Mrs M Hirst Mr P AE Hurst

Silver Birches Residential Home

Inspection report

70 Erringden Road
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Hebden Bridge
West Yorkshire
HX7 5AR

Tel: 01422882804

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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 12 May 2016 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. The registered manager was on leave at the time of the inspection and was intending to step down from this position. An acting manager was on duty on the day of the inspection and had recently commenced employment. The acting manager were currently working alongside the deputy manager to gain management experience before applying to the Care Quality Commission to become registered as a manager. 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.

We found a number of areas which demonstrated that the premises was not entirely safe and secure such as some fire doors being wedged open and hot water temperatures in some areas exceeding the recommended safe levels. We also found that sufficient measures were not always in place to control the spread of infection.

We found appropriate systems in place for recording receipt and administration of medicines. However we identified some unsafe practices in how medicines were stored and managed, such as taking tablets from boxes and adding them in to the monitored dosage system.

The service was not doing everything possible to assess and mitigate risk. For example, there was no evidence that accidents were reviewed to help identify any possible patterns or themes.

We recommend the provider maintains a close audit of people's needs in relation to staffing levels at the home to make sure people are safe. We also recommend that on-call arrangements are formalised and reflected on the duty rota.

A system of staff training was in place but improvements were required to ensure it was comprehensive and effective.

The manager demonstrated an understanding of their role protecting the rights of the people they cared for. However care records required improvement to ensure they provided robust information relating to people's capacity to make decisions.

We saw people were supported to consume a balanced diet and were weighed monthly so that any changes

in weight could be identified and followed up with relevant healthcare professionals.

Staff supported people to see other health care professionals so they could maintain good health and we saw examples where staff had made referrals where they were concerned about someone's health and wellbeing.

People told us staff treated them with dignity and respect. It was clear staff respected people and their belongings. We saw many caring interactions between staff and people who lived at the home. It was clear that staff knew people well and were attentive to people's individual care needs.

There was an ongoing programme of improvement with people's care files. We found some lacked specific detail. However, there was greater evidence of person centred care in the updated care files we reviewed. We also saw that revised care files were well laid out and easy to understand.

Whilst we saw good examples of person centred care, there were still some practices which needed to be reviewed to ensure the service delivered fully person centred care. For example, we saw occasions where people's relatives rather than the person themselves were asked for permissions regarding care and we also saw a bath chart which showed what day's people should have a bath. This suggested a rigid rather than person centred approach to care.

We saw little evidence of a programme of activities in the home and our discussions with people and observations showed people would have benefitted from more stimulation and meaningful occupation. The acting and deputy managers told us they would look into arranging activities in these areas.

We saw a complaints procedure and policy was in place and saw the procedure had been followed with complaints responded to in a timely manner.

The acting and deputy manager were open and transparent and understood where improvements were required. However, we identified some shortfalls in the management of the service. The Commission had not been informed of certain incidents which had occurred at the service and some areas for improvement were identified by the Commission, rather than through the service's own quality assurance processes. We were also concerned that private and confidential records were not always kept securely.

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

The 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.

Sufficient measures were not in place to control the spread of infection and ensure the premises was safe.

We identified some unsafe practices in how medicines were stored and managed.

The service was not doing everything possible to assess and mitigate risk.
Staff understood safeguarding procedures and how they should report any suspicions of abuse.

Staff were recruited safely. We asked the provider to review staffing levels to ensure the arrangements in place were appropriate.

Is the service effective?

Requires Improvement

The service was not always effective.

A system of staff training was in place but improvements were required to ensure it was comprehensive and effective.

Care records required improvement to ensure they provided robust information relating to people's capacity to make decisions.

People were supported to consume a balanced diet and were supported to maintain good health.

Is the service caring?

Good

The service was caring.

Staff were attentive to people's individual care needs. Staff knew people well and were able to tell us about their likes, dislikes and care needs.

People told us staff treated them with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care files were being improved so that they contained more detailed and person centred information. Revised care files were well laid out and easy to understand. However some care files still lacked specific detail.

There were still some practices which needed to be reviewed to ensure the service delivered fully person centred care.

