Mr & Mrs A S Benepal

# Shalden Grange

## Inspection report

1-3 Watkin Road
Boscombe
Bournemouth
Dorset
BH5 1HP

Tel: 01202301918

Date of inspection visit:
13 September 2017
15 September 2017
26 September 2017

Date of publication:
01 December 2017

## Ratings

| Overall rating for this service | Inadequate |
|---|---|

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

# Summary of findings

## Overall summary

This was an unannounced inspection which took place on 13, 15 and 26 September 2017.

Shalden Grange provides accommodation, care and support for up to 35 people. At the time of this inspection there were 19 people living in the home.

The home has a registered manager in post. 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.

A comprehensive inspection took place in December 2016. The service was not meeting the regulations and was rated Inadequate. CQC took enforcement action which included putting the service in Special Measures and imposing specific conditions on their registration. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe.

A focussed inspection to ensure that improvements were being made was carried out in April 2017. This inspection looked at the questions of, 'Is the service safe?' and 'Is the service well led?'. We found improvements for both of these key questions and the rating for 'Is the service well led?' was changed from Inadequate to Requires Improvement.

Following the inspection in December 2016, the registered provider had employed consultants to help with a review of the service and to assist with implementing the required improvements. They completed their work with Shalden Grange at the end of July 2017.

At this inspection there were a number of areas where sufficient progress and improvements had not been made. We found seven breaches of the regulations. Breaches relating to person centred care, safe care and treatment, good governance and staffing had been identified at the previous three inspections, as well as at this inspection. There was a breach of the regulation relating to consent at the two previous comprehensive inspections and this inspection. Two other regulations relating to the safe recruitment of staff and notification of events and incidents to CQC had been breached at the two previous comprehensive inspections. At the focussed inspection in April 2017, systems had been put in place to ensure the regulations were complied with. However, these improvements had not been maintained and these regulations were again in breach at this inspection.

Where sufficient progress and improvements had not been made, this meant people were at risk of not receiving safe and effective care. For example, there were continued shortfalls in the management and administration of medicines, premises safety, risk management and health and safety. Staff induction, training and supervision had not been completed and people did not always have their rights protected

because the service did not operate in accordance with the Mental Capacity Act. Care planning was still lacking in detail and contained inconsistencies and there was little activity and occupation for people living in the home.

The registered manager did not have the same level of oversight of the service as had been demonstrated during the inspection in April 2017. The culture of the service was, again, reactive rather than proactive in ensuring that a good standard of care and accommodation was provided for the people living in the home. Following our inspections in September and December 2016 and April 2017, some improvements were made and this was seen at our focussed inspection in April 2017. The improvements that had previously been made had not been sustained and the implementation of improvements had not been maintained. This meant that people were not kept safe and provided with good care from staff who had been properly trained to work to current standards and good practice guidance.

At this inspection we found that improvements had been made with regard to promoting dignity and respect and to receiving and acting on complaints. Staff were more confident and there were improved interactions between staff and people living in the home.

People in the home told us that they felt cared for and were comfortable. Staff confirmed that there were enough of them on duty on each shift to meet people's needs. They were also positive about the training that they had completed in recent months.

CQC is now considering the appropriate regulatory response to the shortfalls we found. We will publish a further report on any action we take.

## 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.

People were not always protected against the risks associated with the unsafe management and use of medicines.

The risks to people's health and safety whilst receiving care had not been properly assessed, and in some instances, action had not been taken to mitigate any such risks.

Staff had not always been recruited safely.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff did not always receive the training, supervision and support they needed.

People's rights were not always protected because the service was not acting in accordance with the Mental Capacity Act 2005.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Staff did not always recognise the need to engage with people and provide appropriate occupation.

There were incidents where staff did not respond to people's needs or requests and people were not actively involved in making decisions about their care.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Some people had not had their needs met and other people

were at risk of their needs remaining unmet because assessments and care plans were not robust and contained errors and omissions.

The service had a complaints policy and had established an effective system for identifying, receiving, recording, handling and responding to complaints.

## Is the service well-led?

**Inadequate**

The service was not well-led.

The provider was not meeting their responsibilities to manage the service under the Health and Social Care Act 2008. There were repeated breaches of regulations.

Quality monitoring systems were ineffective and record keeping required improvement.

