Holt Green Residential Homes Limited

Silver Birch Lodge

Inspection report

Bold Lane
Aughton
Ormskirk
Lancashire
L39 6SH

Tel: 01695424259

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This unannounced inspection took place on 1 November 2016. We last inspected Silver Birch Lodge in September 2014. At that inspection we found the service was meeting the regulations that we assessed.

Silver Birch Lodge is situated in a quiet village location, near Ormskirk and Burscough. The home provides accommodation for up to 31 older people, who require help with personal or nursing care needs. Accommodation is all at ground floor level with easy access for those with mobility difficulties. Some bedrooms have en-suite facilities and direct access to the garden areas. There is ample parking available within the grounds of the home. A range of amenities are nearby within the village centre and public transport is easily accessible. At the time of the inspection there were 27 people living at the home.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager had notified the CQC of any incidents and events as required by regulation.

People living in Silver Birch Lodge told us that they felt "secure" and "safe" living there and relatives we spoke with told us they were "satisfied" with the care being provided. We spoke with people living at the home in their own rooms and with those who were sitting in communal areas. People told us that they felt they were being well looked after and staff listened to them. People told us the staff who supported them knew how they liked to be supported and always checked with them how they wanted to be helped.

People who lived at the home told us about the organised activities that went on in the home and their own interests that were supported. There was a programme of organised activities for people to take part in if they wanted to.

Relatives we spoke with told us that they did not have any concerns about how their relatives/friends were looked after and supported by the staff in the home. We saw that the staff offered people assistance but respected their independence. We saw that staff took the time to speak with people and took up opportunities to interact with them, engage and offer reassurance if needed.

People had a choice of meals and drinks, which they told us they enjoyed. People who needed support to eat and drink received this in a supportive and respectful manner. We saw that people were supported to maintain their independence as much as possible. We looked at the risk assessments in place for people and these included risk assessments for skin and pressure area care, falls, moving and handling, mobility and nutrition and for the management of a different conditions or the use of specific medication.

Systems were in place for the recruitment of staff and for their induction, training and development. Staff training relevant to the needs of the people living in the home was provided. Staffing levels were not being

formally monitored to assess how many staff would be needed to support people according to their needs across all times of the day and night. We have made a recommendation that the service consider the use of a formal tool to help improve their continuous monitoring of staffing levels and to systematically assess the deployment and skill mix of staff needed across all shifts.

The staff employed were aware of their responsibility to protect people from harm or abuse. They knew the action to take if they were concerned about the safety or welfare of an individual. They told us they would be confident reporting any concerns to a senior person in the home and that the registered manager was "approachable". The service had in place a procedure to receive and respond to complaints and people told us they knew they could speak to the manager or staff about anything that concerned them.

The environment of the home was welcoming, the communal areas were decorated and arranged to make them homely and relaxing, and we found that all areas used were clean and free from unpleasant odours. The moving and handling equipment we saw in use, such as hoists, were clean and being maintained. We have made a recommendation that the service seeks advice and guidance from a reputable source regarding their risk assessments and procedures in relation to laundry procedures to help mitigate cross infection risks.

Medicines were being safely, administered and stored and we saw that accurate records were kept of medicines received and disposed of so all of them could be accounted for. Controlled medicines [those liable to misuse] were in good order. We found that the service worked with local GPs, district nurses and health care professionals and external agencies to provide appropriate care to meet people's different physical, psychological and emotional needs.

The service followed the principles of the Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards. This helped to protect the rights of people who were not able to make important decisions themselves. We have made a recommendation that the home takes advice about best practice in in relation to providing evidence of who holds Power of Attorney (PoA) for people to help ensure that the right people had been involved in making decisions on people's behalf.

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 areas required reviewing.

The service did not have risk assessments and procedures in place to mitigate the cross infection risks in the laundry and sluice areas.

There were adequate staff on duty during the day to support people but staffing was not being kept under continuous review to make sure staffing was adjusted promptly if needed.

Staff understood their responsibility to safeguard people and the action to take if they were concerned about a person's safety.

Records were kept of medicines received and disposed of so all could be accounted for.

Is the service effective?

Good

The service was effective.

Staff received training relevant to their roles received supervision on a regular basis.

Staff knew the people who lived there well and worked with other agencies and services to help make sure they got the support they needed.

People had a choice of nutritious meals, drinks and snacks.

Information about who held Power of Attorney (PoA) for some people needed to be clear for staff to help ensure that the right people had been involved in making decisions on people's behalf.

