Serendib Limited

The Birches

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This was a focused inspection which we carried out and was unannounced on 27 March 2018.

The Birches is a residential home which provides care to older people including some people who are living with dementia. The Birches is registered to provide care for up to 19 people. At the time of our inspection there were nine people living at the home.

The Birches is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

We carried out an unannounced comprehensive inspection of this service on 21 November 2018. Breaches of legal requirements were found. After the comprehensive inspection, the provider did not write to us to say what they would do to meet legal requirements in relation to the breaches. We inspected the service against two of the five questions we ask about services: 'Is the service Safe?' and 'Is the service Well Led?' This is because the service was not meeting some legal requirements in these areas.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our previous inspection of this service on the 21 November 2017 we found that the medicines system was not safe as staff had failed to ensure allergy information was up to date, and staff were administering a medicine to a person that they were allergic to. The policy for medicines administration had not been updated to include any information on how staff systematically audit the system to ensure it was operated safely. There was no evidence the storage temperatures of medicines were recorded regularly.

There were also issues around infection control, and an unsafe environment as electrical work had to be undertaken to ensure the environment was safe. We found the decoration of some parts of the home was poor and a frayed carpet was a trip hazard.

These were all breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

We also found that the service had not ensured that people's health and welfare needs were protected and promoted as good governance systems were not comprehensively in place. This was a breach of Regulation 17 HSCA RA Regulations 2014 Good governance.

We undertook this focused inspection to confirm that they now met legal requirements. This report only

covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Birches on our website at www.cqc.org.uk.

At this inspection we found the provider had made some changes, but overall there was little improvement in the overall safety or governance of the home and the provider continued to be in breach of the regulations of the Health and Social Care Act 2008.

We found there was a continued lack of oversight by the provider to check that quality monitoring had been carried out effectively. The quality monitoring systems included reviews of people's care plans, food temperature checks and checks on medicines management. These checks and systems were still not reviewed by the provider to ensure people received a good, safe quality of service. Accidents, incidents and falls continued to be recorded but were still not analysed to reduce the likelihood of further incidents from happening.

Safety audits continued to be undertaken by staff, which was also demonstrated at our last inspection. The shortfalls we saw at that time, had not been improved upon, which mean that audits fell short of covering all the areas necessary to ensure people's safety in the home. For example audits of the medicine system had not revealed the information that people's allergies differed from the care plan and the information in the medicines administration file. Where people had medicines prescribed on a PRN or 'as required' basis, recording of when these had been administered was not in place.

The potential for cross contamination or cross infection in the home had not been reduced. We found areas could still not be disinfected properly, and the storage of equipment encouraged the transfer of infection. These issues became apparent as the provider had not produced procedures to ensure they knew what the processes included from beginning to end. Similarly there was no process or procedures to ensure audits were comprehensive and covered all areas to ensure people were safe in the home.

Some areas of the environment had improved and most of the electrical issues had been completed, the frayed carpet had been replaced, and the corridor walls had been painted. We found there were further issues around the safety of fire and evacuation procedures where a recent inspection had raised concerns with the basement area, where detectors were required and not in place.

There were a number of bedrooms and bathrooms that were not being used and we could not find any evidence where the water systems were maintained to reduce the potential for legionella growth.

People had fallen in the home, but there had been no falls audit to investigate the circumstances to see if patterns emerged. Checks on the first aid boxes had not been done which meant they could not be relied on in an emergency to provide staff with first aid items.

The provider had not ensured good governance systems had improved and these remain ineffective.

We found continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made

significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Some areas of safety had improved since our last inspection. However people were still at risk from harm as staff did not ensure all areas of medication administration was safe. The administration of medicines was not consistently secure and written instructions to ensure medicines were given accurately were not in place.

Infection control procedures were not detailed, and people were placed at risk from the potential for transfer of infection from a poor environment.

Policies and procedures had not been updated to include information for staff to ensure policies were followed consistently.

Periodic safety tests of the environment had been recorded by staff, though gaps were not identified and shortfalls were not identified. Safety certificates produced by external contractors were available, but remedial work had not taken place to ensure the safety of people.

Is the service well-led?

Inadequate

The service was not well led.

Some quality assurance systems were in place, however there was no oversight or governance by the nominated individual to ensure people' safety was not compromised.

Records of some audits were completed by staff, however these were not overseen by the nominated individual to ensure that shortfalls were identified, resolved or improved and did not endanger the safety of those in the home.

The Birches

Detailed findings

Background to this inspection

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

We undertook an unannounced focused inspection of The Birches on 27 March 2018. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 21 November 2017 inspection had been made.

The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led. This is because the service was not meeting some legal requirements.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our on-going monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

We looked at information received from local authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. We considered their concerns and on-going work to improve the service provided to people.

We reviewed the provider's statement of purpose. A statement of purpose is a document which includes a standard required set of information about a service. We looked for notifications the provider had sent to us, but could not find any. Notifications are changes, events or incidents that providers must tell us about.

We spoke with two people who used the service, the nominated individual, a senior carer, one care worker and the cook.

We looked at records relating to all aspects of the service including care, staffing, and quality assurance. We also looked at three people's care records.