# Shalden Grange

**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 checked 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.

This inspection took place on 13, 14 and 26 September 2017. The first day of the inspection was unannounced and carried out by an inspector and a specialist advisor. The second day was completed by two inspectors and the third by one inspector.

Before the inspection we reviewed the information we held about the service; this included any events or incidents they are required to notify us about. We also contacted the local authority safeguarding and commissioning teams to obtain their views.

Before the inspection, we asked 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. They did not return a PIR and we took this into account when we made the judgements in this report.

We spoke with and met eight people who were living in the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with seven staff, as well as the registered manager and one of the registered providers. We looked at 14 people's care and medicine records. We also looked at records relating to the management of the service including audits, maintenance records, and seven staff recruitment files.

Inadequate

# Is the service safe?

## Our findings

Some people were living with dementia and were unable to tell us whether they felt safe. We observed that, where this was the case, they responded positively when staff approached them, they smiled and reached out to staff. Other people told us that they were comfortable and content living at Shalden Grange. However we found shortfalls regarding the management of medicines, premises safety and staff recruitment practice which may place people at risk of harm.

At our inspection in December 2016 serious shortfalls in the systems to prevent and control fire, the servicing and maintenance of the building and equipment, access for people with disabilities, lack of suitable bathing and showering facilities, the provision of hot water in some parts of the home, infection prevention and control, assessment and management of risks to people including the risk of malnutrition, dehydration and skin breakdown were found. There were also concerns about the management of medicines, unsafe recruitment, training and supervision of staff and ineffective systems to protect people from abuse.

During our inspection in April 2017 we found that some improvements had been made; staff recruitment practices were safe and notifications regarding specific events were being made to CQC. Some areas of medicines management and administration had improved, as had the assessment and management of risks to people.

During this inspection we found that various prescribed medicines were left out and accessible in people's rooms. All of these items were topical medicines including moisturising creams, soap substitutes steroid creams and pain relief gels. Three people also had "over the counter" medicines including indigestion relief and cough mixture left out in their rooms. There were no risk assessments or checks in place to ensure that the items were safe for the person to take with their other prescribed items or to ensure that the items were used and stored safely. In addition, none of the tubes or bottles of prescribed creams and medicines had opening dates recorded on them to indicate how long they had been in use and to monitor when they needed to be replaced.

For medicines that had been prescribed in a variable dose, Medicine administration records (MAR) contained information regarding the maximum amount that could be given in a 24 hour period and the actual amount given each time was recorded. There was no information either on the MAR or in care plans to help staff assess what dose should be given in the event that people were unable to instruct staff themselves. Although the risk of administering too much medicine had been reduced, there was still a risk that people may not receive a dose that was effective.

One person was prescribed a medicine in a variable dose at night time. MAR showed that the maximum dose was administered every night. There was no information on the MAR or care plans about this medicine, why the maximum dose was being given or any reference to a health professional about this. Staff were able to tell us that the person themselves had a good understanding of the medicines they were prescribed and they always requested the maximum amount.

Separate MARs were in place to record the use of topical creams that had been prescribed. None of the MAR had clear directions advising staff of the frequency of application or where the cream should be applied. Some MARs were in place for items that staff advised us were no longer required.

During previous inspections staff did not have guidance about medicines that were prescribed on an 'as required basis' (PRN). At the inspection in April 2017, care plans had been created for some people who had been prescribed PRN medicines for pain relief. These provided basic information about what the medicine was for, how often it could be given and the maximum amount to be given in a 24 hour period. We advised the registered manager that PRN care plans should be developed to ensure staff had clear instruction about the circumstances when a PRN medicine could be given. At this inspection no further improvements had been made to PRN care plans. This meant that people may not receive their medicines in the most effective way.

Some PRN medicines were only being offered at specific times of the day such as every morning when they could be offered at any time during the day if a person was experiencing specific symptoms. One person was prescribed medicine to help relieve anxiety. The MAR showed that this was offered to the person every morning and refused as it was not required. However, daily records showed that the person had experienced periods of anxiety at various other times of the day. The medicine may have helped them if it was given to them when staff noted that they were anxious but there was no evidence on MAR or in other records that this had been done.

A number of the MAR had gaps. Audits of MAR had not highlighted this to be an issue and it had not been established whether the person had received the medicine but the record had not been completed.

One person was prescribed a special tooth paste to be used twice a day. An entry in the MAR for this had been signed morning and evening to state this had been done. We checked the person's daily care records and saw that there were a number of days where the person had not had support to clean their teeth or had only received support once a day.

