Mrs M Hirst Mr P AE Hurst

Silver Birches Residential Home

Inspection report

70 Erringden Road
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Hebden Bridge
West Yorkshire
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Tel: 01422882804

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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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 23 March 2017 and was unannounced.

Silver Birches residential home is registered with the Care Quality Commission to provide accommodation and to support people with their personal care. The home is registered to support up to ten people. There were eight people living at the home at the time of the inspection.

There was a registered manager in position. This person had previously been deputy manager at Silver Birches residential home and had achieved registered manager status since the last inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in January 2016 we found breaches of regulations in relation safety and good governance. On this inspection we found actions had been taken to achieve compliance in these areas. People living at the service told us they felt safe and staff we spoke with confirmed this. Staff had received safeguarding training and although unsure about what might constitute abuse, told us they would report concerns they had to the registered manager.

Some improvements had been made in the way medicines were managed and we found systems for receipt, storage and administration of medicines were safe.
Accidents and incidents were documented and the registered manager was working on developing an accident analysis matrix to help identify trends and reduce the risk of recurrence.

Risk assessments and personal emergency evacuation plans were in place but were not always a true reflection of people's circumstances.

The premises were clean, well maintained and appropriate safety checks were in place.

Effective recruitment processes were in place and staff training was up to date. Staffing arrangements needed to be kept under review, particularly in view of the recent changes in staff and current vacancies. Regular staff supervisions had taken place and the registered manager had introduced a programme for annual appraisals.

People were supported to have choice and control of their lives. However it was not clear how people's consent was obtained in relation to care planning and sharing information with relatives.

Some people had experienced weight loss and we could not be assured systems were in place to make sure people received the diet they needed.

People had access to health care professionals as they needed.

Staff respected people and their belongings. We saw a number of caring interactions between staff and people who lived at the home. People demonstrated fondness towards staff.

Person centred care plans were in place; however staff did not routinely look at these.

People had access to activities, reading materials and music of their choice.

A complaints procedure was in place but this needed updating to reflect current management arrangements.

People had confidence in the registered manager. At the time of our visit the registered manager was having to cover staff vacancies and therefore did not have the time they needed to dedicate to managerial duties. They were confident this situation would be resolved as more staff were appointed.
Some auditing of the quality of the service was being done. However there was a lack of overview at provider level.
We found the provider was in breach of regulation 14 in relation to meeting nutritional and hydration needs.

You can see what action we told the provider to take at the back of the full version of the report.

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

The service was safe but some further improvements were needed.

Staff had received safeguarding training and knew to report any concerns.

Systems for managing medicines were safe.

Risk assessments did not always reflect current needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training and support relevant to their role.

It was not clear how people's consent was obtained in relation to care planning and sharing information with relatives.

Food was of good quality but people were not always supported to make sure they received the diet they needed.

Is the service caring?

Good

The service was caring.

Staff were kind and patient in their approach.

Staff were respectful of people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Person centred care plans were in place but these were not routinely accessed by staff to make sure they were aware of people's assessed needs.

People had access to activities of their choice.

The complaints procedure was in need of some updating.

Is the service well-led?

Requires Improvement

The service was not always well led.

People had confidence in the registered manager.

Some systems were in place for auditing the quality of the service but there was a lack of provider oversight.

Due to staffing issues the registered manager had difficulty in finding sufficient time to attend to managerial tasks.

Silver Birches Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 23 March 2017 and was unannounced. The inspection team consisted of two adult social care inspectors.

We spent time speaking to people who lived at the home and observing care practice. We looked at three people's care records in detail, medication records and other records relating to the management of the service including staff recruitment and training records and policies and procedures. We looked around the home including some people's bedrooms.

We spoke with five people who lived at the home, the registered manager, four members of care staff, a member of the management team, a person visiting their relative and a visiting district nurse.