Is the service caring?

Good

This service was caring.

People told us that they were well cared for and happy living in the home.

We saw that people were treated with respect and kindness and their independence, privacy and dignity were being protected and promoted.

Staff demonstrated good knowledge about the people they were supporting, for example information on their backgrounds and their likes and dislikes.

Is the service responsive?

Good

The service was responsive.

Support was provided to follow their own interests and faiths and to maintain relationships with friends and relatives and local community contact.

We saw that people made their own choices about their daily lives in the home. There were organised activities for people if they wanted to take part

There was a system in place to receive and handle complaints or concerns raised.

Is the service well-led?

Good

The service was well led.

Quality audits were used to monitor care planning, medication management, risks and other aspects of care and service provision.

Accidents and incidents in the home had been recorded and notifications required by the regulations that have been submitted to the Care Quality Commission (CQC).

Staff told us they felt supported and listened to by the registered manager and senior staff

Silver Birch Lodge

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 check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited the home on 1 November 2016. The inspection was carried out by an Adult Social Care Inspector.

We looked around the home and spent time speaking with and observing people and staff in various areas of the home including the dining rooms and lounge areas. We were able to see some people's own bedrooms and bathrooms and the communal bathrooms.

During the inspection we spoke with nine people who lived in the home, two relatives, three of the care staff, a registered nurse on duty, a member of the domestic staff and the registered manager. We spoke to people living in the home alone and in groups, in private and in communal areas.

We looked at care plans for five people living in the home, their medication records and care plans relating to the use of their medicines. We observed medicines being handled and discussed medicines handling with staff. We checked the medicines and medication records for people and spoke with members of nursing and care staff with responsibility for medicines.

We looked a sample of the records relating to the maintenance and management of the service and records of checks being done on how quality of the service provision was being monitored. We also looked at the staff rotas for the previous two months and staff training records.

Some people living at the home could not easily give us their views and opinions about their care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us better understand the experiences of people who could not easily talk with us. It is a useful tool to help us assess the quality of interactions between people who use a service and the staff who support them.

Before our inspection we reviewed the information we held about the service. We looked at the information we held about notifications sent to us about incidents affecting the service and people living there. We looked at the information we held on safeguarding referrals, concerns raised with us and applications the registered manager had made under Deprivation of Liberty Safeguards (DoLS).

The registered manager of the home had completed and submitted 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. The PIR provides an opportunity for providers to share information and evidence about their service. This is used by inspectors to help plan inspections. The information providers give is considered alongside all other sources of evidence, including inspection visits.

Requires Improvement

Is the service safe?

Our findings

The people we spoke with who were living at the home spoke positively about their home and how they felt living there. One person told us, "I feel entirely safe, entirely happy" and another said "I feel I am well looked after, I feel I am safe and I am comfortable here". One person said to us "I think there must be quite a few places that are a bit dodgy but this place has been good, I feel it's a safe place to be living. No one [staff] here oversteps the mark". Another told us ,"I have no worries, I feel secure and the staff check on me in the night, so I feel safe".

We spoke with people's relatives as they visited the home. They told us that they did not have any concerns about how their relatives were being cared for.

We saw the environment was homely and comfortable for the people who lived there. The moving and handling equipment we saw in use, such as hoists, were clean and being maintained. Records indicated that the equipment in use in the home had been serviced and maintained under contract agreements and that people had been assessed for its safe use. We looked around the home and saw that all areas used by the people who lived there were clean and fresh

There were two laundries within the home and these had hand-washing facilities. There were sluicing facilities for the disposal of the waste and for cleaning commode pots or bedpans in both of them. One laundry area had the sluice facility located behind a door within another smaller room. The other laundry had the sluicing basin situated in the laundry room where clothes were washed, dried and stored. This is not in line with guidance from the Department of Health (2013) for health and adult social care about the prevention and control of infections. Both laundry areas had only one door to enter with linen to be washed and to leave by with clean linen. This made it difficult to have a flow through system so that dirty linen can arrive through one door and be quickly washed before drying and removal through a separate exit to clean storage. We raised this poor facility with the registered manager. We recommended that the service consider current best practice and guidance, seek advice and guidance from a reputable source, review their risk assessments and procedures in this respect, and take the appropriate action to update their practices accordingly to mitigate the cross infection risks.