We saw little evidence of a programme of activities in the home.

A complaints procedure was in place and being followed.

Is the service well-led?

Requires Improvement

The service was not always well led.

The Commission had not been informed of certain incidents which had occurred at the service.

Some areas for improvement were identified by the Commission, rather than through the service's own quality assurance processes.

We were concerned that private and confidential records were not always kept securely.

The acting and deputy manager were open and transparent and understood where improvements were required.

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 12 May 2016 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 also had a look around the home including some people's bedrooms.

We spoke with seven people who lived at the home, the acting manager, the deputy manager, one member of care staff and a visiting healthcare professional.

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. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). 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.

Inadequate

Is the service safe?

Our findings

On our arrival at the home, we were able to walk in through an unlocked door and through the downstairs area without finding any staff. The door we used to enter the home took us through the kitchen area where we immediately noted a collection of knives attached to a magnetic holder above the work surface. We also saw a bucket containing cleaning fluids at the bottom of the stairs, including a bottle of bleach. We saw some people were in the dining room eating their breakfast and asked if they knew where we would find a member of staff. The acting manager called out to us and we found they were in a small office area off the kitchen. We told the acting manager that we were concerned about security as we had been able to walk through the home unchallenged but they said the door needed to be unlocked to allow staff to go in and out with laundry. However, when we later discussed this with the deputy manager, they told us they had not considered this previously but recognised the risks and said they would review the situation.

On our walk around the home we found a number of doors, including the kitchen door, labelled as fire doors which needed to be kept closed, wedged open. This meant a fire could spread easily and the doors with automatic closures could not close automatically when the fire alarm sounded.

Of the ten bedrooms, six had ensuite facilities but all had a hand wash basin. We found there were no staff handwashing facilities such as liquid soap and paper towels in any of the bedrooms we visited, although it was available in toilets and bathrooms. The deputy manager told us there were no thermostatic mixer valves in place to regulate the temperature of hot water in any areas of the home. When we tested the hot water in two bedrooms and in the communal bathroom we found the temperature to be in excess of 50 degrees celcius. This far exceeds the recommended temperature of 43 degrees celcius which put people at risk of injury.

Call bells were available in all of the bedrooms, toilets and bathrooms. However the deputy manager confirmed there was no call bell available in the lounge or conservatory area where most people spent their time.

This meant the premises were not always safe and sufficient measures were not in place to control the spread of infection.

This was a breach of the Regulation 12 (2)(d)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the systems in place for managing and administering medicines. We saw medicines were stored in a locked cupboard in the office area just off the kitchen. This area was not separated from communal areas of the home by any lockable door. Although medicines were stored in a locked cabinet we saw the acting manager leave the keys to the cupboard in a letters tray on their desk top on several occasions. French windows to the outside of the home were adjacent to the wall where the medicine cabinet was stored. We found these doors to be unlocked throughout our visit. This risked people being able to gain access to the medicines cupboard.

Medicines were dispensed from the pharmacy wherever possible in a monitored dose system (MDS). This consisted of sealed compartments containing the tablets prescribed for the person at each time of administration. Other medicines were dispensed in boxes or bottles. We saw records were made of the amounts of all medicines received into the home. We checked boxes of Warfarin (a medicine used to thin blood) for two people and were unable to reconcile the amount of tablets left in the boxes with the amounts recorded as received and administered. The deputy manager told us this was because staff had taken tablets from the boxes and put them into the MDS compartments. This meant the seals on the MDS compartments had been broken.

We found appropriate systems in place for recording receipt and administration of medicines. However the risks associated with safe storage and taking tablets from boxes and adding them to those dispensed in the MDS system demonstrated unsafe practice.

This was a breach of the Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw accidents for both people who lived at the home and staff were recorded on a form produced by the service. The form included little detail of the incident and there was no recorded follow up to the accident or incident. For example, one entry named the person, recorded their age and gender and then read: 'Fallen in doorway, possible hip fracture, paramedics called, taken to hospital.' There was no evidence that accidents were reviewed to help identify any possible patterns or themes. When we asked the deputy manager about this they said they reviewed accidents if it was the same person involved. However, we read in one person's notes that they had sustained two falls over the last month, which were logged on the accident form. There was no risk assessment or documented care plan in place to reflect this. This meant the service was not doing everything possible to assess and mitigate risks to people.

