Archmore Care Services Ltd

Birchwood Grove

Inspection report

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Ratings

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

Overall summary

We inspected Birchwood Grove on the 19 and 20 October 2015. Birchwood Grove provides accommodation and nursing care for up to 23 people, who have nursing needs, including poor mobility and diabetes. Most people were living with advanced dementia. There were 22 people living at the home on the days of our inspections. The age range of people varied from 60 – 100 years old.

The provider, Archmore Care Services Ltd had taken over the home in April 2014. Since April 2014, Birchwood Grove had been subject to various renovations, including new flooring, new paintwork and building extensions. Accommodation was provided over two floors with stairs and a passenger lift connecting the floors. Hallways were light and bright and a garden at the back of the home was available for people to use. This was the first inspection of Birchwood Grove under the new provider.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People commented they felt safe living at Birchwood Grove. One person told us, "It's safe and snug." However, for people at high risk of skin breakdown, turning charts

Summary of findings

were not consistently in place. The recording of topical cream was not clear and failed to provide sufficient guidance. Where people's call bells had been removed, the provider was unable to demonstrate that people were checked upon hourly as per instructions within their risk assessment. We have therefore identified this as an area of practice that needs improvement.

Moving and handling risk assessments did not consistently provide sufficient guidance on the size of the sling required to safely move and transfer a person. We have made a recommendation for improvement in this area.

The requirements of the Mental Capacity Act 2005 (MCA) were not being adhered to. Mental capacity assessments were not completed in line with legal requirements. Decisions were being made in people's best interests; however, there was no evidence of a mental capacity assessment. Where restrictive practice was taking place, next of kin's were signing consent forms without appropriate authority. We have therefore identified this as an area of practice that needs improvement.

Staff felt the home was sufficiently staffed. People's care needs were met and the home presented as calm and relaxing. However, people living with advanced dementia were left for periods of time with little activity and stimulation. We have therefore identified this as an area of practice that needs improvement.

Feedback had been sought from people, relatives and staff. Resident and staff meetings were held on a regular basis which provided a forum for people to raise concerns and discuss ideas. Incidents and accidents were recorded, and consistently investigated.

Staff members had a good understanding of people's personal history, likes, dislikes and personality traits. It was clear staff had spent time building rapports with people. Staff interacted with people in a kind and friendly manner and people appeared at ease in the company of staff. People and their relatives spoke highly of the caring nature of staff. One person told us, "The carers are all nice."

Effective recruitment procedures were in place. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed to work in Birchwood Grove all had registration with the nursing midwifery council (NMC) which was up to date. Training schedules confirmed staff's training was up to date and nursing staff received clinical training.

Nursing and care staff felt supported by management, said they were well trained and understood what was expected of them. There was sufficient day to day management cover to supervise care staff and care delivery. The current management structure at the service provided consistent leadership and direction for staff.

Everyone we spoke with was happy with the food provided and people were supported to eat and drink enough to meet their nutritional and hydration needs. Any dietary requirements were catered for and people were given regular choice on what they wished to eat and drink. Risk of malnourishment was assessed and acted upon.

The provider and registered manager undertook quality assurance reviews to measure and monitor the standard of the service and drive improvement.

We found one breach 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 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

Birchwood Grove was not consistently safe. Medicines were stored safely and people received their medicines when they needed them. However recording of topical creams was inconsistent and lacked guidance. Turning charts were not consistently in place and the provider was unable to demonstrate that people were checked upon hourly as per their risk assessment. Moving and handling risk assessments were not robust and lacked guidance.

Staff had received training in how to safeguard people from abuse and were clear about how to respond to allegations of abuse. Staff recruitment practices were safe.

Is the service effective?

Requires improvement

Birchwood Grove was not consistently effective. The requirements of the Mental Capacity Act 2005 (MCA) were not being met. Capacity assessments were not completed in line with legal requirements. Next of kins were making decisions for people without the appropriate authority to do so.

People and relatives spoke highly of the staff and felt staff were sufficiently trained. People were supported to have sufficient to eat and drink and maintain a balanced diet. Staff were aware of special diets and dietary preferences.

