New Outlook Housing Association Limited

Silver Birch

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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Silver Birch is a residential care home providing personal and nursing care to six people who are living with a learning disability and/or have a sensory impairment. The service can support up to seven people.

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

People were supported by staff who knew them well and the risks to them, but people's care records did not consistently provide staff with the most up to date information on how to support them safely and effectively. A number of incidents had not been recognised as safeguarding concerns and had not been reported to the appropriate authorities. Medicines were not always appropriately managed. We were not fully assured regarding some areas of infection control and the provider's infection control policy was not up to date. Accidents and incidents were recorded but there was a lack of analysis to identify any trends learn lessons when things went wrong.

Staff felt supported and valued, but raised concerns regarding the lack of specialist training available to them to enable them to support people effectively.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of safe, effective and well-led key questions the service was able to demonstrate how they were meeting some of the underpinning principles of right support, right care, right culture. The service applied the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. The outcomes for the people using the service reflected the principles and values of Registering the Right Support by promoting choice and control,

independence and inclusion. People's support focused on them having the choice and opportunities to gain new skills, where appropriate, and to become more independent.

Quality assurance systems had failed to identify areas for improvement found on inspection. The current systems in place did not provide the registered manager with complete oversight of the service. The service worked alongside other professionals to obtain support for people. Relatives were complimentary of the service, the care staff and the registered manager.

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

Rating at last inspection
The last rating for this service was good (published 7 January 2018).

Why we inspected
We received information in relation to a number of incidents that had not been recognised as potential safeguarding concerns, staff training and a lack of learning from accidents and incidents.
As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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 reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at 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.

The provider responded to the concerns raised during the inspection and action was taken to address these concerns.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safeguarding service users and good governance at this

inspection.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	**Requires Improvement**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

Silver Birch

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 Care Act 2014.

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 one inspector and a medicines inspector.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

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 and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service. People who used the service who were unable to talk with us used different ways of communicating including using Makaton, symbols, objects and their body language. We spoke with five members of staff including the registered manager, locality manager, senior care and care workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We spoke with three relatives to obtain their views of the service. We also spoke with the registered manager to obtain further information and had correspondence with the nominated individual in order to gain assurances on actions taken in response to concerns raised during the inspection.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Systems were not in place to ensure concerns of a safeguarding nature were consistently recognised and acted upon. For example, records showed there had been a number of safeguarding incidents that had not been reported to the appropriate authorities for further action.
- Staff understood the need for safeguarding people but had failed to recognise and report to the registered manager a number of incidents which may require further action. Staff told us they would value additional training in this area.
- There was no overall analysis of accidents, incidents or safeguarding concerns which meant opportunities to learn lessons were lost.

This was a breach of Regulation 13, Safeguarding service users from abuse and improper treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Where a safeguarding concern had been identified internally, appropriate action had been taken to keep the person safe from harm.
- Relatives told us they felt their loved ones were safe at the service and had no concerns regarding their care.
- The registered manager and locality manager were currently reviewing records to establish if further safeguarding concerns needed to be raised with the Local Authority and notified to CQC.

Assessing risk, safety monitoring and management

- Risk assessments relating to some people's needs were not in place or had not been reviewed for some time. For example, risks associated with health conditions such as diabetes or risk of choking.
- Staff were aware of the risks to people and where additional risks had been identified, actions were taken to address these to keep people safe. For example, where a person had displayed a number of behaviours that could lead them to harming themselves, actions were taken and appropriate support sought to keep the person safe.
- A member of staff told us, "I know for a fact if I have an issue I will make a point of going to the care plan and it gives me what I need."

Using medicines safely

- Medicines were not always appropriately managed which meant people were not protected from unnecessary risks and harm.

● Staff did not have access to all the information they needed in order to support people with their medicines in the best way. For example, some people had personalised PRN protocols for "when required" medicines that stated when they needed their medicines. However, these were not in place for all medicines that needed to be given this way.
● Medicines were not always stored safely and in line with the medicines policy.
● The medicines policy was not specific to the service and referred to tasks that were not carried out at the service and staff were not trained to deliver.
● People received the correct medicines at the times they were prescribed and when they needed them.
● People were given their medicines in a way that had been recorded as their preference.
● The service had sufficient, appropriately skilled staff to meet people's needs and keep them safe.
● Staff had the appropriate training and competency to support people with their medicines.

