Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Birchwood Grove

64 Sydney Road, Haywards Heath, RH16 1QA

Tel: 01444458271

Date of Inspection: 30 September 2013

Date of Publication: October 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Adiemus Care Limited
Overview of the service	Birchwood Grove provides support and accommodation for up to 24 people. The home supports elderly persons with dementia and other mental disorders.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 30 September 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service and talked with staff.

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.

What people told us and what we found

During our visit we met and spoke with four people living at the home. As the home looked after people with dementia we found that some of the people that we spoke with were unable to provide us with meaningful verbal accounts of their experiences in the home. Therefore we gathered evidence by spending time watching how people spent their time, the support they got from staff and whether or not they had positive experiences.

We saw that staff addressed people by their preferred names. Personal care was carried out in private and staff were discreet when asking about care needs. We saw that people felt comfortable in approaching staff and asking for assistance.

Everyone that we spoke with told us that they were happy living at the home and that they felt that their care needs were being met. One person said, "I love it here. The staff are very good, I am so fond of them here".

We found that people had planned care that met their needs. We also found that people's consent had been obtained prior to treatment where appropriate.

We found that the home had followed safe recruitment processes, and had systems in place to ensure that people living at the home received a safe and good quality service.

People we spoke with told us that the home was clean. One person said, "It's always clean, they are always cleaning here". We found that the home was clean and that staff took infection control seriously.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

People that we spoke with during our visit told us that staff always gained verbal consent before starting any personal care. One person said, "They always ask me, they don't just get on with it".

We spoke with two members of staff who were both aware of their responsibilities regarding consent. One staff member said, "I always explain to people what I am doing and ask for their permission. If they are unable to communicate their wishes to me verbally I look at their facial expression to look for signs that they are happy for me to continue". The other staff member said, "I always ask people for consent before I do anything. If they say no I will come back later on and see if they are ready then for me to help them".

We looked at five care records and saw that all of the records contained care plans which had been read and signed by the person or their representative. Care records were reviewed with people or their representatives annually. At these annual reviews people had signed again to say that they were happy with the contents of their care plans and any changes that had been made. We also saw that people's records contained instructions for staff on gaining consent. For example, one care plan stated, 'Staff to always seek permission and explain clearly to X what they aim to do. For example, can I wash your face?'

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements. In two of the records that we looked at we saw that people had participated in mental capacity assessments in order to ascertain whether they had the capacity to make decisions about their care. We saw that the form had been completed

correctly. The staff that we spoke with discussed the decisions around using these forms and demonstrated a good understanding of The Mental Capacity Act 2005 (MCA).

In three of the records we looked at people had a form which told staff that they should not be resuscitated in the event of their death. This form had been completed, signed and dated by a General Practitioner (GP). The form also stated that the person and their family had been consulted about this decision. In all of these records we also saw that the records contained an Advanced Care Plan. This document outlined the person's wishes for their care at the end of their life, and had been signed by the person or their relative where appropriate.

During our inspection we observed staff applying some of the core principles of the Mental Capacity Act 2005 when supporting people. For example, staff followed the presumption that people had capacity to consent by asking if they wanted assistance and waiting for a response before acting on their wishes. Staff maximised people's decision making capacity by seeking reassurance that people had understood questions asked of them, positioning themselves so that eye contact was made, and repeating questions if necessary in order to be satisfied that the person concerned understood the options available. Where people declined assistance or choices offered we saw that staff respected these decisions.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

During our visit we spent time in the lounge, and watched a lunch time service observing people's experience.

We saw that people wore clothing appropriate for the time of year and were dressed in a way that maintained their dignity. We observed personal hygiene needs were supported. For example, people's fingernails were trimmed and clean, men were clean shaven and people's hair was clean and groomed.

We saw sensitive staff interactions with people. For example, we observed that staff bent down to people sitting in chairs to speak with them face to face at their level. Staff spent time talking with people and giving sensitive responses at a pace and level appropriate for the person.

We saw that people were offered cold and hot drinks throughout the day and that staff reminded and encouraged people to drink.