This was a breach of the Regulation 12 (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw from care files that some risk assessments had been completed and were up to date. We saw where one person had been assessed as at risk of skin breakdown via a 'Waterlow' assessment tool, a wound assessment had been completed and the district nurses were involved with dressing the wound. We saw evidence people had been referred to the Speech and Language Therapy Team (SALT) where they had been assessed at risk from choking when swallowing food.

One person we spoke with said, "I feel safe here. I don't have to worry about things here."

Staff we spoke with told us they would report any signs or suspicions of abuse. They recognised different forms of abuse and one staff member said that although they were a little unsure of formal reporting procedures, they knew where the information was to guide them and they would not hesitate to do this. This meant staff knew how to keep people safe.

We reviewed three staff files and saw safe recruitment procedures had been followed. This included seeking references from previous employers and carrying out disclosure and barring service (DBS) checks. The DBS checks people's criminal record history and their suitability to work with vulnerable people.

Duty rotas showed two staff on duty from 8am until 5pm. However, we were concerned that only one member of staff was on duty daily between five and nine pm, since the home did not employ a separate cook or cleaner. This meant that the staff member would be responsible for clearing away after the evening

meal, preparing and serving supper and evening drinks, assisting any people who requested a bath or shower in the evening, assisting people with their bedtime routines and ensuring people's care needs were met. The deputy manager told us another member of staff who lived in the flat above the home was on call in case of emergency and they made other arrangements if that person wasn't available. These on-call arrangements were not recorded on the staff rota. None of the people we spoke with expressed any concerns about staffing levels other than one person telling us they were always busy.

We recommend the provider maintains a close audit of people's needs in relation to staffing levels at the home to make sure people are safe. We also recommend that on-call arrangements are formalised and reflected on the duty rota.

Requires Improvement

Is the service effective?

Our findings

We saw in staff files that mandatory training had been completed and was up to date for most staff. The deputy manager had identified staff that required training updates. However, we noted that although moving and handling theory training had been completed, staff had not had formal practical training from a suitably qualified moving and handling trainer. The deputy manager told us this training was done 'in house' at present, but neither they nor the acting manager had any moving and handling trainer qualification. This meant care staff were not being trained by people qualified in the most up to date moving and handling techniques. We spoke with the acting manager and deputy manager about this and they said they would look into the acting manager gaining a moving and handling 'train the trainer' qualification which would enable them to update and cascade their knowledge to care staff.

We saw some staff had received additional training in subjects such as person centred care, challenging behaviour, record keeping and assessing needs. Almost all of the training staff received was through 'Social Care TV' and therefore lacked any practical element or opportunity for discussion. We discussed with the deputy and acting manager about the support Skills for Care can offer to providers. The deputy manager said they would follow this up.

We saw evidence that regular observations of practice were taking place and formal supervisions had been carried out every six months, although the deputy manager told us they were planning to carry these out on a monthly basis in future. A staff member we spoke with told us they felt supported in their role.

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. 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.
We spoke to the deputy manager who told us nobody in the home required a DoLS at the present time. They described in what circumstances they would deem a DoLS necessary and demonstrated good understanding of the process.

However we saw what the service called mental capacity assessments were simply a statement made that, in the opinion of staff and relatives, the person had capacity. Where people lacked capacity there was no assessment of people's ability to understand or retain information that would enable them to make decisions and no information about how people could be supported in making both minor and major decisions about their lives.

There was a lack of evidence in care files that people's consent had been sought despite them having been assessed as having capacity. We saw documentation to show people's relatives had been asked for permission, for instance for administration of medicines and for having photographs taken, but not the person themselves.

