infection control practices adopted by the home were not robust. Regulation 12(1)(2)(h)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **We found the assessments of people's needs conducted prior to admission were not always fully completed and therefore failed to provide important information for the staff team.** Regulation 9(3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **We found that people were not always treated with dignity and respect and their privacy was not always protected.** Regulation 10(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **We found that systems and processes had not been established in order to maintain securely records in respect of each service user.** Regulation 17(1)(2)(c)(d)(i).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **We found that the registered person had not ensured quality management systems had been effectively implemented to assess, monitor and improve the quality and safety of the services provided.** Regulation 17(1)(2)(a)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

We found that the registered person had not notified the Commission of all incidents of abuse or allegations of abuse in relation to a service user.

Regulation 18(1)(2)(e)