People had access to relevant health care professionals and received appropriate assessments and interventions in order to maintain good health.

Is the service caring?

Good

Birchwood Grove was caring. People's friends and family were welcomed at the home and staff supported and encouraged these relationships.

Staff demonstrated they cared through their attitude and engagement with people. People were valued and staff understood the need to respect their individual wishes and values. Privacy and dignity was upheld.

Relatives were encouraged to bring their pets in and the provider recognised the companionship pets brought to older people.

Is the service responsive?

Requires improvement

Birchwood Grove was not consistently responsive. A dedicated and compassionate activities coordinator was in post who provided meaningful activities. However, in their absence, people were left for periods of time with inactivity and only the television for stimulation.

People told us they felt able to talk freely to staff or the management team about their concerns or complaints.

Summary of findings

Is the service well-led?

Good

Birchwood Grove was well-led. People, relatives and staff spoke highly of the registered manager and provider. The provider promoted an inclusive and open culture and recognised the importance of effective communication.

There were effective systems in place to assure quality and identify any potential improvements to the service being provided. Forums were in place to gain feedback from staff and people. Feedback was regularly used to drive improvement.

Birchwood Grove

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 checked 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 visited the home on the 19 and 20 October 2015. This was an unannounced inspection. The inspection team consisted of two Inspectors, a Specialist Nurse Advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection, we spoke with six people who lived at the home, a visiting relative, five care staff, registered nurse, chef, provider and registered manager. Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority, looked at safeguarding concerns that had been raised and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home.

We looked at areas of the building, including people's bedrooms, the kitchens, bathrooms, and communal lounges. Many people were living with advanced dementia and were therefore unable to engage with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during the morning and afternoon on both days of the inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we reviewed the records of the home. These included staff training records and procedures, audits, five staff files along with information in regards to the upkeep of the premises. We also looked at ten care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Birchwood Grove. This is when we looked at their care documentation in depth and obtained their views on how they found living at Birchwood Grove. It is an important part of our inspection, as it allowed us to capture information about a selected group of people receiving care.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living at Birchwood Grove and were comfortable with the staff that supported them. One person told us, "It's safe and snug." A visiting relative confirmed they felt confident leaving their loved one in the care of the staff. Nursing and care staff felt confident people's safety was protected and the environment was maintained to a high standard. Despite people's high praise, we found elements of care which were not consistently safe.

Management of pressure damage is an integral element of providing care to people living in nursing homes. Pressure damage is often preventable and requires on-going monitoring and nursing care input. On the days of the inspection, no one was experiencing a grade two, three or four pressure ulcer as described by the European Pressure Ulcer Advisory Panel (EPUAP) grading system. People's susceptibility to pressure damage was assessed using the Waterlow Score, a risk assessment scoring systems for pressure area damage. Where people had been identified at high risk of skin breakdown, a skin integrity care plan was implemented which provided guidance on the actions required to minimise the risk. For example, one person had a Waterlow score of 23 (high risk), their subsequent risk assessment identified the need for a profiling bed with an air flow mattress and to be repositioned every two to three hours. However, the provider was unable to demonstrate that the person had been re-positioned every two to three hours, as a turning chart to record this was not in place. We found this was a consistent theme throughout the home. We brought this to the attention of the registered manager who took action immediately and began implementing turning charts for staff to complete.

For people assessed at high risk of skin breakdown, topical creams (medicine that is applied to body surfaces) were applied as part of the risk management plan to reduce the risk of skin breakdown. However, recording of the application of topical cream was not clear. Documentation failed to record the name of the topical cream to be applied, how often and where. Recording by staff noted that topical creams were applied all over. Due to the nature of topical creams, they should only be applied to the affected areas of the skin or areas at risk. We brought this to the attention of the registered manager and have identified this as an area of practice that needs improvement.

