Care Quality Commission

Random inspection report

Care homes for older people

Name:	Birchy Hill Nursing & Residential Home
Address:	Birchy Hill Sway Lymington Hampshire SO41 6BJ

The quality rating for this care home is:	zero star poor service
The rating was made on:	

A quality rating is our assessment of how well a care home, agency or scheme is meeting the needs of the people who use it. We give a quality rating following a full review of the service. We call this review a 'key' inspection.

This is a report of a **random inspection** of this care home. A random inspection is a short, focussed review of the service. Details of how to get other inspection reports for this care home, including the last key inspection report, can be found on the last page of this report.

Lead inspector:	**Date:**							
Craig Willis	1	6	1	1	2	0	0	9

Information about the care home

Name of care home:	Birchy Hill Nursing & Residential Home
Address:	Birchy Hill Sway Lymington Hampshire SO41 6BJ
Telephone number:	01590682233
Fax number:	01590682217
Email address:	
Provider web address:	

Name of registered provider(s):	Angel Care Plc
Name of registered manager (if applicable)	
Type of registration:	care home
Number of places registered:	70

Conditions of registration:		
Category(ies) :	Number of places (if applicable):	
	Under 65	Over 65
dementia	70	0
mental disorder, excluding learning disability or dementia	70	0

Conditions of registration:
The maximum number of service users to be accommodated is 70
The registered person may provide the following category of service: Care home with nursing (N) to service users of the following gender: Either whose primary care needs on admission to the service is within the following category: Dementia (DE) Mental disorder, excluding learning disability and dementia (MD)
The registered person may provide the following category/ies of service only: Care home with nursing (N) to service users of the following gender: Either Whose primary care needs on admission to the home are within the following categories: Dementia (DE) Mental disorder, excluding learning disability or dementia (MD)

Date of last inspection								

Brief description of the care home
The home is registered to provide nursing and personal care for up to 70 older people who have dementia or mental health issues. The home has a garden to the rear and a large car park to the front. The village of Sway has a train station and shops, chemist, post office, GP surgery, church, hotels and pubs. People wishing to live in the home or their representatives are given written information about the home and the service that it provides and are invited to visit the home. A copy of a report of the most recent inspection of the home is made available to people.

What we found:

This random inspection was completed because of concerns we had following the last key inspection on 18 September 2009. The purpose of the visit was to assess whether the home had taken the action we said they needed to in the key inspection report. Since the last key inspection a new manager has been employed in the home.

We inspected the care plans of four people who live in the home. All four plans had been updated since the last inspection and had been added to where necessary. The plan for one person had been updated with a continence assessment that was missing at the last inspection. Two of the plans we inspected had been updated with the addition of information about the support the people need to manage their aggression. These plans gave clear information about what form their aggression was likely to take and the action that staff should take. One of the plans inspected had been updated with clear information about the care the person needed to prevent pressure ulcers. We found that this person had a pressure relief mattress on their bed that matched what was assessed as necessary in their care plan. We also found that a person who was assessed as needing one to one care had a member of staff providing specific support to them. Whilst the care plans now give the information they need to, we still identified some areas that required further clarification. Some of the plans contained vague information and instruction for staff, for example, "staff to give reassurance and monitor movements at all times" and "requires permanent observation". Neither of these two people were assessed as needing one to one support or were provided with it so it would not be possible to follow the instruction in the care plan. The manager reported that she had taken remedial action to correct the errors and missing information in the plans and she now planned to introduce a new care planning system after staff training. We assessed that the requirements in the key inspection report relating to care plans and ensuring people receive the care and treatment they need had been complied with.

During the visit we inspected the medication storage and records. The medication administration record for the morning of the visit had not been completed. The nurse on duty told us he had administered medication to all of the people living on two wings of the home, but had not completed the administration record sheet as he had not had time. The manager was present during this conversation and informed the nurse that he had not followed the correct procedure. Since the last inspection the home has obtained a controlled drugs cabinet and it has been fitted in the clinical room. We inspected the controlled drugs register and found that it had not been completed correctly. One entry in the register records that ten pain relief patches were received on 14/11/09 and one was administered to the person at 1100 on 16/11/09. This indicated that the record had not been completed when the medication was received into the home. We were in the clinical room at 1100 and the nurse did not come in to remove the patch whilst we were there. The medication administration record for this medication records that it was administered at 0800 on 16/11/09. The nurse who administered the medication was spoken with during the visit and reported that the medication had been administered at approximately 1100. The patch administered needs to be replaced every 72 hours, so it was not clear when the person would next need it. This may lead to the person not receiving the pain relief they need.

The manager reported that since the last inspection a contract for the disposal of unused

and spoilt medicines had been signed. There were records of medication that had been disposed of and there were specific bins for the disposal of medicines available in the clinical room. It was noted that one of these bins was very full. The manager reported that this was due to a backlog of unused medication that they were clearing and that they had amended their processes for ordering medication to prevent a similar build up in future.

It was noted that the temperature of the clinical room was recorded as being above 25 degrees Celsius on four days in the two weeks before the visit. The medication stored in that room states that it should be stored below 25 degrees. This is to prevent the medicine being altered by the temperature and becoming ineffective. Although staff had recorded the temperature no action had been taken to ensure that the room was cooled. The manager reported that she would look at ways of making the air conditioning units in the room more effective.