Staff were knowledgeable about people's preferences and lifestyle choices. Staff spoken with told us about the needs of people. Staff knew what people could do for themselves and what they needed support with. Staff told us that they understood what care needs people had because they were encouraged to read their care records. Staff told us that they had a hand over of care at the beginning of every shift at the home which gave staff the opportunity to pass on relevant information to each other about the people they were caring for.

Care and treatment was planned and delivered in a way that ensured people's safety and welfare. We looked at the care records of five people living in the home. These were personalised and provided detailed guidance about how their needs should be met. For example, one care record stated, 'Mr X wears glasses. Staff to help him clean his glasses and remind him to wear them whenever he is walking'.

Care records had risk assessments which identified hazards that people may face and provided guidance on how staff should support people to manage the risk of harm. For example, people had malnutrition risk assessments in place which along with people's

weights were recorded monthly, assessed the person for their risk of malnutrition. Risk assessments had been updated monthly or more frequently if care needs or risks had altered.

During our visit we observed the care and support people received and found this was appropriate and reflected the instructions in the corresponding care records. We saw that care records were altered to reflect a change in the persons care needs. For example, where a person had type two diabetes the care records clearly detailed how staff should be caring for this condition. They showed how and when glucose monitoring should take place; Along with how to recognise when the person was outside of their normal blood glucose range and what they should do if this happened. We were also able to see documented evidence that staff had followed the instructions within the care records for this person.

People's health care needs were documented in their records and contact with health professionals was recorded. Additional monitoring records were in place where required for people with specific needs. For example, people at who were identified as at risk of dehydration had fluid balance charts in place. This allowed staff to monitor how much a person was drinking.

All of the people that we spoke with expressed satisfaction with the care and support they received. One person said, "I have had a lovely lunch and the people here look after me so well. They are a lovely people".

Staff that we spoke with told us that they felt able to give people the care that was required. One staff member told us, "We look after people well here, we know our residents and we all work hard to make their quality of life as good as it can be".

We observed people eating their lunch and found that people were being supported by staff with their nutritional requirements. We saw that staff had ensured that people who required aids to assist them with their independence had them in place. We also saw that staff were receptive to people's needs and were offering people assistance when needed throughout the meal service whilst promoting independence where possible.

The atmosphere throughout the inspection was calm, and friendly. Staff were observed to have a good relationship with the people living at the home. When talking to people, staff were friendly and professional.

The Deprivation of Liberty Safeguards (DoLS) were only used when it was considered to be in the person's best interest. We spoke with the person in charge on the day of our visit. They demonstrated a clear understanding of the legislation.

We asked staff about the home procedures in the event of a medical emergency. Staff were aware of their responsibilities. Staff had received first aid training in line with the provider's policy. They told us that they felt that they had received sufficient training and support and therefore felt able to deal with medical emergencies should they arise.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed.

People were cared for in a clean, hygienic environment.

Reasons for our judgement

There were effective systems in place to reduce the risk and spread of infection. The people that we spoke with all told us that they felt that the home was cleaned frequently and to a high standard. One person said, "They come in every day and clean my room".

During this inspection we walked around the home looking at the cleanliness of communal areas, bathrooms, toilets, and some bedrooms including their en suite facilities. In all the toilets, bathrooms, and en suite facilities that we looked at in the home we observed that the hand wash basins and wet areas were clean. We observed that raised toilet seats and toilet surrounds were clean. We also saw that hoists, bath seats, and shower chairs were clean and stain free. We were shown the cleaning schedules for carpets in the communal areas and people's rooms and saw that they were being vacuumed daily. The provider may wish to note that cleaning schedules that we looked at did not show that carpets were shampooed on a regular basis. In some areas of the home carpets looked discoloured and stained.

We looked at cleaning schedules and checklists for the home. We saw that cleaning checklists were being completed appropriately and that they reflected what we saw when we were walking around the home. The provider may wish to note that we saw a stand – aid hoist in one area of the home which was dirty with grey and brown staining and visible debris on it. The staff member in charge told us that it was the responsibility of the night staff to clean this equipment. However the night staff cleaning rotas did not have this equipment listed. We also noted that the night staff cleaning rotas had not been completed by staff since 3 November 2013. All areas of the home smelt fresh and clean on the day of our visit.