Staff we spoke with had a good understanding of people's nutritional needs. We saw the food was freshly prepared, nutritious, home-made and looked tasty. Most people appeared to enjoy the meals they were offered. We heard one person eating their food say, "It's lovely." Another person told us, "The food is good, regular food." We saw a range of fresh fruit such as sliced melon and pineapple was offered at mealtimes. Breakfast choices included cereal, porridge and toast; lunch offered was home-made soup and sandwiches, with a meat and potato pie served at teatime. People were offered a choice of hot and cold drinks during the day. A visiting health care professional told us, "People get drinks when they need them; a choice of dinks, and regularly throughout the day." We saw people were offered biscuits with their drinks during the morning and homemade buns during the afternoon. Fresh fruit was available at all times. We did observe however, that when staff were called to other tasks some people had to wait over 10 minutes after asking for a drink before receiving one.

We saw people had been referred to the SALT team where they had been assessed to have difficulty in swallowing.

People were weighed monthly and any concerns discussed with the GP. For instance, we saw in one person's care file they had lost half a stone since the start of the year. We saw in the person's care notes that the GP had been consulted about this. We spoke with the deputy manager who told us the person was now at an appropriate weight which was remaining stable although staff were continuing to monitor any fluctuations.

We saw in people's care files that they had access to a wide range of health care professionals including GPs, the district nursing team, community matron, speech and language therapists, dentists, opticians and chiropodists. A health care professional we spoke with said, "If they've got any concerns they'll contact me straightaway. They couldn't be more friendly to me and approachable."

Good

Is the service caring?

Our findings

We saw many caring interactions between staff and people who lived at the home. People looked relaxed and told us they felt well cared for. One person said, "It's very good here. I'm very happy here. I feel completely happy." Another person told us, "It's as nice a place as any. They look after us. There isn't anything I could complain about. They're all lovely." We heard staff laughing and joking with people, with one person telling a member of staff, "You're a lovely lass. I love you." We spoke with a health care professional who told us, "It's very calm and friendly. The staff are always there for them. They are so attentive. I would recommend it to people."

One example of the attentiveness of staff was in a person's care notes. The notes showed that when the person had complained of feeling sickly, staff had offered to make them a cup of peppermint tea to ease their nausea.

We saw that staff knew people well and were able to tell us about their likes, dislikes and care needs. One person said, "I think staff know me well. They know I don't like spicy food."

People told us staff treated them with dignity and respect. One person told us, "I think they treat me with dignity and respect. They knock before they walk in to my bedroom."

People were smartly dressed and it was evident that staff supported them well in meeting their personal care needs. People's clothing was well cared for and smelled fresh and clean.

We saw people's bedrooms were highly personalised with people's own pictures and ornaments in their rooms. One person's bedroom had been decorated and furnished with items of their choosing to reflect their interests and lifestyle preferences. It was clear that staff respected people's belongings and supported them to look after them. We saw a number of paintings hanging on the walls in communal areas which had been painted by a person living at the home.

We saw some photographs around the home of people who lived there but noted the walls in the dining room were almost entirely covered in framed staff training certificates from Social Care TV. This gave the impression of the room being more of a workspace and detracted from the homely furnishings.

We found people who lived at the home demonstrated a caring attitude to each other and appeared content in each others company. An example of how this was encouraged was people all sat together around a large dining table at mealtimes. There was a very homely atmosphere within the home.

We saw in people's care plans that people's changing needs were considered and there were effective systems in place for end of life care.

Requires Improvement

Is the service responsive?

Our findings

The deputy manager told us there was an ongoing programme of improvement with the care plans and we saw this when we reviewed people's care files. The deputy manager was aware that there was a long way to go with the improvements and acknowledged that some care files lacked specific detail. There was greater evidence of person centred care in the updated files which were written in the first person and therefore from the point of view of the individual concerned.

At the beginning of one of the care files we reviewed was a photograph of the person and a pen picture of their life, interests, emotions, preferences and health. For example the pen picture included headings such as 'The person who knows me best', 'My life so far', 'Current and past interests, jobs and places lived, 'Things that may worry or upset me' and 'How we can communicate.' This document had been signed as reviewed on two occasions by the person concerned. This demonstrated a person centred approach to care as did further records giving specific details about the persons preferrences in relation to activities and socialising.