Guidance produced by the Health and Safety Executive identified that, 'assessment of risk is a significant component of safe care. Risk to both the person being cared for and those providing care, will vary greatly according to the individual's needs, the environment where care is provided, the type of care being provided and the competence of the staff member.' Due to the care needs of people living at the home, the majority of people required support from staff members to safely move and transfer. Throughout the inspection, we observed a sample of moving and handling transfers. Two members of staff were always present along the use of a mobility aid (hoist). Staff continually explained to the person what was happening, providing reassurance and talking to the person throughout the transfer. Individual moving and handling risk assessments were in place which considered individual transfers, such as bed to chair or sitting to standing and the equipment required. However, the risk assessment failed to specify what hoist would be appropriate, the sling size required for the individual and what sling attachment loops should be used. The risk assessment also failed to take into account the views and preferences of the individual being hoisted and what may prevent a safe transfer.

We asked staff members how they knew what sling size to use and what loop attachments were required to safely move and transfer people. Staff confirmed sling sizes were used based on the weight of people. Throughout the inspection, we observed that people were supported to move and transfer in a safe manner; however, for new members of staff, sufficient guidance would not be available. We brought this to the attention of the registered manager who on the second day of the inspection had begun reviewing all moving and handling risk assessments. We have identified this as an area of practice that requires on-going improvement.

We recommend that the service considers the Health and Safety Executive guidance: Getting to grips with hoisting people.

A call bell system was available in people's bedrooms and bathrooms which enabled people to request assistance from staff. We were informed by staff that some people's call bells had been removed due to risks associated with having their call bell in the room, such as becoming entangled in the call bell or being unable to use the call bell. Risk assessments were in place which documented the reasons why call bells were removed. For example, one

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person's risk assessment identified that due to the advanced stages of their dementia, they would struggle to understand the purpose of the call bell and there could be the risk of them becoming caught up in lead of the call bell. To mitigate the risk, it was agreed for the call bell to be removed and for the person to be checked upon hourly. Staff members told us they had checked but identified this was not documented. Throughout the inspection, we identified two people living with significant advanced dementia who remained in bed. The provider was unable to demonstrate that these people had regularly been checked upon in line with their risk assessment. We have therefore identified this as an area of practice that needs improvement.

On both days of the inspection, Birchwood Grove presented as calm and relaxing. It was clear staff members were busy but were not rushed. Staffing levels consisted of four care staff in the morning, three in the afternoon and two at night. Registered nurses were on site 24 hours a day and during the week, ancillary staff covering the catering and housekeeping, and the management team were also present. Staff members commented they felt the home was sufficiently staffed. One staff member told us, "The staffing levels are fine, no concerns." Another member of staff told us, "The staffing levels are good."

Medicines were managed safely and consistently. People commented they received their medicines on time and people were also encouraged to self-administer their own medicines. Where people self-administered, a robust risk assessment was in place along with input from the GP. As part of the inspection, we spent time observing medicines being administered. Medicines were administered by the registered nurse. Whilst administering medicines, the registered nurse preserved the dignity and privacy of the individual. For example, they gained consent from the individual and clearly explained to the person, it was time for their medicine. A clear, non-touch technique was used when administering the medicine.

Medicines were ordered in a timely fashion from the local pharmacy and Medication Administration Records (MAR charts) indicated that medicines were administered appropriately. MAR charts are a document to record when people received their medicines. Records confirmed medicines were received, disposed of, and administered correctly. Birchwood Grove had a dedicated medicine room available which safely stored medicines in lockable trollies. Medicine fridges were maintained and kept at a recommended temperature. Extreme temperatures (hot and cold) or excessive moisture causes deterioration of medicines and some are more susceptible than others. Documentation confirmed the temperatures of fridges and clinical rooms were checked on a daily basis and were consistently within the recommended limits.

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised at the home. Staff files confirmed that staff had completed an application form, references were obtained and forms of identification were present. Disclosure and Barring Service checks (DBS) had been requested and were present in all records. Staff files contained evidence to show where necessary; staff belonged to the relevant professional body. Nursing staff were registered with the Nursing Midwifery Council and had up to date pins. This showed us that the provider had checked that people had no record of misconduct or crimes that could affect their suitability to work with people.

There were a number of policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed staff had received safeguarding training as part of their essential training at induction and that this was refreshed regularly. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. Staff members were clear of their own responsibilities under the Care Act 2014 and confirmed they would not hesitate in raising a safeguarding concern.

Requires improvement

Is the service effective?