As part of our inspection planning we reviewed the information we held about the home. This included information from the provider, notifications and contacting relevant local authorities. The provider had completed a PIR and returned it to us within timescales. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in January 2017 we found a number of issues relating to safety of the environment and people living at the home.

On this inspection we found actions had been taken to address all of these issues. For example, issues relating to security of the home had been addressed, a new call system was in place which included pendants for people to wear and automatic closures had been fitted to fire doors throughout the service. Water temperatures were being closely monitored, although we found the hot water in one of the bathrooms running at a very high temperature. The registered manager and a member of the management team told us they would address this immediately.

Staff we spoke with had an awareness of safeguarding people and told us they would report any concerns they had to the registered manager although some lacked clarity regarding what might constitute abuse. The registered manager told us they would be revisiting safeguarding issues in staff supervision to make sure newer staff had a thorough understanding in this important area.
One person we spoke with said they felt safe and the home and said, "There's a lot worse places than this. It's safe."
At our last inspection we found medicines were not always managed safely. When we looked at the systems in place for managing and administering medicines on this inspection we found issues had been addressed and a safe system was now in place. We saw some protocols were in place for medicines to be taken on an 'as required' (PRN) basis. However these were not in place for all PRN medicines and some lacked detail such as why the medicine had been needed and whether the desired effect had been achieved. We raised this with the registered manager who made some additions to the protocols during our visit.

We found appropriate systems in place for recording receipt and administration of medicines.

Accidents and incidents were documented. However no information was logged on the form about actions taken as a result of the accident/incident such as care plans or risk assessments amended as a result. The registered manager told us they had a plan in place to develop an accident analysis matrix to help identify trends and reduce the risk of recurrence. This meant the service was seeking ways to mitigate risks for people who used the service.
Some risk assessments for such as falls, bathing and general risks were in place in people's care records. We saw these were updated monthly or as needs changed. However, we saw some people who were at risk nutritionally did not have appropriate risk assessments in place. We also identified where some people had lost significant amount of weight, the general risk assessment, although recently updated, did not reflect this and showed the person's weight as 'normal'. This meant risk assessments were not always a true reflection of people's needs or were able to demonstrate how risks to people were mitigated. We discussed this with the registered manager and a member of the management team who said they would address the issue.

We saw each person's care records included a personal emergency evacuation plan (PEEP). However we

found the detail in these conflicted with that in other areas of the care file. For example, one person's PEEP said they would be able to walk to the nearest assembly point unaided but their moving and handling assessment said they were very unsteady and could not be left to walk alone. This lack of up to date information could put people at risk in an emergency situation.

We checked three staff files and saw new employees were appropriately checked through robust recruitment processes. Our checks and discussions with the registered manager confirmed all the necessary procedures had been completed before staff had started working in the home. These included obtaining references, confirming identification and checking people with the Disclosure and Barring Service (DBS). The DBS is a criminal convictions and cautions check on staff. We found people received a DBS check prior to commencing employment. This meant safe recruitment procedures were followed to make sure staff were suitable to work with vulnerable people. However, we saw two staff files did not contain any photo identification. We spoke with the registered manager who told us they would rectify this omission immediately.

At our last inspection duty rotas showed two staff on duty from 8am until 5pm and we were concerned that only one member of staff was on duty daily between 5pm and 9 pm, particularly as care staff were also responsible for cooking, cleaning and laundry duties. We found these arrangements were still in place at this inspection. The registered manager told us they were usually available to support during the evening as they almost always worked until after the night staff had come on duty although this was not reflected on the duty rota. Further support was available from a member of staff who lived in a flat above the home and who shared on-call duties with the registered manager. Evening, night time and weekend on call arrangements were included on the duty rota.

The registered manager told us a number of staff had recently left the service and they had recruited new staff to the vacancies. One full time night staff vacancy had just been filled and they were currently recruiting for a part time staff member. We were concerned current staff shortages meant the registered manager was working long hours, providing on call support and had little time available to concentrate on their managerial role. However they told us they were confident this situation would be resolved when staff vacancies had been filled.

