Pine View Care Homes Ltd

Silver Birches

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Silver Birches is a residential care home providing a regulated activity for up to 19 people. The service provides support to people with dementia, physical disability and mental health. At the time of our inspection there were 16 people using the service. The care home accommodates 19 people in one adapted building.

People's experience of using this service and what we found

The environment was not always safe or clean. This meant people were at increased risk of infection.

People's risks such as pressure damage and diabetes were not always managed safely. Care plans did not always contain the most up to date information. We identified personal emergency evacuation plans (PEEPS) which had not been updated, which put people at risk in the event of a fire.

Medicines were not always managed safely.

We observed, and heard from relatives, there was a lack of staff. Staff were not all up to date with training.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The service was not well-led. Where there were audits in place, they had failed to take action on the concerns we found at inspection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 3 August 2022). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We received concerns in relation to staffing, infection prevention and the environment. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We inspected and

found there were concerns with the provider's compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards, so we widened the scope of the inspection and included the key question of effective as well.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We have identified breaches in relation to the need for consent, safe care and treatment, governance and staffing at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this time frame and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

Silver Birches inspection was an 'inspection using remote technology'. This means whilst we did visit the service on one day, we did not visit on subsequent days and instead used technology such as electronic file sharing to gather information, and phone calls to engage with relatives of people using the service as part of this performance review and assessment.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Silver Birches

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 inspectors 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.

Service and service type
Silver Birches is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Silver Birches is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 7 February 2023 and ended on 3 March 2023. We visited the service on 7 February 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people, 8 relatives, the registered manager and nominated individual, cook, cleaner, and 1 member of care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a variety of documents including personal emergency evacuation plans, 4 care plans, and multiple medication records. During the inspection we continued to liaise with the registered manager and nominated individual to obtain additional documents and assurances and we contacted 2 healthcare professionals who worked with this service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Management of pressure areas was not always safe. Pressure relieving mattresses were not always set to the appropriate level set out in care plans and the pumps for these mattresses had not been serviced in a timely way. While people did not have current skin breakdown, this put people at increased risk of pressure damage.
- Management of diabetes was not always safe. One person had out-of-date guidance for insulin with their medicine administration record, this had not been updated with the new dose when new guidance was given. However, no harm came to this person as they did not receive the incorrect dose of insulin. Relevant people's blood sugar recordings were not consistently recorded as being completed before food was given. This put people at risk of unsafe care and treatment with their diabetes management.
- People's care records did not always contain consistent information. One person 's records stated they preferred food to be soft or chopped up to aid them to eat. Care staff and kitchen staff told us this did not happen as it was not necessary, and this was supported by another part of the person's records. This lack of consistent information and update to the person's records could result in the person being provided with a meal prepared not in line with their wishes.
- People were at risk in the event of a fire. Some Personal emergency evacuation plans (PEEPs) contained out of date information and people's needs were not fully covered in these plans. There was a risk the incorrect plans may be picked up and used in an emergency as people had both paper PEEPs, which did not reflect current need, and PEEPs stored on the computer. The computer records reflected current need and therefore contained conflicting information to the paper records.
- The environment was not always safe. 1 wardrobe was not attached to the wall, which could put people at risk of injury if the wardrobe was to fall on them. In 1 bedroom, a towel rail was missing, which left a fixing on the wall with sharp corners. This meant people were at risk of skin tears. People were observed to walk around the home and entered other people's rooms, this meant not just the people whose room it belonged to were at risk of injury as those walking unattended were also at risk.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of

people using the service. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider addressed the concern with the wardrobe not being attached to the wall on the day of inspection on site and updated the environment through painting damaged surfaces. Outdated PEEPS were removed, and staff were all trained in evacuation following the first day of inspection.