Our findings

People and visitors spoke positively about the home and the care and support provided by the team of staff. One person told us, "I tell them how I feel." Another person told us how staff listened to them. Staff members spoke highly of the training they received and felt the provider encouraged them to pursue training courses which would aid their development. Although, people, visitors and staff spoke highly of the home, we found areas of practice which were not consistently effective.

High levels of restrictive practice took place at Birchwood Grove. For example, to exit the home or enter the garden, a key code was required. A stair gate was in use, observations of care found many people had bed rails in place. Lap belts were used along with reclining chairs. Where restrictive practice was implemented, we found the principles of the Mental Capacity Act 2005 (MCA) were not being adhered to. The MCA 2005 is designed to protect and restore power to people who lack capacity to make specific decisions. The philosophy of the legislation is to maximise people's ability to make their own decisions and place them at the heart of the decision making. Where people had bed rails in place, bed rail risk assessments were in place which considered the person's likelihood to roll out of bed and whether they may get out of bed unsupervised. Under the Mental Capacity Act (MCA) 2005 Code of Practice, where people's movement is restricted, this could be seen as restraint. Bed rails are implemented for people's safety but do restrict movement. The bed rails risk assessments failed to identify if the person consented to the bed rails. Where people could not consent to bed rails, mental capacity assessments had not been completed. Assessment of capacity should be undertaken to ascertain if the person could consent to the restriction of their freedom for example use of bed rails. If not, it must be explained why the bed rails were implemented in their best interest and if other options were explored. We identified people whose bed rail risk assessment identified they were at low risk of falling out of bed and at low risk of getting out of bed unsupervised. Their care plan also identified they required support to regularly re-position, but it was agreed for bed rails to be implemented. There was no documentation of any other least restrictive options considered, such as a low profile bed.

For people who required use of lap belts or reclining chairs, risk assessments were in place, but for where the person was unable to consent to the form of restraint, the provider had not completed mental capacity assessments. A restraint form was in place which was often signed by the person's next of kin. The form identified whether the next of kin consented to the use of forms of restraint, such as bed rails, lap belts and reclining chair. Where the next of kin had provided consent, we requested evidence that the next of kin had lasting power of attorney for health and welfare to make that specific decision. The provider was unable to demonstrate that the person's next of kin had appropriate authority to be making these decisions. There was also no underpinning mental capacity assessment to reflect the person lacked capacity to make the specific decision regarding the use of restraint.

When looking at people's care plans, we found the provider had completed mental capacity assessments, but again had not adhered to the principles of the Mental Capacity Code of Practice. The assessment was not decision specific (didn't include a decision) and also failed to record what date and time it was undertaken. Therefore the provider could not demonstrate what decision was required to be made. Individual's care plans, also made reference to decisions made in people's best interest. For example, one person's call bells were noted as being removed in their best interest. However, there was no underpinning mental capacity assessment or evidence of a best interest meeting being held.

Due to the above concerns in relation to mental capacity assessments not adhering to the principles of the Code of Practice and not being completed in line with legal requirements, we have identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff did however; demonstrate a firm understanding of the concept of consent and gaining consent. One staff member told us, "Mental capacity is about people's ability to make informed decisions. We always ask people and gain their consent. For people who may not be able to verbally communicate, we monitor their facial expressions and body language to gauge if they consent or not." Another staff member told us, "Mental capacity is about protecting people who are unable to make decisions for themselves."

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS form part of

Is the service effective?

the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place intended to keep people safe. Where restrictions are needed to help keep people safe, the principles of DoLS ensure that the least restrictive methods are used. In March 2014, changes were made by a court ruling to DoLS and what may now constitute a deprivation of liberty. If a person is deemed under continuous supervision and control and not free to leave, they may be subject to a deprivation of liberty. The registered manager told us that DoLS applications had been made for all people living at the home, apart from one person whereby DoLS was not applicable. Staff members had a good understanding of the meaning of DoLS and were consistently aware that DoLS applications had been made for everyone apart from one person.