Although people we spoke with did not express any concerns about staffing levels and we saw staff responded to call bells in a timely manner, we continue our recommendation that the provider maintains a close audit of people's needs in relation to staffing levels at the home to make sure staff are available, at all times, to meet people's needs.

We found the home to be clean and tidy throughout. Hand washing facilities had been put in place for staff in all areas where they may provide personal care. This meant infection control measures were in place. We saw COSHH (Control of Substances Hazardous to Health) data sheets were in place for chemicals such as cleaning products in use at the home. This meant any accident involving these products could be responded to appropriately and safely.
We saw up to date records of maintenance of the building such as electrical testing, water testing and gas safety. This meant the safety of the environment was monitored appropriately.

Requires Improvement

Is the service effective?

Our findings

We reviewed the training matrix which the service had implemented since our last inspection and saw most training was up to date or booked. Most training was completed though an on-line/video training system. From our review of the training matrix we saw two new staff members had not yet completed the practical moving and handling training. We spoke with the registered manager who assured us these staff members only worked alongside experienced staff who had completed the training. The registered manager was attending the 'train the trainer' moving and handling' course in May 2017 but recognised they needed to arrange practical training for new staff before this time.

We saw some staff were completing NVQ level 2. However, we did not see evidence of training relating to people's specific needs such as diabetes and Parkinson's disease. The registered manager told us this was an area they were exploring.

New staff completed a three month induction programme which included service specific information, health and safety and other induction training, policies and procedures and shadowing an experienced member of staff. The registered manager told us the length of time spent shadowing would depend on the experience and needs of the new staff member. At the end of the three month period, the registered manager completed a supervision, during which the staff member would be asked about service policies/procedures to test their knowledge.

Staff new to care were enrolled in the Care Certificate. This is a government recognised training programme designed to increase the knowledge and check the competency of staff new to care.

Staff supervision was held every three months and the registered manager planned to make the fourth supervision an annual appraisal. We saw a matrix was in place to plan these throughout the year. Staff confirmed supervisions had started to take place and were a useful tool to aid their development and explore any concerns.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS requires care homes to make applications to the local authority where they suspect they are depriving people of their liberty.

The registered manager told us none of the people living at the home had a DoLS authorisation in place but understood the circumstances under which they might need to make application.

We did not see any completed mental capacity assessments. However, all the care files we looked at included a statement saying the person had full capacity. The registered manager told us all of the people living at the home had full capacity although in one person's care file, we saw their family member had signed consent for the person to have their photograph taken.
There was nothing in place to demonstrate people's wishes and consent in relation to information about them being shared with their family. For example, the registered manager told us some people's relatives would want to know when their relation had seen the doctor. It is important where people have capacity to make decisions about their health and welfare that staff establish their wishes about sharing information with their family prior to doing so.

The registered manager told us some people had a lasting power of attorney in place. However they were unsure if these were for financial matters or for health and welfare. We brought to the attention of the registered manager the importance of establishing staff involved the right people in decisions.