Some of the people living at the service were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. Therefore, we used the short observational framework tool (SOFI) to help assess whether people's needs were appropriately met and identify if they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

At our previous inspection in November 2017 the provider was in multiple breach of one regulation of the Health and Social Care Act 2008 (Regulated Activities). The breaches were evidenced in regulation 12, safe care and treatment because the systems in place for the management of medicines was not adequate. Infection control procedures were not sufficient and there was a risk of cross contamination which put people using the service at risk. The environment had not been suitably maintained which people at risk of unsafe care and treatment. At this inspection we found that some improvements had been made in some areas but there continued to be breaches of the legal requirements.

At our previous inspection on the 21 November 2017 we found the medicines system was not safe as staff had failed to ensure allergy information was up to date, and staff were administering a medicine to a person that they were allergic to. The policy for medicines administration had not been updated to include any information on how staff systematically audit the system to ensure it was operated safely. There was no evidence the storage temperatures of medicines were recorded regularly.

Following that inspection the provider failed to send us an action plan stating how they intended to address these shortfalls.

At this inspection we found that some areas had improved but there were still significant shortfalls. The provider had arranged for staff to commence monitoring the storage temperature of medicines. Records demonstrated they were stored within limits which ensured they remained potent. Staff we spoke with were aware what to do if storage temperatures were above or below these limits. However not all liquid medicines which are required to have a date when they were opened, had one added to the bottle to ensure they were used in a timely fashion and remained potent.

Auditing of the medicines system had commenced and staff checked the system regularly. However the medicines policy had still not been updated and the provider had failed to put in place a procedure to ensure staff checked the medicines system systematically. Staff had made a number of checks but these had failed to reveal the absence of information vital to ensuring consistent medicine administration. For example there was an absence of written records where people were prescribed PRN or 'as required' medicines. For others who were allergic to some medicines there was inconsistent and contradictory information recorded in the MAR charts and in their care plan. These did not match, one person had three additional medicines recorded in their care plan that they were allergic too which was not recorded in the MAR chart.

Staff were observed regularly to ensure they remained proficient in medicines administration. Of the seven staff that were qualified to administer medicines, one had their competency checked in March 2017, another had been checked but there was no date entered on the form and the other five staff had yet to have their competency checked.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014 Safe care and treatment.

At our previous inspection on the 21 November 2017 we found issues around infection control.

The laundry floor did not ensure it could be cleaned or disinfected properly, and the plinth that the washing machine was placed on was rusty which did not allow adequate cleaning or disinfection. There was inadequate separation between clean and soiled linen, which placed people at risk of cross infection or cross contamination in the home. Some areas of the home did not have pedal operated bins to ensure infection controls were upheld. Staff were able to access to the policy and procedure on infection control however it was not personalised to the home, and did not include procedures to enable the reduction of cross infection or cross contamination.

At this inspection we found that some areas had improved. The laundry floor had been re-sealed and the washing machine plinth had been improved, and so reduced the potential for cross infection and cross contamination.

However, we found a bucket and two mops were stored in the laundry. Staff were aware that the colour coded mops were used in different areas of the home. Red was used in the toilet areas and blue on the hard flooring. Both these mops were placed together in the same red coloured bucket, which increased the potential for cross infection and cross contamination. The policy for infection control has not been updated, and there was no procedure for staff to refer to when cleaning or disinfecting areas.

We found infection control risks in a number of other areas in the home. On the ground floor, the shower room and bathroom require attention to remove the rusty items, and treat the flaking paint on the wall. Both wash hand basins require attention. The stair carpet to the first floor is stained and a yellow waste bin was stored in a corridor. There were still no adequate and consistent arrangements for keeping the service clean and ensure that people were protected from acquired infections.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Infection control.

At our previous inspection on the 21 November 2017 we found issues around an unsafe environment. There was no evidence to prove the environment had been suitably maintained and systems were safe. There was an electrical report which had not been actioned. There was a frayed carpet which was a trip hazard and there was bricks supporting pipework in a toilet. There was wallpaper which had been torn and in other areas was peeling off the walls and there was no written plan for the proposed refurbishment of the building.

At this inspection we found that some areas had improved. Most of the electrical issues in the report had been completed, and only advisory items remained to be actioned. The frayed carpet had been replaced, and the corridor walls had been painted. The bricks supporting the pipework had been boxed in and this area was now cleanable and less unsightly.

However we were still unable to access any written plan of refurbishment, which may have included improvements to areas we identified previously in the report. We asked the staff if they were aware where any plan was located they said they did not know. Safety checks on the fire and evacuation system had been done, however the latest electrical report stated the system was 'unsatisfactory' but did not explain why. We contacted the electrical contractor who stated improvements were required in the fire detection in the basement laundry area. We could not find any action by the provider to resolve the issue.

There were a number of bedrooms and bathrooms that were not being used. We could not find any evidence where the safety of people had been considered and the water systems maintained to reduce the potential for legionella growth.

People had fallen in the home, but there had been no falls audit to investigate the circumstances to see if patterns emerged. Checks on the first aid boxes had not been done which meant they could not be relied on in an emergency to provide staff with first aid items.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe environment.