People spoke highly of the food provided. One person told us, "I get plenty of food and it's very nice." Another person told us, "The food, it's not bad." The provider had spent considerable time making the dining experience a sociable and pleasurable experience for people. Tables were decoratively laid with napkins and table cloths. The menu was on display on each table for people as a visual reminder. People were asked on the day at lunchtime what they preferred to eat and two options were available. Adapted cutlery and plate guards were provided which enabled people to eat independently. Where people required one to one support with eating and drinking, staff provided assistance. Staff sat down with the person and provided assistance in an unhurried and dignified manner.

Birchwood Grove provided care and support to people living with a swallowing difficulty. For people assessed with swallowing difficulty, a soft or puree diet is required along with the use of thickened fluids when drinking is to minimise the risk of choking and aspiration. Thickened fluids are easier to swallow; however, the quantity and texture must be appropriate for the individual as otherwise they can place the person at risk of aspiration. Clear guidance was available in the dining room on the amount of thickener to the amount of fluid. Where the need for a soft or puree diet was identified, this was provided.

People's nutritional needs were assessed on a monthly basis using the MUST scoring system (Malnutrition Universal Screening Tool). Where people were identified at high risk of malnourishment or dehydration, eating and drinking care plan was implemented which provided guidance for staff to follow. Weight records confirmed people were not losing weight and most people were maintaining a stable weight or gaining weight. Where required, food and fluid charts were in place. These provided staff with an overview of the person's nutritional and fluid intake on a daily basis.

Staff we spoke with were knowledgeable about the people they were looking after and were able to talk about their individual preferences and daily routines. Some of the staff team had worked at the home for many years with one member of staff having worked at the home for 20 years. Nursing and care staff spoke highly of the provider and registered manager and commented they felt supported. One staff member told us, "I think we all now feel really supported and listened to." Staff received regular supervision. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Regular supervision provides an insight into what the role of the person being supervised entails, the challenges they face and what support they need. It is an aspect of staff support and development.

The management team recognised the importance of a strong skilled workforce. Nursing and care staff received regular training which enabled them to carry out their roles and responsibilities. Training schedules confirmed staff had received training in dementia care, diversity and equality, person centred care and managing challenging behaviour. Registered nurses received on-going clinical training which also maintained their continuing professional development. The registered manager told us, "We regularly attend events organised by the local council in relation to nursing care. We recently attended a nutrition and hydration event along with a wound event." The provider encouraged staff's on-going development. Staff members took active roles and took the lead in many areas. For example, one staff member was the champion for continence; another staff member was the champion for dignity, nutrition and infection control.

For those staff members who were champions, the registered manager told us, "They take the lead in their specific area. They attend training events and feedback to the team. They also provide guidance and help mentor their colleagues. One staff member told us, "I'm the champion for continence which means when someone

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moves into the home, I assess them for any continence needs they may have." Another staff member for the champion for dignity, they told us, "I show the other staff the principles of dignity, attend various forums and feedback to staff." The registered manager spoke passionately about having a staff team who share learning and learn from one another.

Good

Is the service caring?

Our findings

People and relatives spoke very highly of the care provided at Birchwood Grove. One person told us, "The carers are all nice." Another person told us, "They are kind to me." A visiting relative spoke highly of the kind and caring nature of all staff members who worked at the home.

Staff knew the people they cared for. They were able to tell us about people's past lives, likes and dislikes and how they used this information to support and care for people in the home. This meant staff could reminisce with people, understand what might make people feel happy or sad, and ensure hobbies or interests were pursued. One staff member told us, "One lady can hear voices which can really upset her. When she hears the voices, we just reassure her, cuddle her, hold her hand and tell her she is safe. She has a teddy which also provides comfort and we always make her she has her teddy." Another staff member told us, "One person use to be a postman and they are well known in the community. They can often call out but they recognise our voices which reassures them. "

Guidance produced by the King's Fund identified the importance of a care home's environment when supporting people living with dementia. For people living with dementia, 'changes to lighting, floor coverings and improved way-finding, can have a significant impact on their well-being'. 'Evaluation has shown that environmental improvements can have a positive effect on reducing falls, violent and behaviours that challenge, and improving staff recruitment and retention'. The providers had recently renovated Birchwood Grove. All walls had been painted a light bright colour. Flooring had been replaced and was now a neutral colour which promoted orientation for people living with dementia. Outside people's bedrooms, the provider had implemented memory photo frames. These included various pictures of the person and their family. This helped orient the person to their bedroom and reduce dependency on staff to orient people to their bedrooms.

