Bupa Care Homes (CFHCare) Limited

Birch Court Care Home

Inspection report

Egerton Street
Howley
Warrington
Cheshire
WA1 2DF

Date of inspection visit:
07 October 2016

Date of publication:
27 January 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We undertook a focused inspection of Birch Court on 7 October 2016.

At the previous inspection of this service in August 2015 we found the service had been rated as inadequate in relation to the effective section and an action plan had been provided to evidence how this would be addressed.

This focused inspection was carried out to look at concerns raised anonymously with regard to staffing levels especially on one specific unit of the home.

This report only covers our findings in relation to the Safe section.

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

Birch Court Nursing and Residential Home is split into five separate single story houses: Brook House; Moss House; Fern House; Bank House; and Waterside House. Each house has the capacity to accommodate 30 people. All bedrooms are single and are located on the ground floor. The home is located in the Howley area of Warrington and is within easy access of local amenities including shops, social and educational facilities. At the time of our visit there were 23 people living in Brook House, 24 people living in Fern House, 18 people in Moss House, 22 People in Waterside House. Bank House was currently unoccupied.

A manager had recently been appointed to Birch Court and had submitted her application to the Care Quality Commission to become the registered manger. 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 found that since our last inspection the previous registered manager had left the service. We also found the staffing levels were a cause for concern. We were aware that concerns had been raised by Warrington Council regarding the staffing levels throughout the home.

At time of our visit we found that there were insufficient staff on Moss House to ensure the safety and well-being of people living there. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Requires Improvement

The service was not always safe.

On occasions there were insufficient staff available to meet the assessed needs of the people who lived in the home.

Birch Court 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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook a focused inspection of Birch Court on 7 October 2016. The inspection was unannounced. We carried out this inspection in response to anonymous concerns about the staffing levels especially in one specific unit of the home.

We inspected the service against one of the five questions we ask about services: is the service safe and responsive to individual need.

The inspection was undertaken by one adult social care inspector.

Before the inspection we checked with the local authority safeguarding and commissioning teams for any information they held about the service. We considered this together with any information held by the Care Quality Commission (CQC) such as notifications of important incidents or changes to registration. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

During the inspection we met with six of the people who used the service. People were not always able to communicate verbally with us but expressed themselves in other ways such as by gesture or expression. Due to the nature of people's complex needs, we did not always ask direct questions. We did however chat with people and observed them as they engaged with staff during their day to day activities. We spoke with six staff members as well as the newly appointed manager, area manager and the clinical lead.

We received information from Warrington Council about the outcome of their recent contracts monitoring visits. The information they shared with us indicated that they had found evidence that the service had made some improvements in the areas they looked at.

We looked at records including three care files, staffing rotas, the training matrix, accident and incident reports, complaints and audit reports.

We had discussions with the area manager, newly appointed manager who had been in post for two weeks and the clinical lead. They were able to share information and provide documentation to demonstrate how they had addressed the areas of concern previously identified by The Care Quality Commission (CQC) and Warrington Council.

We also looked around the building and facilities and, by invitation, looked in people's bedrooms.

Requires Improvement

Is the service safe?

Our findings

When we visited Birch Court we saw that the arrangements to ensure people received safe care and treatment were in place. However we saw that the staffing levels were insufficient to ensure that people received a timely response to their care needs.

Our observations during the inspection indicated that at times there were not enough staff on duty especially on Moss House. The rota showed that one nurse and three care staff were on duty from 8am until 8pm on Moss House. One nurse and one carer were on duty between 8pm and 8am. Eighteen people were accommodated on the unit, of whom 16 had been assessed as needing the assistance of two staff in respect of moving and handling.

Staff told us that they were sometimes unable to provide care and support in a timely manner for the people who resided on Moss House. They said that this was due to the fact that at best there were four staff on duty and as most of the people needed two staff to support them, staff had to prioritise people's needs. They said that this impacted most unfavourably upon the people who lived there.
We viewed accident and incident reports from April until October 2016 and noted that there were 24 recorded slips, trips or falls. We noted that the majority of these were unwitnessed. Staff told us that they were unable to observe people all the time as they did not have sufficient staff.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that there were sufficient staff to ensure the safety and well-being of people at the home at all times.

Care plans were reflective of people's individual needs. Staff were fully aware of people's needs, abilities and preferences. We saw that staff interacted well with people who lived at Birch Court and there was an atmosphere of mutual trust and respect. However we observed that although staff worked very hard to assist people in a timely manner they were unable to be fully responsive to people's needs due to the staffing ratio.

We observed that staff were not readily available to assist a person when they were in need of assistance. For example we saw that one person needed to wait ten minutes before a staff member became available to provide assistance as they needed two staff to assist them. At that time the staff on duty had been assisting another person who lived at the home.

It was apparent that staff understood what people using the service were trying to communicate but there was insufficient numbers of staff to enable them to provide quick timely support. Staff also understood their role in respect of moving and handling and told us that they could not or would not transfer people who had been assessed as needing the assistance of two people on their own.

We were given a list of the people living at Birch Court and brief details of the dependency and care needs. It was clear from the information provided why people needed two staff for most tasks.

The area manager provided us with details of an audit tool which had recently been implemented to address dependency levels and the issue regarding staffing levels. We saw that this had been developed to ensure that staffing levels were appropriate to need. We saw that two people had just been admitted to Moss unit which had raised the dependency levels on the unit. The area manager addressed our concerns regarding staffing levels with immediate effect and ensured that one extra staff member was commissioned to work on Moss House 24 hours a day. He told us that the newly appointed manager would complete her own staffing review analysis the following week and advise us of the outcome.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that there were sufficient staff to ensure the safety and well-being of people at the home at all times.