Using medicines safely; Preventing and controlling infection

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● Whilst the provider informed us there were processes to dispose of medicines safely, we heard from 1 staff member, who was responsible for medicines administration, that medicines which were refused were sometimes put down the sink if they were not needed. This is not an appropriate or safe way to dispose of medicines. There was also a lack of guidance for staff in the provider's policy about how medicines should be disposed of.
● People and visitors were not always safe from the risk of catching and spreading infections. Mattresses, pressure relieving cushions and pillow covers were not always clean and free from stains. Damage throughout the home to skirting boards, door frames, chipped paintwork and handrails and ripped furnishings, provided exposed surfaces which could allow bacteria to grow and provided increased infection risk to people. There was a routine maintenance plan, however this was not effective at resolving the concerns we saw.
● Personal protective equipment (PPE) was not always stored or disposed of appropriately. Discarded PPE was found at the front of the building on the ground. The clinical waste bin at the front of the home was unlocked and overflowing. Whilst people did not access this area, it provided additional risks of vermin.
● The provider's infection prevention and control policy was not up to date as it still contained guidance staff should be wearing face masks, and did not reflect updated government guidance which stated masks only needed to be worn in an outbreak. Staff were following the new guidance as they were not wearing face masks. However, this lack of update to the guidance could be confusing to staff.

Medicines and infection control risks were not always managed safely. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
Visiting aligned to government guidance and people were able to have visitors when they wanted.

Staffing and recruitment
● There were not always enough staff to support people in a safe and timely way. Six people needed 2 staff to reposition them safely. On some days, only 2 staff were working. When these staff were supporting people with repositioning, there were no staff to support other people if needed. Multiple people in the home were at risk of falls, they had motion sensors near them so if they stood, urgent staff support was required. If the two staff were repositioning someone, they would not be free to urgently respond to a motion sensor. This

put these people at increased risk of injury.
● Relatives told us there were not enough staff at the service. One relative told us staff, "run around a bit" and they, "work under pressure." We were told by another relative, "The staff are never around."

There were not always enough staff to meet people's needs and ensure their safety. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Disclosure and Barring Service (DBS) checks had been completed for all staff. This provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. It was the provider's policy to request annual declarations from the staff as opposed to regular DBS checks. Annual declarations had been completed by all staff.

Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse
● Processes in the home meant people were sometimes subject to neglectful care. For example, people were exposed to an unclean environment and furniture which was soiled and stained.
● However, people and relatives told us people felt safe. One relative told us, '[Name] seems safe and [Name] is happy enough."
● We are not assured the provider knew their responsibilities in relation to safeguarding people from harm. For example, the provider had not identified it was neglectful for people to lie on soiled mattresses.
● Systems were in place for staff to report accidents and incidents.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- DoLS conditions were not always being met. For example, 1 person's DoLS condition was to be supported to engage in activity daily and staff were to note the person's response and the impact of activity on the well-being of the person. Activities were not taking place daily and there was no reason for this recorded and where they did take place, the impact on well-being was not always recorded. This meant the condition of their DoLS was not being met.
- Best interest meetings to make decisions in people's best interests did not always have the relevant people involved. For example, 1 person's relative was appointed the Lasting Power of Attorney for health and welfare, yet it had not been recorded they had been consulted over a best interest decision about medicines. The Lasting Power of Attorney for health and welfare is the person's chosen representative to make decisions around health and welfare of their behalf when they become unable to make this decision for themselves. This meant decisions may be being taken without consulting appropriate representatives for their input.
- Best interest decision-making had not always been fully recorded. We identified 1 best interest decision where the outcome of the decision, made after consideration of all relevant factors, was left blank. This may mean staff might not know what the conclusion is from the best interest decision making process and therefore may not know how best to support the person in their best interests.

The principles of the MCA were not always followed. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff training records showed staff had received MCA training. However, the training had not resulted in the above concerns being identified and addressed.

Adapting service, design, decoration to meet people's needs; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People were not cared for in a well-equipped, well-furnished and well-maintained environment which met their needs. For example, the carpet was wrinkled up in 1 person's room creating a trip hazard, and soft furnishings such as chairs were ripped.

● People were not always provided their own clothes to wear. Five relatives told us clothes got muddled and disappeared frequently. One relative said, "[Name of visitor] visited and [Name of person] was wearing trousers. This was odd as [Name of person]'s never owned a pair of trousers." This demonstrated a lack of dignity show to people.

● Relatives gave us mixed feedback about being involved in care planning. One relative told us, "We've never had a talk about a care plan." Whilst another relative told us, "[Name] does have a care plan because I am just about to sign it."

● People appeared comfortable in their environment and spent time in their own rooms, communal areas and the garden. People had their possessions and own toiletries in their rooms.