The service did not employ a cook and therefore care staff prepared meals. We saw there was a menu displayed in the dining room with the main meal served at teatime and a smaller meal available at lunch. On the day of our visit the lunch consisted of soup, potted beef sandwiches and a slice of cake. We were concerned about the portion size served at lunchtime as only two small quarters of sandwich were served to each person. The registered manager told us some people had small appetites and would not finish the food offered. We observed everyone ate all their sandwiches but were not offered more. We saw snacks were not offered during the morning which the registered manager told us was an isolated omission. The food served at teatime appeared appetising with a choice of fish, new potatoes and carrots and home-made rice pudding as a dessert. We saw cream, butter and whole milk was used in the preparation of meals to increase people's calorific intake.
We were concerned about people's nutritional intake as a review of a number of people's records indicated a decline in their weight. When we asked staff if anyone was at risk nutritionally we were told no-one was. Nutritional risk assessments were not in place and food or fluid charts were not used. We saw some reference to people's food intake in people's daily records but this was not specific. We saw no record of dietician involvement regarding people's poor nutritional intake. We asked the registered manager if they had made referral to the dietician for people losing weight. They said they had not but would inform the GP if someone's weight had decreased. We reviewed one person's nutritional care records and saw this had happened. However, the person had not liked the supplement prescribed, stating it was too sweet. We asked the registered manager what subsequent actions they had taken and they told us they were continuing to monitor the person's weight. Their answers did not provide us with sufficient reassurance that the person's nutritional needs were being fulfilled as the person's weight had continued to decline. This person was also diabetic; controlled though medication and diet. When we asked what provisions the service had to maintain their dietary needs, the registered manager told us they did not keep diabetic specific food and they would offer them smaller pieces of cake or smaller portions of pudding. This concerned us given the person's weight loss. Following our discussions the registered manager made a diabetic rice pudding for the person's teatime dessert using sweeteners rather than sugar. The registered manager acknowledged further education was needed regarding nutrition and the provision of special diets.

This was a breach of the Regulation 14 Meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did observe people being offered drinks and when one person became confused and thought it was tea time, they were immediately asked if they were hungry and supplied with toast and a cup of tea.

We recommend the service seeks advice relating to good nutrition and the provision of special diets without

delay.

We saw from care files that people had access to health care professionals including GPs, the district nurses, speech and language therapists, dentists, opticians and chiropodists.

We spoke with a visiting district nurse who confirmed with us the good work the service had done in supporting them to enable the healing of a pressure sore which the person had acquired outside of the home.

Good

Is the service caring?

Our findings

We saw staff supported people with a caring, patient and friendly manner.

One person we spoke with commented, "It's a nice place. Staff are nice." A relative told us, "I think our care is really good. [Person's name] is happy here. They look after you well." They also told us they did not think their relative would still be alive if it wasn't for the good care provided at the service.

Staff we spoke with demonstrated a caring attitude to the people living at the home. One staff member told us, "I love it. With it being small you get to know the residents really well. It's not like the big care homes. You get a more personalised stay with us." Another staff member told us they enjoyed their role and said, "It's nice coming somewhere where they're treated beautifully."

We observed some kind interactions between staff and people living at the home. For example, one member of staff came into the lounge and exchanged warm greetings with the two people sitting in the room. They laughed and joked with them and clearly had built a good rapport with both people. On another occasion a staff member came to change the music in the lounge since the CD had finished. They put another CD on which one person objected to, saying. "That's not my sort of music." The staff member asked what they would prefer and changed the music to a more relaxing sound which the person was happier with.

Our observations were that people had been appropriately supported in their personal hygiene needs. Ladies' hair had been nicely styled, gentlemen had been supported to shave and clothing was well cared for.

It was clear staff took time to make sure people's bedrooms were clean and tidy and nicely personalised with personal possessions. This demonstrated a respect for the people living at the service.

We saw people's relatives and friends were welcomed when they visited the home and good relationships had been built up. This meant good communication was maintained between the service and people's relatives.
Confidential records and documentation were stored in a locked cupboard in the office. This meant people's private information was kept securely.

Requires Improvement

Is the service responsive?

Our findings

Before people came to live at the home a needs assessment was completed from which the plan of care was devised including risk assessments.

We reviewed care records for three people and saw improvements had been made to include more person centred information including a quick reference synopsis page at the front of the care file and plans written in the first person. Care records included sections on people's health, personal care, skin care, medication and sensory needs as well as good information on the person's daily routine. These were clear and concise and care plans included goals which would assist in the review of the effectiveness of the care plan. However, these would benefit from further work to enhance the person centred approach, such as documented evidence of likes and dislikes for food, toiletries and routines.