Staffing and recruitment
● People were supported by a consistent group of staff who knew them well, a number of whom had worked at the service for many years.
● Staff told us recruitment systems and processes were followed correctly prior to them commencing in post. We looked at two staff files and saw that appropriate checks had been made prior to staff commencing in post.
●There were a number of staff vacancies at the time of the inspection, but all posts were covered by existing staff and a consistent group of bank staff picking up extra shifts. The registered manager told us "Recruitment is absolutely dreadful at the moment, I like to have service users on the interview panel; you need to see if you have the right fit for the people living here." A relative told us, "Here the staff group is consistent and I get regular feedback."
● The service was actively recruiting to vacant posts, but the registered manager acknowledged in the current climate, it was difficult to recruit people with the right skills for the job.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were somewhat assured that the provider was using PPE effectively and safely. Hand sanitiser was not available in a communal bathroom and more bins were required to dispose of PPE appropriately.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Some areas of the service were worn and tired which would impact on the ability to maintain a clean and hygienic environment.

● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Not all COVID-19 risk assessments in place had been updated to reflect the latest government guidance.

● We were somewhat assured that the provider's infection prevention and control policy was up to date. The policy was updated in January 2022, but prior to that had not been updated since April 2020.

● People using the service were supported to maintain contacts with their relatives. A system was in place to support people to have visits from relatives and any other important people in their lives.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.
The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

We have also signposted the provider to resources to develop their approach.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● Staff felt supported, but told us they would welcome additional training to support them in their role and enable them to meet people's needs effectively. One member of staff told us, "Any additional support or training would be welcome to help us support [person]", and another member of staff told us, "We desperately need some training, especially mental health; I have been asking [registered manager's name] for training in mental health and I know they are looking into it."

● The training matrix in place provided the registered manager with oversight of staff training. However, they acknowledged that since the pandemic, all staff training had been e-learning and they recognised the need for staff to receive face to face training to improve their skills and test their knowledge.

● A relative told us, "I think they [care staff] are excellent. When they get new staff, they make sure they do know how to treat [person]. I've never had a problem with any of them."

● The registered manager told us, "[Staff] supervisions have been sporadic to be fair over the last 12-18 months with COVID being short staffed, I try to do them every couple of months." Staff confirmed this and added the registered manager was approachable and if they needed to speak to her, she would make time for them.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● The service worked alongside other healthcare agencies to meet people's needs for example the local GP and Community Psychiatric Nurses. Efforts had also been made to access additional support from Community Learning Disability Teams. However, referrals to SALT [Speech and Language Teams] had not been considered for two people whose care plans recorded they required a 'soft' diet.

● Relatives spoke positively of the care and support their loved ones received and told us they were kept up to date and informed of any changes in their care needs. One relative told us, "I cannot praise [care staff's name] enough, they know [person] so well and how to support them. If I was in any doubt at all I wouldn't leave them there." Another relative said, "[Names of care staff] have been there a long time and [person] looks at them like family. They know what they are saying; they can read them.

● Diaries and communication books were in place to ensure information was shared across shifts and staff were kept up to date with any changes in people's needs.

Adapting service, design, decoration to meet people's needs

● Some areas of the service were currently undergoing a refurbishment in order to improve the living environment.

● The service benefitted from large, landscaped garden which was enjoyed by the people living at the service.

● One person had recently been supported to move to another room in the home and their relative told us, "[Person] can move round independently and know their way around. I know I don't have to worry about them when I'm home."