Staff understood the importance of physical contact to reassure and communicate care and affection to people living with dementia. Throughout the inspection, when interacting with people, staff regularly used human touch to comfort/reassure the person. When talking with people, staff also sat and held the person's hand. One staff member told us, "If people are experiencing a bad day or distressed, we often cuddle or hold their hand. This reassures them."

We saw people being treated by all staff with kindness. During the inspection, one person was observed lying on the floor. The registered nurse told us this was an aspect of their behaviour that could challenge at times. Staff members were seen staying with the person. They continually reassured the person and comforted them. The person was spoken to in a calm manner and staff enquired if they were hurt. The person was then offered the choice of going back to the lounge or their bedroom. Another person was seen becoming agitated. Staff responded and they came and sat with the person, providing reassurance, orienting them to time and place.

Staff understood how to support people with dignity and respect. Staff clearly valued the contributions people had made in their own lives and told us they respected them as individuals. This was further supported from our observations of the way they engaged with people and in the discussions they had. They respected people's privacy and their right to make their own decisions about how they wanted to spend their day. People were called by their preferred name and people responded to staff with smiles. Where people requested personal care, staff responded discreetly and sensitively. When personal care was being provided in people's own bedrooms, signs were displayed on the person's bedroom door, informing others that personal care was taking place and not to disturb.

Staff at Birchwood Grove recognised the companionship pets brought to older people. On the days of the inspection, relatives were seen bringing their pet dogs to the home. One relative brought their dog in and went round to each person so they could stroke the dog. People clearly enjoyed the companionship of the dogs, spending time patting and stroking the dogs. Visiting relatives confirmed they have always been welcomed in bringing the dogs into the home.

Nursing homes play an important role in the care of older people at the end of life. Birchwood Grove provided care and support to people who were receiving end of life care, although on the day of the inspection, no one was receiving end of life care. We spent time exploring how dignified care would be provided to people at the end of their life. The registered manager told us, "We implement

Good

Is the service caring?

end of life care plans which detail what the person would want to happen. We also work in partnership with the hospice and palliative care team." Registered nurses advised they felt confident in administering anticipatory medicines and would contact the district nurses if the use of a syringe driver was required. The management and staff team expressed a commitment to ensuring that people did not pass away alone. One staff member told us, "One resident recently was end of life; I stayed with them, holding their hand until they passed away."

The provider promoted an inclusive environment. People were involved in the running of the home and resident meetings were used as a forum to enable this. Minutes from the last resident meeting in September demonstrated food; activities, complaints, staff and cleanliness was discussed. A monthly newsletter was also produced and made available for people and their relatives. The recent newsletter (September 2015), included an article written by one of the 'residents'. It included their views on living with a health condition.

Relatives told us they were free to visit and keep in contact with their family members. They said they were made to welcome when they visited. Throughout the inspection, we saw relatives coming and going, spending time with their loved ones in the communal areas or the person's own bedroom.

Requires improvement

Is the service responsive?

Our findings

People commented they were well looked after by care staff and that staff were understanding of their individual need. Although the provider employed a dedicated activities coordinator, concerns were raised regarding the opportunity for social and meaningful activities. One person told us," I get bored very easily; I'm bored most of the time. I'd like to go out but I'm stopped at the door."

For people in care homes it is important they have the opportunity to take part in activity, including activities of daily living, which helps to maintain or improve their health and mental wellbeing. They should be encouraged to take an active role in choosing and defining activities that are meaningful to them. Guidance produced by the Social Care Institute of Excellence (SCIE) advises that for people living with dementia, keeping occupied and stimulated can improve quality of life. The provider employed a dedicated activities coordinator who was responsible for the organising of activities. The activities coordinator worked 25 hours per week and worked alternative weekends. They told us, "The key word is purposeful. I try to transmit energy and relate to what people like to do." A basic structure of group activities was available which included arts and craft, choir and exercise sessions. One to one activities were also provided. For one person, the activities coordinator identified they enjoyed ships, so together they looked at relevant books. Bowling games were also identified as a huge success along with cooking and baking.