People we spoke with who lived there told us that the staff came to help them when they needed them. One person told us "There are more staff about in the mornings but they are very busy." We were also told, "They [care staff] seem very busy these days, don't have the time to sit and talk and take a bit of extra time. When there are all the staff on they do, it's no problem then".

We could see that there were sufficient care staff available to support and spend time with people during the day of the inspection. Staff we spoke with confirmed that they passed on information about any changes and additional needs at staff handovers. We saw safe recruitment procedures were in place to help ensure staff were suitable for their roles.

On the day of the inspection the registered manager was on duty, a registered nurse with two care assistants

on the nursing unit, and a senior carer on the residential part of the home and four care staff to support people. Rotas indicated that at night a registered nurse and two care staff supported the people living in the home. There was an activities coordinator in the home supporting people with different activities and interests. The registered manager confirmed that recruitment was on going to fill gaps in the staffing establishment.

The rotas were difficult to follow had been altered at times to help cover shifts. They indicated that the early shifts during the week were generally well staffed, as we observed. Staff we asked confirmed that was usually the case. However, we noted that at some evening and weekends shifts staff levels were not at consistent levels.

On the day we inspected there was one kitchen assistant on duty in the evening and the care staff were setting tables and helping the kitchen assistant with the prepared food. At the evening meal two staff would be occupied giving out evening medications in different parts of the home and from our observations nine people needed support and assistance to eat their meal. Some people would want their meals in their rooms and need assistance from the three care staff available. Staff told us that people who were having their meal in their rooms would get the meal earlier so they could be helped.

We found that there was not a formal dependency tool in use to help assess how many staff and nursing were needed and how they needed to be deployed to meet people's personal and nursing care needs. The layout of the home meant that staff were split between the nursing and residential areas of the home. Dependency assessment tools can help to assist in formally assessing and monitoring how many staff will be needed to support people according to their needs and conditions. The registered manager described how they also used their judgement and knowledge of the people living there as well to assess if someone needed closer observation and support. We recommended that the service consider the use of a formal tool to help improve their continuous monitoring of staffing levels and help to systematically assess the deployment and skill mix of staff needed across both day and night shifts.

We saw that needs and risk assessments had been carried out with people regarding their care needs. We saw that the assessment and management of risk had been reviewed and updated by staff so that people received appropriate support and treatment. For example, we saw where changes had taken place in nutritional risks for one person The risk assessments identified current risks and the control measures to help minimise them. People's care plans included risk assessments for skin and pressure area care, the use of bedrails, falls, moving and handling, mobility and nutrition. We saw that checks had been done on beds and bedrails to check that they were correctly positioned. We saw where the maintenance person had highlighted faults and that they had addressed them.

The care staff we spoke with told us about the training they had done in recognising and reporting abuse. All the staff we spoke with knew the appropriate action to take if they believed someone was at risk of abuse. The staff we spoke with were confident that the management team would follow up any concerns they might raise and that take action to make sure people were kept safe.

We looked at the way medicines were being managed and handled in the home. Controlled medicines [those liable to misuse] were in good order. We found that medicines were being safely administered and records were kept of the quantity of medicines kept in the home. Medicines storage was well organised and regular stock checks were done. This helped to prevent any accumulation of medication and reduced the risk of errors occurring. Clinical room and refrigerator temperatures were monitored and the records showed that medicines were stored within the recommended temperature ranges. This helped to make sure that the medicines were in good condition for use.

Good

Is the service effective?

Our findings

People told us the staff who supported them knew how they liked to be supported and always checked with them how they wanted to be helped. One person told us they had various allergies and said, "The staff here and the kitchen manage them all very well". One person told us "I can say that I am very content here and well looked after. I would say that 99.9% of the time the service is excellent and also the food".

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA).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). 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 were being met.

Some people were not able to make some important decisions about their care due to living with dementia. We looked at care plans to see how decisions had been made around their treatment choices and 'do not attempt cardio pulmonary resuscitation' (DNACPR). The records in place showed that the principles of the Mental Capacity Act 2005 Code of Practice were being used when assessing a person's ability to make a particular decision.

We noted that information around who, if anyone, held Power of Attorney for a person was not being made clear in people's care plans. Powers of Attorney show who has legal authority to make decisions on a person's behalf when they cannot do so themselves and may be for financial and/or care and welfare needs. We also noted that some people had consent forms signed by family members although it was not clear if they had the relevant PoA to do so. We recommend that the home take advice about best practice in this area, reviews it practices regarding the signing of consent by others, and adjusts its policies accordingly.