We saw that revised care files were well laid out and easy to understand and contained some good information. However, we saw one person used a piece of medical equipment in the home and there was no mention of this in the care file. When we asked the deputy manager about this, they told us they had archived the information since the person had been using the equipment for a number of years. They showed us the archived information and said they would reinstate this in the care plan since the information was still current.

We saw care plans were reviewed and updated six monthly unless any changes occurred in between. We saw detailed monthly reports in people's carer files which documented any key information for the month.

Whilst we saw good examples of person centred care we saw some examples of people's relatives rather than the person themselves being asked for permissions regarding care. For example, permissions forms for taking photographs and administration of medicines asked for the consent of relatives rather than the person concerned.

We also saw a bath chart pinned on the wall of the office area, showing what days people should have a bath. This suggested a rigid rather than person centred approach to care.

We saw little evidence of a programme of activities in the home. One person told us, "I get bored during the day. Very occasionally we have people come in and do some activities; play music and sing songs."

We observed in the lounge during the morning and for part of the afternoon and saw little staff presence or stimulation apart from the television. However, we did see some people reading the day's paper in the conservatory. One person told us staff were usually too busy with other jobs to spend time with them. We saw staff were busy with domestic jobs such as washing up, cooking and laundry. We spoke with two people both of whom said they would like to be involved in helping out with some of those jobs, particularly cooking. When we spoke with them about the plants around the home they said they would like to learn

more about those also.

We told the acting and deputy managers about these conversations and they said they would look into arranging activities in these areas.

One person told us, "I haven't ever needed to complain, but I'd tell my family first if I'm not happy, then speak to the home if nothing is done."

We saw a complaints procedure and policy was in place and saw the procedure had been followed with complaints responded to in a timely manner.

Requires Improvement

Is the service well-led?

Our findings

The person currently registered as manager for Silver Birches is also the provider. They were not available on the day of the inspection due to being on leave, and were intending to step down from this position. The person managing the service at the time of our visit told us they were new to management but were working with the deputy manager to further their management skills and then intended to apply to the Care Quality Commission to become registered as the manager. The deputy manager told us they would continue to support the person until they had achieved registered manager status. We found the acting and deputy manager to be supportive of the inspection process and open and honest about areas where improvements were needed.

It was evident during the inspection that the management team were involved in the care of people living at the home. People knew the acting and deputy manager well and were clearly fond of them.

We noticed when planning for this inspection that we had not received any statutory notifications in over five years, other than those to inform us when there had been a death in the home. Providers are required to inform the Care Quality Commission by way of statutory notification of a number of events or incidents that have happened in the home. This includes where people living at the home have received certain types of injury. When we looked at accident records we saw examples of accidents for which it may have been necessary to make statutory notifications which had not been reported to the Commission. Following the inspection we wrote to the provider to inform them any further failure to submit statutory notifications could lead to enforcement action.

We saw the provider had some systems in place to audit the safety of the home. For example checks on Legionella safety, gas safety, electrical safety and call system operation were all in place and up to date. We saw a monthly health and safety audit of the home had been completed and fire safety tests were made weekly. Whilst some of these audits were robust, they had not been sufficient to identify the issues mentioned within the 'Safe' section of this report.

We saw that the views of people involved with the service were sought through questionnaires. We saw seven responses from the previous years' questionnaires and saw that any issues had been addressed. The acting and deputy managers told us they were always available to speak with people who lived at the home and their relatives. They told us any minor issues brought up through discussion would be addressed immediately.

We were concerned that private and confidential records were not always kept securely, for example people's care files were kept in a cupboard in the dining room that we found unlocked during our inspection, old care notes were stored in storage boxes on top of a filing cabinet in the dining room and information about people was left on the desk in the office area that was open to the kitchen and dining room.

This was a breach of the Regulation 17 (2)(d) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1)(2)(a)(b)(d)(h)(g) The premises were not always safe and sufficient measures were not in place to control the spread of infection. The service was not doing everything possible to assess and mitigate risks to people. Medicines were not consistently managed in a safe and proper way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1) (2)(d) Private and confidential records were not always kept securely.