A sensory box was available alongside a light for ceiling projections (displaying images on the wall). The activities coordinator told us how they made use of modern technology such as laptops to engage with people. The activity coordinator told us, "I connected the laptop to the TV, and on google earth, we googled people's childhood homes which was a great success." The activities coordinator had also started attending the local authority activities forum to gain and share ideas.

On a daily basis, the activities coordinator kept a record of the activities undertaken by the person, what was offered and how they responded. The activities coordinator told us, "It's important, it guides what activities I put on and makes sure everyone is getting 1-1 attention." From talking with the activities coordinator it was clear they were passionate and dedicated to their role.

We were informed that the activities coordinator started work at 10.00am. We therefore spent time observing people in the communal lounge on both days of the inspection. On the days of the inspection, the activities coordinator provided chair exercises, one to one with knitting and a group choir singing activity. On the first day of the inspection, we spent time with people between the period 15.00pm to 16.00pm. Seven people living with advanced dementia were in the communal lounge. Staff popped in and out, but staff did not stop to sit with people or provide stimulation. The only form of interaction was the television. The positioning of one person in a recliner chair meant they were in the corner of the room and was looking at the back of another's person's chair. If they wished they would be unable to watch the television. One person kept asking us, "What's going on?" During this timeframe, no one presented as agitated or distressed, however, for people living with dementia, there were periods of time where there was little activity. On the second day of the inspection, the activities coordinator was observed supporting care workers with the tea and coffee round. This lasted for approximately 30 minutes. During this timeframe, the activities coordinator was engaging with people in a positive manner. However, this took them away from their role as the activities coordinator.

Staff members confirmed they felt staffing levels were adequate but identified they did not have time to spend one to one with people, undertake activities or sit and have a cup of tea with someone. This led us to raise concerns about the opportunity for activities at weekends when the activities coordinator was not working. The activities coordinator told us, "I can't see any evidence of activity work being undertaken by staff because they are too busy with essential care work." One staff member told us, "On weekends without (activities coordinator), we make sure there's music on, and ask what people want to watch on TV."

People had mixed opinions about the activities provided. Some people spoke highly, while others commented they felt bored and lonely. One person told us they often felt lonely but thought it was nice other residents enjoyed the company of one another. Another person told us, "I get bored very easily; I'm bored most of the time. I'd like to go out but I'm stopped at the door." We therefore spent time looking at how staffing levels were calculated and if staffing levels allowed for staff members to provide social and psychological support. The registered manager told us,

Requires improvement

Is the service responsive?

“Our staffing levels are determined by the individual care needs of people.” Each person’s care needs were calculated and assessed at how many hours of care per day they required. The total number of care hours per week was then calculated and staffing levels were based on this number.

We reviewed the dependency tool and how staffing levels were calculated. When people’s individual care needs were assessed, the dependency tool considered personal care, continence, nutrition and mobility. The registered manager confirmed that the dependency tool did not incorporate people's psychological needs and need for activity. They told us that the activity care coordinator hours were an addition to the care homes. Guidance produced by the Alzheimer’s Society identified that psychological need is just as important as basic care needs. Keeping occupied and stimulated can also improve the quality of life for the person with dementia.

From our observations, it was clear that people’s care needs were met in a timely manner. When supporting people to eat and drink, staff members took their time, enabling the person to eat and drink at their own pace. Calls bell were rarely heard and the home presented with a calming atmosphere. However, people were often left for periods with inactivity and little stimulation. We have therefore identified this as an area of practice that needs improvement.

People said that they would be very comfortable in raising a complaint or concern and most said that they would raise this with the registered manager, whom they knew personally and who was available to them. A copy of the complaints policy was provided to people when they moved into the home and copy of the policy was also on display in the home. The provider had received one complaint in the last year. The complaints file showed complaints had been thoroughly investigated in line with the provider’s own policy and appropriate action had been taken. The outcome had been clearly recorded and feedback had been given to the complainant and documented

Good

Is the service well-led?