We saw in care records that people who had capacity to make decisions about their care and treatment had been supported to do so. We saw that care staff at the home communicated well with the people who lived there and gave people the time they needed to express their wishes. One person had a 'living will' so that their wishes were clear for the future should they be unable to communicate them.

People's health and support needs had been assessed before admission and we saw that people living at Silver Birch Lodge had access to health care professionals to meet their individual health care needs. The care plans and records that we looked at showed that people were being seen by appropriate professionals to help meet their particular physical, nursing and mental health needs. We saw records in the care plans of

the involvement of the community teams, district nurses and well as opticians, chiropodists and dental services

We saw that people's care plans had a nutritional assessment in place and that their weights were monitored for changes so action could be taken if needed. We saw that advice had been sought from the dietician or the speech and language therapist (SALT) if a person needed this. There was also information on specific dietary needs such as diabetic diets and soft and pureed meals as well as where people had dietary intolerances or allergies. This information was recorded in the care plans.

Our observations included the lunchtime meal in the first dining room. We saw that lunch was a relaxed occasion and staff spoke with and encouraged people as they served or helped them with their meals. We saw that care staff assisted people in an unhurried way and also prompted and encouraged people, where appropriate, with their meals and drinks. We saw there was a choice of food at all mealtimes in the home and people were asked what they wanted.

Training and personnel records we saw indicated that staff were supported to do the training relevant to their roles. Staff told us that during induction they had worked alongside a more experienced and senior staff member for support and guidance. We were told, "If I am unsure about anything I can just ask, there are a lot of staff with experience and knowledge who will help you".

Good

Is the service caring?

Our findings

The people who lived at Silver Birch Lodge that we spoke with made positive comments about the staff approaches and the care and support provided to them in the home by care staff. One person told us, "I am very happy here, well looked after". One person said, "I am very impressed with the young lads that work here. Extremely good and helpful. Nothing seems too much trouble for them; they help me to be independent. It's a home from home". One person told us "They [care staff] do seem to be interested in me as a person, especially the younger ones. When they can they will sit and have a chat, but they are often very busy".

Relatives we spoke with told us there were no restrictions on their visiting. One relative told us "I have found the staff to be caring and kind and they make me feel welcome whenever I visit".

We used the Short Observational Framework for inspection, (SOFI) to observe how people in the home were being supported and engaged by staff and how they were spending their time. During lunch we found there was good interaction between staff and people living there and a lot of good humour and laughter and displays of empathy with the people they were supporting.

We saw that where they could the staff took the time to chat with people in the lounges and took up opportunities to interact and include everyone in activities and conversations. At lunch, a care worker was chatting with people about their previous jobs and about football and encouraging people to join in the conversation. The atmosphere in the home was inclusive and relaxed.

We saw that people who could not easily speak with us were comfortable and relaxed with the staff that were helping them. We saw staff talking to people in a calm and friendly manner. People confirmed to us that their privacy and dignity were respected and said they were always asked how they wanted to be looked after. We saw that staff promoted people's privacy by knocking on bedroom and bathroom doors and asking if they could come in. All the bedrooms were being used for single occupancy and this meant that people were able to spend time in private or see people in private if they wished to. Bedrooms we saw had been made more personal places with people's own belongings, such as photographs and ornaments to help them to feel at home with their familiar and valued things.

We found that nursing staff had received training on supporting people with bereavement and loss and had done the 'The Six Steps' palliative care programme through the local hospice.This was a programme aimed to enhance end of life care and support. Some care staff had received training on, promoting hydration, communication and supporting people at the end of life in line with their roles.The district nursing service and the person's GP also worked with the home to provide the right care and treatments at the end of a person's life. All the care staff we spoke with demonstrated an understanding of how important it was to support people and families properly at the end of life.

We found that information was available for people in the home to help support their choices.This included information about support agencies such as advocacy services that people could use. An advocate is a

person who is independent of the home and who can come into the home to help support a person to share their views and wishes.

Good

Is the service responsive?

Our findings

During our inspection we received positive comments from the people living there about their daily life in the home. They told us that daily their routines were flexible depending on what they wanted to do. One person said to us, "I am very much my own master here and go out swimming and I spend time in the garden, when the weather is good". We were told by one person "I have progressed well living here, I have become more mobile and they [care staff] have encouraged me to do things". Another person told us "We had a quiz this morning and that was quite enjoyable.