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 Act 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● We observed people's consent was obtained prior to them being supported. Relatives told us they considered their loved ones to be treated with dignity and respect and their wishes were always considered.
● Staff spoken with understood the principles of the MCA and DoLS and what this meant for people living at the service.
● Systems were in place to ensure where people were being deprived of their liberty, the appropriate parties were involved. A member of staff told us, "We have tried to make this a home. We try and give service users as much freedom and choice as possible." They went on to describe how they sat with a person to record their daily notes that day and include them in the process.
● Systems were in place to provide oversight of all DoLS applications that were in place, when reviews were required and renewal dates.
Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Peoples individual needs were assessed. Care records held information regarding people's preferences and what was important to them, including their health, social, religious and cultural needs.
● A relative told us, prior to their loved one moving into the home, "I was invited and able to have a meeting with the manager and have a look round. They have been really good like that; I can visit at any time but I always do an LFT and wear a mask. We went through the care plans and I was able to highlight what I want for [person] moving forward. We do think [person] is very capable in terms of looking after themselves and they are supporting them to be a bit more independent and we have noticed this."

Supporting people to eat and drink enough to maintain a balanced diet
● We observed people enjoyed their meals together and saw their preferences were considered at mealtimes. Staff cooked individual meals to meet people's preferences and one person told us, "I had tomato soup, it's my favourite."
● Staff were aware of how to support people at mealtimes and the importance of ensuring they followed their plan of care. A member of staff told us, "[Person] can tell you what they want, they are very regimented in their ways and like their drinks and meals when they want them." They provided an example of what this meant for this person on a particular day and how staff accommodated these requests. A relative

commented positively regarding how care staff had supported their loved one to try and maintain a healthy weight.

Requires Improvement

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Quality assurance systems in place had failed to identify concerns found on inspection.
- Safeguarding concerns had not been consistently recognised and raised with the local authority.
- There was no overall analysis of accidents and incidents resulting in opportunities to learn lessons when things go wrong were lost.
- Specialised training in autism and mental health were not in place to provide staff with the additional skills to meet people's needs.
- Risk assessments were not consistently reviewed or in place, to provide staff with the most up to date information regarding the people they supported.
- Medication audits that had recently been completed by management had failed to identify incorrect information was recorded in some people's medication care plans.
- Care records failed to consistently provide staff with information regarding distraction techniques or how to support people who may display behaviours that could challenge others.

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

- The registered manager had been in post 16 months and arrived at the service during the pandemic. Following recent safeguarding concerns, an action plan had been put in place to address the issues raised. Actions included providing staff with additional guidance on how to complete daily records and charts that provided specific information regarding behaviours that may challenge others. Staff spoken positively about this additional training.
- Staff spoke positively of the service and told us they would recommend it as a place to work and to service users and their families.

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

- The provider had on display the last inspection rating of the service.
- Staff were aware of the service's whistleblowing policy. One member of staff told us, "If I see anything I don't feel comfortable enough to deal with I'd speak to the manager. They are approachable and supportive and I'm confident they would deal with things."

● The provider was responsive to the feedback provided on inspection and demonstrated a willingness to address the concerns identified.
● A relative told us, "There have been a couple of times when I've been worried about things and they have sorted things out straight away. I cannot fault them."

Notifications had not been submitted to CQC in line with legal requirements. We are reviewing the potential failure to notify and will report on this once completed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People's views of the service were regularly sought through daily conversations and monthly meetings. A member of staff told us, "We sit down with service users, get them together and have a cup of tea and ask individual service users what they like." They went on to describe the facial cues and noises made by some service users which enable staff to read and understand their wishes.
● Relatives spoke highly of the service, the care staff and the registered manager. They told us they were kept informed of events during the pandemic and were in regular contact with the service and their loved ones. One relative told us, "The manager is approachable, and I can listen to her and call her directly; first thing she did was give me her direct number." Another relative told us, "They are an excellent care home and I really relate to [registered manager's name]; they are very easy to talk to and they sent a lot of pictures [of loved one] during lockdown as well. They were excellent."
● Staff felt supported and listened to by the registered manager. One member of staff said, "It's a pleasure working with registered manager and locality manager."

Working in partnership with others
● The service worked in partnership with other professionals and agencies, such a social workers, community psychiatric nurses, learning disability nurses and GPs.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment A number of incidents were not recognised as potential safeguarding matters to be reported and acted on.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes in place did not provide the registered manager with effective oversight of the service.