We were shown the homes policies and procedures for infection control. They were all current and in date at the time of our visit. The home had a lead person responsible for infection control. We also saw evidence that the manager completed infection control audits. The last audit had been completed on 25 April 2013.

We were shown evidence that all staff had attended training in infection control within the

past two years. This training had been delivered in line with the provider's policy.

We saw that rooms were equipped with hand washing facilities. We saw that the home had a good supply of personal protective equipment (PPE) and watched staff using and disposing of their gloves and aprons correctly. Staff told us that they had a plentiful supply of PPE. One member of staff told us that the home supplied them with their own supply of rubber gloves as they found that some gloves affected their skin adversely as they suffered with contact dermatitis.

We were shown the homes laundry room which was in the basement of the home. We saw that staff separated and bagged linen up correctly. We were shown the processes that the home used to ensure that laundry was separated and washed at the correct temperatures. We saw that the laundry had a clear flow of dirty to clean laundry and that clean laundry was stored separately to dirty laundry. The home also had arrangements in place to remove clinical waste from the premises. We saw staff segregating, bagging, and storing clinical waste appropriately until it was collected.

The staff that we spoke with demonstrated a good understanding of their role in the prevention of the spread of infection. Staff confidently discussed, when and how they washed their hands, and when they used PPE and how they disposed of it.

We saw that the home had been awarded a five* rating for food hygiene by the local Environmental Health Officer in September 2012.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

There were effective recruitment and selection processes in place.

Appropriate checks were undertaken before staff began work. We looked at three staff files. The home was able to demonstrate that appropriate checks had been completed prior to each staff member commencing work at the home.

A new employee check list was used to ensure all the necessary steps for safe recruitment had been followed, in line with the home's recruitment policies.

The pre-employment checks included two written references being obtained and a verbal verification of the references. Any gaps in the person's employment history were identified and accounted for.

Each person was required to undergo a criminal records check to ensure they had no prior convictions that would make them unsuited to work with vulnerable people. The certificate number and outcome was recorded in the staff file.

Photographic identity was seen and a photo placed in the employees personnel file which was stored electronically.

Original certificates of any qualifications mentioned on the employees application form were seen. Copies of the certificates were stored in the file.

Where staff were applying who were from outside the United Kingdom (UK), the provider checked that they were entitled to work in the home. Their right to residence and any work restriction imposed by the immigration authorities were checked and recorded. UK citizens were required to provide their National Insurance number.

Each prospective staff member was required to complete a health declaration prior to commencing work.

New members of staff were provided with a job description and contract that made clear what their specific role and responsibilities were. They also completed an induction period that allowed them to shadow more experienced staff until they were assessed as

competent to provide care.

Complaints

✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

People were made aware of the complaints system. A copy of the complaint process was available and displayed in the entrance hall to the home. We also saw that the complaint policy contained details of the timescales for responding to complaints. The policy told people where they could follow up the complaint if they were unhappy with how the home had dealt with it. The poster gave contact details for the Care Quality Commission.

People had their comments and complaints listened to and acted on, without the fear that they would be discriminated against for making a complaint. People told us that they felt that if they needed to complain that they would feel comfortable doing so. They said that they felt that staff would listen and act on it and that they felt they wouldn't be discriminated against for complaining. One person said, "If I needed to complain I would, I know they would help me". We saw that the home had regular relative's meetings. The last of these had been on the 15 September 2013. We could see from the minutes of these meetings that relatives were able to express any concerns that they had about the service and also make suggestions for improvements to the service. We could see that where this had happened the manager had listened and had made changes to the service where appropriate.

People's complaints were fully investigated and resolved where possible to their satisfaction. We asked for and received a summary of written complaints people had made and the providers' response. The manager recorded both verbal and written complaints and had a summary of how these complaints had been resolved. We were shown the complaint file and the responses given when people had raised concerns. We saw that complaints had been fully investigated and a response was made, within the agreed timescales, to the complainant.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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