Care plan assessments are in place and demonstrated that peoples' abilities had been assessed. However there were still no recognised process in place, for ensuring staffing levels were adequate, and the right mix of staff with the required skills, competencies, qualifications, experience and knowledge, were available to meet people's individual needs. For example three nights of the week there was no 'senior' carer who could be identified to take charge in an emergency.

We looked at the people's personal evacuation plans (PEEPs). These inform staff how to safely assist people to leave the premises in an emergency. Copies of the PEEPs continued to kept on people's files so were not readily available in an emergency. We saw these had not been reviewed recently, but reflected people's current mobility needs. Staff we spoke with were aware of the location of the PEEPs and fire and emergency evacuation equipment.

People told us they felt safe with the staff who supported them. One person said, "I feel safe here, the staff are nice." A second person said, "They [staff] always have a smile on their face."

Care staff safeguarded people from abuse. Staff said they would report any concerns of abuse to a senior member of staff, or where necessary contact and external agency. For example the local authority safeguarding or CQC and said they would do so if they felt their concerns were not dealt with internally. Staff confirmed they had been provided with the relevant training and guidance to ensure people were safe. However we could not confirm this due to the continued lack of training records.

Staff we spoke with had a clear understanding of the different kinds of potential abuse, and said they had received training on how to protect people from abuse or harm. They were aware of their role and responsibilities in relation to protecting people and what action they would take if they suspected abuse had occurred within the home.

One member of staff said, "If someone was being abused, I would tell the seniors' (senior care staff). Staff we spoke with were aware of whistle blowing, and said they had not witnessed anything that required to be reported on or caused them concern. A second member of staff told us they were currently updating their online safeguarding training.

Staff told us they felt there was enough staff to care safely for the people in the home, as the number of people who used the service had decreased recently. There was now a senior carer and two care staff in the mornings, afternoon and evening and two waking care staff at night. A cook and housekeeper were also included on the rota.

However staff confirmed they had still not taken part in a recent fire drill and the last recorded fire drill was July 2017. Following the last inspection we were assured by the provider they would organise fire drills to

bring the staff group up to date with the evacuation procedures. We saw that there had been recent fire training which the majority of staff had attended. However staff confirmed there had been no fire drill included in this training. That meant there was a continuing potential that staff were not fully aware what action to take in the event of such an emergency.

Staff were subject to a thorough recruitment procedure that ensured staff were qualified and suitable to work at the home. There had been no new staff employed since our last inspection. We could not gain access to the recruitment files as the provider was unable to attend the inspection, and care staff do not have access to the personnel files held at the home.

There continued to be a lack of consistent overseeing by the nominated individual, where there was no review of incidents or documents to ensure short falls were identified and addressed. This continued of analysis resulted in there being no lessons learnt. If there had been that could have been used to inform staff development and staff practice to ensure a safe environment.

Inadequate

Is the service well-led?

Our findings

At our previous inspection on the 21 November 2017 we found the service had not ensured that people's health and welfare needs were protected and promoted. This was because good governance systems were not comprehensively in place and those that were had failed to identify shortfalls in the service.

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

Following that inspection the provider failed to send us an action plan stating how they intended to address these shortfalls.

There were systematic and widespread failings in the oversight and monitoring of the service which meant people did not always receive safe care which maintained and improved their well-being. Despite the previous inspection identifying shortfalls in governance systems and the overall safety in the home, we found that insufficient progress had been made to the auditing and governance systems of The Birches.

At this inspection we found that the provider had continued to arrange for the senior staff to undertake some audits. However the provider did not undertake any checks to ensure any audits that had been completed were accurate, or ensure that audits were comprehensive and covered all of the homes environment, policies and procedures, and care planning and support documentation. That did not ensure the safety of people in the home, or demonstrate a well led home.
We asked the senior carer on duty what the provider did when they visited they said, "In the past two months he has visited regularly." They went on to say, "[Named] does a walk around, does shopping, but does not look at audits, he questions the seniors if they have been done."

We found evidence that some audits were completed. For example the medicines audit was partly completed by staff. However the provider had failed to ensure a procedure was in place that could be followed and ensure all areas were audited and safe. The result was the audit was not comprehensive and areas that required to be checked were missed. There was a similar situation with the checking of the environment, control of infections, falls and equipment.

People were not included the running of the home. There was no evidence people were included in decisions about their care, support and service they received. At the time of our inspection, surveys or other methods of collating opinions or views about the service provided had not been undertaken with people or their relatives. This meant that opportunities had not been taken to gather feedback to improve the service for the people living at The Birches.

The provider did not have systems or methods in place to continuously learn, and therefore improve the service. For example, the information we supplied through the last inspection report was actioned and changes made to the environment policies and procedures. However with the limited knowledge or foresight of the provider and lack of registered manager improvements have been limited.

The provider did not understand their responsibility to submit notifications to the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law in a timely way. For example one person had a fall which resulted in a head injury, there was no notification sent to CQC to indicate the outcome of any investigation or action to reduce the risk of any future similar occurrence.

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

We found the last report was not displayed in the home, which is a legal requirement.