We saw some people's records did not fully reflect their current needs as some risk assessments such as nutritional risk assessments and specific plans of care regarding people's nutritional needs were not in place.
We saw the risk assessments which were in place, were reviewed monthly and care plans every six months or when people's needs changed.

The registered manager told us people were involved in their care planning, however none of the care plans we looked at had been signed by either the person concerned or the member of staff who developed the care plan. We did see that people had signed the review form but we could not be assured plans of care were drawn up with people's full involvement. The registered manager told us they would address this.

Staff we spoke with told us they did not read the care records, just the daily records which were kept in separate folders. The registered manager told us the reading of people's care records was not included in the induction training. This meant staff, particularly those new to the service, were not always aware of people's care and support needs. We discussed our concerns with the registered manager who said they would integrate the folders and ensure staff read people's care records and sign to say they had done so.

We saw a complaints procedure was in place and a copy was on display in the entrance hall. The procedure needed to be updated to reflect current management arrangements.

During the morning we saw people sitting quietly in the lounge listening to music. A staff member came in to ask if people wanted to take part in an activity but people declined. The registered manager told us activities were organised according to people's choice. We saw activities on offer included bingo, quizzes and games. People told us they enjoyed watching quiz shows on television and we saw them enjoying one such programme during the afternoon. Staff and people told us activities had to be fitted around these shows and we saw this was the case, with people engaging in a game after the television quiz had finished.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager who was registered with CQC in November 2016.

They told us that since their registration there had been a number of staff changes and whilst these were positive for the service they had to dedicate time to inducting and supporting new staff members which had impacted on the time they had to dedicate to managerial duties. This had been further impacted by the registered manager being one of the two members of staff on care duty. The registered manager told us they were working currently six days each week, usually until past 10pm in order to complete paperwork. They said they were confident this situation would improve when vacancies had been filled and new staff had completed their inductions.

A staff member we spoke with told us they would not hesitate to discuss any concerns with the registered manager and commented, "If I've got a problem [registered manager] would be there (for me)." They also told us, "[Registered manager's] doing a great job. Think [registered manager] could do with more help from good staff."
The registered manager was open and honest and supported the inspection process. They told us of plans they had to drive further improvements within the service including review of policies and procedures and training staff in the development and review of care plans.

We saw systems were in place to audit the safety of the home. This included checks on water, gas and electrical safety. Actions had been taken to address all of the issues identified during our last inspection. We saw an audit of the environment which had previously been conducted on a monthly basis had been changed to six monthly. The registered manager told us this was on the advice of the infection control officer from the local authority. However, the audit included general checks on the environment which we would expect to be conducted on a more frequent basis.

We did not see any evidence of provider audit. The registered manager told us they had regular Skype calls with the provider but no auditing was completed. At the time of our inspection the registered manager was solely responsible for all aspects of governance, including development of care records. This meant any auditing of records was being done by the person who had the responsibility for the development and review of the records. This meant there could be the potential for a lack of objective auditing and support for the registered manager.

We saw the provider sent out questionnaires to people living at the service and their relatives annually and although only five had been returned, we saw the results were largely positive with comments such as, 'well cared for and nice, friendly, warm environment', 'staff know their clients well', 'help when needed', and 'I feel my opinion is valued'. We asked if the results of the survey were analysed for service improvement and were told not, with the forms filed in a cupboard. We identified two people had expressed the food was only adequate and one person had said they did not know how to complain. We asked if people had a copy of the complaints policy and the service user guide. The registered manager said they did not but would

address this.

Staff told us a meeting had taken place recently involving all staff and any concerns and suggestions were discussed. However, they said this had been an informal gathering and therefore there were no documented minutes. They agreed they needed to show evidence such meetings occurred and would do so in future. They told us they planned to hold regular meetings throughout the year.

We concluded that although there were no direct breaches of regulation in relation to governance of the service, we would strongly recommend that the registered manager would benefit from support from the provider to ensure effective governance.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People using the service did not always receive nutrition suitable to their needs, Regulation 14 (1)