Staff support: induction, training, skills and experience

● Staff were not all up to date with training. For example, this service supports people with dementia and provides care at the end of people's lives. Yet in the 12 months before the inspection, only 5 of a possible 9 staff had completed training in dementia awareness and only 3 of a possible 9 staff had completed training in end-of-life care.

● One staff had not completed practice with a mat used to evacuate people who were unable to walk. This put people at risk of unsafe evacuation in the event of a fire or other emergency situation.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Staff supported people to eat and drink enough to meet their needs. People could exercise choice and could access enough food and drink.

● Following a review of the food quality, with a questionnaire provided for people, feedback was sought, acted on and improvements were made to the types of food available.

● People with diabetes were not always provided with a diet low in sugar, as guided by their care plan. When sugary foods were provided, it was not always recorded in the daily records where a low sugar option had been provided as an alternative. This put people at increased risk of ill health from a diet that was not low in sugar.

● Healthcare professionals told us referrals for people from Silver Birches for support were sought promptly.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to have adequate oversight of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The registered manager and provider had failed to ensure the quality assurance systems were reliable, robust and effective to drive improvements. The lack of governance meant the issues found at this inspection around the environment, infection prevention and control and management of pressure care and diabetes had not been rectified in a timely way.
● There were quality audits in place; however, they had failed to address the concerns we identified at inspection. For example, a medicines audit had failed to identify a medicines document which contained outdated information, which placed a person at risk of harm from receiving medicines incorrectly.
● There was a lack of oversight of record keeping. It had not been identified by the provider's own checks that blood sugars, which should have been checked before meals, were being documented as being checked after meals. Additionally, we identified 2 repositioning charts with the same dates, but different times and positions recorded on them. This showed staff were not completing people's records accurately. Repositioning charts are charts which record which position the person has been supported onto, to ensure they are moved regularly to reduce the risk of pressure damage to the skin.
● The provider had not always identified risks or introduced measures to mitigate the risks in a timely manner that reflected the level of risk and impact on people using the service. For example, we identified 1 wardrobe which was not attached to the wall at inspection. Whilst it was secured once identified on the day of inspection, this had not been addressed through the provider's own checks.
● The cleanliness of the home was an ongoing concern, which had been raised to the provider by the local authority on 2 occasions before over the 4 months before the inspection took place. This had not been addressed. The lack of action taken by the provider to address these concerns in a timely way put people at risk of exposure to an unsafe environment and infection.
●The provider's systems and processes were not always robust. The provider failed to identify and act on the issue about the laundry, where people's clothes were getting mixed up. The systems and processes in place also failed to identify DoLS conditions had not always been acted on. These were both reported on in

the effective section of the report.

The provider had failed to have effective systems to assess, monitor and improve the quality of the service. This placed people at risk of harm. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Equality, diversity and inclusion training was in place for staff, but at the time of inspection only 4 of 9 staff had completed this training in the last 12 months. The provider could therefore not be assured people's individual diverse needs would be respected in line with their protected characteristics.

● Some relatives reported they were not involved with care planning.

●There was an up-to-date equality and diversity policy in place which staff were able to access.

Working in partnership with others; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Healthcare professionals reported positive experiences of communication with staff from Silver Birches. One said, "Communication seems open and honest." However, whilst they contacted professionals this did not result in the care being of good quality as evidenced in safe, as records were not always updated following healthcare professional involvement. This meant staff did not understand what care to give consistently.

● Relevant organisations such as Care Quality Commission were informed when incidents occurred.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Relatives told us more activities may benefit people. One relative reported, "I am not sure they do enough to stimulate [Name]." And another said, "There is not much for them to do, no activities, just the TV on." This showed the culture of the service was not always sufficiently person-centred as people's individual wishes and needs for activities had not been addressed.

● Silver Birches supported people with dementia, however only 5 out of a possible 9 staff had completed training in dementia awareness. This lack of training completed by staff meant staff were not all trained in best practice for supporting people with dementia in a person-centred way.

● People gave mixed feedback about the care they received. One person told us, "I get no one to help me." Whilst 2 other people said that staff were nice.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to always follow the principles of the mental capacity act (MCA).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff to meet people's needs and ensure their safety

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines and infection control risks were not always managed safely. Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm.

The enforcement action we took:

Issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to have effective systems to assess, monitor and improve the quality of the service.

The enforcement action we took:

Issued a warning notice