At previous inspections medicine records did not include photographs of the people using the service. During the April 2017 inspection staff had advised that photographs had been taken and were about to be added to the medicines records. At this inspection we found that current photographs of each person had not been added to the records.

At previous inspections some people had been prescribed medicines which must be taken at specific times to meet their health needs. There had been no recognition of this in their care plans and where the required times varied from the general times that medicines were administered to other people in the home, this was not clearly highlighted on the MAR. At this inspection we found that some staff were aware of the different times for administration but the actual time medicines were given was not recorded. No care plan about the medicine had been created. A senior member of staff with responsibility for medicines, explained in detail how these medicines were managed and we were reassured that when this member of staff was on duty, the medicines were given as prescribed. However, this information was not recorded and discussion with other staff highlighted that they were not all aware of this.

All new medicines that were prescribed were delivered to the home with a printed MAR chart to reduce the risk of errors. One MAR had been handwritten for a new temporary resident. There were no signatures from the person creating the record or from a second person to confirm that the entries had been checked and reflected the prescription instructions.

We found that there were errors on the MAR for the times of administration for some medicines. Staff explained that, where health professionals had amended times of administration or doses, they had passed this information to the prescriber and pharmacy but MAR had not been reissued.

Discussions with staff revealed that not all of them were aware of the changes and some would rely on the MAR instructions rather than current knowledge. For example, staff had noted that one person had been having difficulty swallowing their medicines and had arranged for most medicines to be provided in liquid form. One item could not be provided in liquid form and there were instructions on the MAR for staff to crush this medicine. On the first day of the inspection, staff were not able to tell us how the medicine was crushed or whether a pharmacist had confirmed that doing this did not affect the efficacy of the item. Staff on the second day of the inspection confirmed that the medicine was crushed between two spoons but that approval from a pharmacist had not been sought. On the last day of the inspection, the registered manager stated that the person no longer required this medicine to be crushed. The registered manager accepted that records did not reflect this and that in future they would seek clarification and advice from a pharmacist.

During the first two days of this inspection we noted that the keys to medicines trollies were not kept securely. This was put right when we pointed out our concerns. This had not been highlighted either by staff or through the audit processes.

This was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not protected against the risks associated with the unsafe management and use of medicines.

Dorset and Wiltshire Fire and Rescue Service visited Shalden Grange on 20 September 2016 and issued an enforcement notice under the Regulatory Reform (Fire Safety) Order 2005: Article 50 requiring urgent works to improve fire safety in the home. This included repair, improvements and maintenance of the fire detection systems, fire prevention systems, assessment and management of risk and training for staff to tackle small fires, call for assistance and evacuate people safely were required. A completion date for the works was set of 1 January 2017. Dorset and Wiltshire Fire and Rescue Service visited again on 17 March 2017 and confirmed that all major works had been addressed and agreed a further deadline to complete some external works that were weather dependant. At this inspection the deadline had passed and the registered manager confirmed that the outstanding work had been completed. During the inspection we asked the registered manager to contact Dorset and Wiltshire Fire and Rescue Service to confirm that the work met their requirements. The fire service visited and confirmed that the work was satisfactory at the time of their visit but noted that it had not been fully completed and therefore further maintenance work would be required within six months.

Three staff had not completed training in fire prevention and the actions to take in the event of a fire. The registered manager confirmed that training had been booked for these staff. As part of the fire risk assessment for the service, there should be up to date personal evacuation plans for each person living in the home. The information for Shalden Grange was kept in a file near to the fire panel. On the first day of the inspection we checked the contents of the box and found that the plans had not been updated since 5 October 2016. Some people on the list were either no longer living at the home or their needs had changed significantly which affected how they would be evacuated from the home. Additionally, other people were now living in the home and there was no information about them in the event of an emergency. The provider has since confirmed that immediate action was taken to address this matter.

We asked two senior members of staff what action they would take in the event of a fire. One staff member

was aware of the file that contained personal evacuation plans and said they would collect this information to assist the fire service. The other member of staff was not aware of the plans and, after prompting, said they would take handover sheets as this would have people's names and room numbers. Further discussions with staff highlighted that not all of them were aware of the roles people should take in the event of an emergency, who would call the emergency services or whether they should try to move people out of the building.