We saw that there were organised activities going on during the day for people to participate in if they wished. This included a singing session and a general knowledge quiz in the morning and 'busy hands' in the afternoon. We joined the small group at 'busy hands' as they were engaged in various domestic tasks, folding towels, cleaning the cutlery and sorting buttons. One told us "We have a bit of a laugh as well". The hairdresser was also in the home during the day and several people were having their hair done.

Other people told us about the activities they enjoyed. We were told, "There are arm chair exercises on Monday, and I always do that". Another person told us they liked to stay in their room and read and staff "Tell me if there is anything going on but it's up to me what I do". One person told us how much they had liked gardening and had a variety of pot plants in their room and by the door leading to the outside space. They said the cleaners made sure they were kept watered for them and that they appreciated that as they enjoyed them now they could no longer garden themselves. They told us the staff were helpful and "Try to keep us happy".

People told us they chose where to spend their time, where to see their visitors and how they wanted their care to be provided. We found that people were able to follow their own beliefs and faiths and see their own priests and clergy as well as take part in religious services. We spoke with people who told us they were able to continue to follow their own faith. One person told us they were able to take holy communion each month and that they appreciated still being able to do that.

None of the people who lived in the home, their visitors or the staff we spoke with raised any concerns about the quality of the care. We asked people whether they felt they could raise concerns if they had any. People told us they had no complaints at the moment but knew whom they could complain to if they were not happy about something. One person told us, "The staff are good to talk to, if I was unhappy I would tell one of them"

The service had a complaints procedure that was on display in the home for people living there and visitors to refer to and use. However, this needed to be updated to make sure the information was up to date and accurate. There was a system in place for logging any complaints received and what had been done in response. There was a system for logging comments made about the service and the care received.

We looked at the care records for five people living in the home in detail. We saw from the care records that people's health and support needs both day and night were documented in their care plans along with

personal information and histories. We could see that some people's families had been involved in gathering background information and life stories. Staff displayed a good understanding of people's backgrounds and lives and this helped them to support them socially and be more aware of things that might cause them anxiety. Care plans had been reviewed to make sure they held up to date information for staff to refer to on people's assessed needs and associated risks.

Good

Is the service well-led?

Our findings

People we spoke with commented positively about how their home was run for them. We were told, "I see the manager often, I can ask about anything. If I have a problem they will help me out".

The service had a registered manager in post, as required by their registration with the CQC, at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service.

The service had a system of holding twice-yearly meetings for the people who lived there and their relatives to attend. The registered manager told us the aim was to make it a social occasion where everyone could come together and discuss any issues in an informal and relaxed situation.

There were records of the staff meetings being held in the home. This helped to give staff the opportunity to raise issues and discuss practice and care matters and promote communication about what was going on.

There were systems in place to assess the quality of the services provided in the home and records of the checks made. We saw that audits were being done on care plans and medication records on a monthly basis. Monitoring checks were being dome on referrals made to others such as the dietician, speech and language therapist and the memory clinic to help make sure they were followed up on. A check was made daily to monitor fluid and nutritional charts and on daily records to make sure information was being accurately recorded.

We also saw that staff had done annual competency checks to make sure their medication practices were still up to date and that the correct procedures were being followed by staff. We saw that records of cleaning routines were also checked to help make sure the cleaning schedule had been followed and to help make sure the premises and equipment were clean and safe to use. Maintenance checks were being done regularly by staff and records kept including water temperatures and emergency equipment. Faults had been highlighted and acted upon to get repairs done and these were recorded.

We looked at the policies and procedures in use by the service. We saw that some policies and procedures had been recently updated. This included the health and safety procedures to make them more robust and reflect current guidance and legislation. However some procedures had not yet been reviewed and updated to make sure they were still in line with current legislation. The registered manager confirmed that this was still being addressed and that all would be reviewed.

We looked at the records of accidents and incidents that had occurred in the home. We did this to check if action had been taken promptly to reduce the risk of it happening again. We saw that incidents had been recorded and followed up with appropriate agencies or individuals and, if required, CQC had been notified. Accidents and incidents in the home were being monitored on a monthly basis and this included an audit of any falls that had taken place. This helped to identify any particular times or situations where a fall might be more likely to happen.

Staff we spoke with told us that they were well supported in the home and that the registered manager was approachable with any issues, they expressed confidence in their manger to deal with any concerns about poor practice. They said they had regular staff meetings to discuss practices and had received supervision for their roles. Staff told us there was a good atmosphere in the home and they "got on well".