During the visit all medication in the home was securely stored in locked cabinets. We found that the requirements in the last key inspection report relating to disposal of medicines and secure storage of medicines had been complied with. We found that the requirement relating to ensuring complete and accurate records are made of all medicines given to people had not been complied with. We have also made a new requirement that medicines must be stored at the correct temperature.

During the visit we spoke with the activities co-ordinator, who reported that a new style chart recording the activities people have participated in has been introduced. We looked at the records of four people who live in the home during the visit. Each person had an 'assessment and activity / therapy intervention' sheet that had been completed since the last inspection. This set out some activities that the person completing assessed would be suitable for the person. The assessments did not state who had completed them, when they were completed or where the information came from, for example discussions with the person themselves or with family members. The records of activities completed had more entries that at the last key inspection, with activities recorded including one to one discussions, singing, keep fit and a quiz. The activities co-ordinator reported that staff do not always complete the activities records fully. The manager reported that she was aware more progress was needed with activities. We assessed that although further improvement was planned by the home there was sufficient evidence to say the home had complied with the requirement from the last key inspection relating to activities.

During the visit we inspected the recruitment records of three members of staff that had started work in the home since the last key inspection. We found that two of the staff files contained evidence of a criminal records bureau disclosure and two written references that had been obtained before they started work. Both of the references for one of these staff members were general references, addressed 'to whom it may concern' and were dated between 7 and 11 months before the person started work. The file for the third member of staff had only 1 written reference on file and that was written 20 months before the person started work in the home. The reference that was on file was not from the referee the person had nominated on their application form. The manager reported that these staff had been recruited before she started working at the home and she acknowledged that the recruitment systems were not working effectively. As a result the manager said she has changed the systems to ensure she has copies of people's references and other checks in the home before a new member of staff starts work. We assessed that the requirement in the last key inspection report relating to staff

recruitment checks had not been complied with.

The last key inspection report contained a requirement relating to staff training. We did not assess this requirement as the time-scale for compliance had not expired. The manager reported that staff had been booked on a number of training courses and training had been planned throughout the year. We will assess this standard fully at the next inspection of the home.

We inspected the reports of visits to the home by the provider or their representative during the visit. There was one report available that had been completed since the last key inspection. This report made reference to another visit on 23 September 2009 but there was no report available of this visit. The report that was available had been completed by a Director of Care for Angel Care. The report did not make specific reference to the outstanding requirements from the last key inspection. The report stated that medication was not assessed during the visit, despite there being three requirements relating to medication following the last key inspection of the home. There was no action plan as part of the report. The manager reported that she was aware of the report but did not use it as part of her work as there were not specific actions to be achieved. We assessed that the requirement from the last key inspection relating to visits to the home by the provider or their representative has not been complied with.

Following the last key inspection the provider submitted a report to us setting out what action they were going to take to address the deficiencies in the service that had been identified. The manager reported that she had developed a process for regular auditing of the service, including analysis of accidents and incidents, health and safety, staff training and reviews of documentation such as care plans. The manager has used these systems to plan the action she is taking to move the service forwards to provide good outcomes for people who live there. We assessed that the work done has demonstrated that the requirement relating to quality assurance has been complied with, however, there is further work needed to ensure all of the identified actions are implemented.

What the care home does well:

The care plans have been reviewed and now contain more detailed information about how people's needs should be met.
People are now provided with the equipment they are assessed as needing, for example pressure relief mattresses that are suitable to meet their assessed needs.
The home has increased the activities that are provided for people, although further work in this area is needed to ensure these improvements are sustained and the provision of activities is further developed.
The manager has developed better systems for assessing how the home is performing, however, further work is needed to ensure all of the identified actions are implemented.

What they could do better:

The medication systems at the home are still not safe. The failure to keep accurate records of the medication received into the home or administered to people increases the risk that people will not receive the medication they have been prescribed at the right time. Medication is also not being stored at the correct temperature. This means there is

an increased risk that the medication will not be effective for people.

The systems for checking new staff before they start work in the home are still not safe. This means that the manager does not have information available to judge whether the staff member has the skills and experience necessary to provide safe care to people.

The systems to ensure the provider is aware of what is happening in the home are not effective. This means the provider does not have clear information about about the action that has been taken to address the shortfalls we have identified in the service. It also means the manager is not provided with clear guidance about the action she needs to take.

If you want to know what action the person responsible for this care home is taking following this report, you can contact them using the details set out on page 2.

Are there any outstanding requirements from the last inspection?				
	Yes	☐	No	☑

Outstanding statutory requirements

These are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action

Requirements and recommendations from this inspection:

Immediate requirements:

These are immediate requirements that were set on the day we visited this care home. The registered person had to meet these within 48 hours.

No.	Standard	Regulation	Requirement	Timescale for action

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
1	9	13	The registered person must ensure medication is stored at a temperature in line with the manufacturer's guidance. This will help to ensure the medication remains effective.	31/12/2009

Recommendations

These recommendations are taken from the best practice described in the National Minimum Standards and the registered person(s) should consider them as a way of improving their service.

No	Refer to Standard	Good Practice Recommendations

Reader Information

Document Purpose:	Inspection Report
Author:	Care Quality Commission
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Further copies from:	0870 240 7535 (telephone order line)

Our duty to regulate social care services is set out in the Care Standards Act 2000. Copies of the National Minimum Standards –Care Homes for Older People can be found at www.dh.gov.uk or got from The Stationery Office (TSO) PO Box 29, St Crispins, Duke Street, Norwich, NR3 1GN. Tel: 0870 600 5522. Online ordering from the Stationery Office is also available: www.tso.co.uk/bookshop

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