Our findings

People, relatives and staff all told us that they were satisfied with the service provided at the home and the way it was managed. One relative told us, "It has a lovely atmosphere. We've been extremely pleased with the home." One staff member told us, "I really enjoy working here."

The ownership of Birchwood Grove has changed over the years. In April 2014, the current provider bought Birchwood Grove. Staff members spoke highly of the change of ownership and the new providers. One staff member who had been working at the home for many years told us, "It's much better now. The home is cleaner, brighter, more hygienic. Everything is improving." Another staff member told us, "I would say this has been the best change of ownership, it's a much nicer place to work in." A third staff member told us, "The new owners have made considerable changes and the improvement is noticeable."

Nursing and care staff told us they felt supported by the management team. One staff member told us, "The manager is very approachable and always available." Another staff member told us. "The provider is firm, fair and very good." Staff spoke highly of morale within the home and felt the team worked well together. The registered manager told us, "A key strength of the home is the staff team and how well they work as a team and communicate effectively." An open and inclusive culture was promoted by the provider and registered manager. The registered manager made themselves known to people and staff and spent time engaging with people and working on the floor. People appeared comfortable in the presence of the management team and it was clear the registered manager had spent time getting to know people, building rapports and supporting staff members.

There was a clear management structure at Birchwood Grove which provided clear lines of responsibility and accountability. The provider and registered manager provided day to day leadership between them. The registered manager told us, "I'm not here; the provider will most likely be here, so there is management oversight." In the absence of the provider and registered manager, the clinical lead provided day to day leadership. The registered manager and provider kept up to date with good practice by attending forums within the local community and engaging with the local authority.

Birchwood Grove had a values statement which directed the ethos and vision of the home. The statement highlighted, 'It is the objective of the home that all residents shall live in comfortable, happy and safe surroundings, and be treated with respect and sensitivity to their individual needs and abilities. We want our residents care to have a person centred approach.' The provider and registered manager expressed a strong commitment for providing care in a person centred and holistic manner (seeing the person as a whole). The registered manager told us, "One of our key strengths is our approach to care and how we focus on our residents and what's important to them." Staff members also confirmed that the key strength of Birchwood Grove was how it supported its residents. One staff member told us, "We are very caring and put our residents first."

People and their relatives were actively involved in developing and improving the service. Regular satisfaction surveys were sent out to people and their relatives to enable them to provide feedback. Satisfaction surveys for 2015 had just been returned from people and their relatives and the provider had not yet analysed the results. Individual feedback was positive with comments such as, 'I'm totally satisfied with the care and attention being given.' Other feedback included, 'There is good communication right through from the management to patient safety.' Staff meetings were held as a forum for staff to air any concerns or raise any discussions. Staff meetings were also used as an opportunity to share practice and learning. The provider organised departmental meetings and overall team meetings. Minutes from the last overall team meeting in June 2015 reflected that care, activities, health and safety, maintenance, kitchen and housekeeping was discussed.

There were open and transparent methods of communication within the home. Staff attended daily handovers. This kept them informed of any developments or changes to people's needs. A communication book was also utilised which allowed staff to record any appointments, key information and other information of importance.

There was a quality assurance system in place to drive continuous improvement within the service. On a monthly basis, the registered manager was undertaking audits. Audits are a quality improvement process that involves review of the effectiveness of practice against agreed

Good

Is the service well-led?

standards. Audits help drive improvement and promote better outcomes for people who live at the home. Health and safety, infection control and medicine administration audits were undertaken. An overall quality audit was also completed which considered the overall running of the home, covering nutrition, medicines, documentation and premises. Where shortfalls were identified, actions were identified to make improvements.

Incidents and accidents were monitored on a monthly basis for any emerging trends, themes or patterns. Each month, the provider calculated how many falls there had been, incidents which resulted in an injury and non-injury. This enabled the provider to monitor how many un-witnessed falls and injuries were taking place. During the month of September 2015, there had been six un-witnessed falls. Documentation enabled the provider to monitor the times of people falling, if it was the same people and ascertain what action to take.

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 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 HSCA (RA) Regulations 2014 Need for consent. The registered person had not ensured care and treatment of service users must only be provided with the consent of the relevant person. Regulation 11 (1).**