Since the last inspection the provider had constructed a wooden storage area underneath a fire escape and within an internal court yard near the laundry. The registered manager advised us that this was to store salt for the water softener and empty cleaning trollies. During our inspection we noted that the cleaning trollies were stored here but still contained combustible items including paper towels, toilet rolls and cleaning cloths.

During our inspections in September and December 2016 and April 2017, we found shortfalls in the maintenance of the building and equipment. Most people were unable to shower or bath because the showers and baths that were in the home did not meet their needs. Some wash hand basins did not have hot water, and others had water that was too hot and could have scalded people. Safety checks on portable electrical appliances had not been carried out and there was no evidence that equipment such as stair lifts and hoists had been serviced.

In April 2017, the registered provider had taken action and created a good sized wet room in an unused area of the home. However, this area was also part of a corridor which led to the laundry, staff room and fire escape. There were two doors either side of the shower area. Neither of the doors had locks or closed properly. There was no form of heating in the shower area and no method for people or staff to summon help if they needed this whilst showering or assisting people. The registered manager agreed to ensure that the doors were adjusted, locks were provided and signs were hung on the outside of the doors whilst the shower was in use to ensure that people's privacy and dignity were protected. They also agreed to look into possible heat sources and to ensure that one of the home's portable call bells was taken into the shower area when it was in use. At this inspection we found that there was a notice for only one of the doors and no locks had been provided. Both doors were closing properly. There was a commode chair in the shower without a full seat over the commode pot opening. There was also evidence of communal toiletries rather that people's individual choices as there were two part used bottles of shampoo and a bottle of hand wash although there was no separate hand wash area. The area was cold to walk through and there was no evidence of additional heating. During the afternoon of the first day of inspection, two linen trollies containing clean sheets and bedding were stored in the area. This could pose a risk of cross infection.

At this inspection, we found that three of the nine bedrooms where we checked the water, did not have hot water but temperatures in other rooms were not excessive. There was no plug in five of the wash hand basins. Two rooms still had taps which were coloured blue so had to be run to establish which were hot and cold. The registered manager advised during the April 2017 inspection that they were still working through the lists of items to be addressed and this would be completed but the work had still not been attended to at this inspection. Following the inspection, the provider confirmed that new boilers and a new hot water calorifier had been installed and all hot water issues had been resolved.

At the inspection in April 2017, we reviewed the system the registered provider followed to ensure their water systems were safe. The registered manager said their maintenance person regularly checked and recorded the temperatures of the water outlets. We asked to see the recorded checks; however these were not available at the premises on the day of our inspection and were not sent to us as requested. After the inspection in April 2017, the registered manager engaged a contractor who visited the premises and

completed a risk assessment that highlighted a number of areas for attention. Certificates were provided at this inspection to confirm that the required tests and checks have been completed.

None of the portable electrical items such as the medicines fridge and vacuum cleaners as well as televisions, lamps, portable heaters and radios that were in people's bedrooms, had evidence on them that they had been checked as recommended within Health and Safety Executive guidance that was highlighted to the registered manager in September and December 2016 and in April 2017. During the April 2017 inspection the registered manager stated that visual inspections were carried out and records of these were kept. We requested this evidence on three occasions during the inspection and twice by email following the inspection. This was not provided. At this inspection the registered manager provided a copy of the new policy regarding the frequency of visual checks and appliance testing. We requested an inventory of all of the portable electrical items in the home and evidence of when each item had last been visually checked or tested. This was requested during the inspection and by email following the inspection. Again, this was not provided. We therefore cannot be certain that there was a system in place to complete and record visual checks for damage or faults on electrical equipment to help control electrical risks.

During the course of the inspection we visited eleven bedrooms. In all of these we found extension cables and gang sockets. Many had plugs which were not fully inserted or the cables trailed across the floor creating a trip hazard. In some cases more than one extension cable were joined together. Some people had portable electrical heaters in their rooms. We asked staff about risk assessments for the extension cables and portable heaters but they were not aware that any had been completed. We asked the registered manager for this information but it was not provided.

Up to date service and maintenance certificates were held for gas and electrical installations, the fire detection and alarm system, stair lifts and passenger lifts, emergency lighting and hoists. The fire risk assessment had been completed during September 2016 and had been rated as 'tolerable' by an independent fire risk consultant. Records showed fire alarms were tested on a weekly basis and records were signed and dated when the tests had been completed. All fire extinguishers had been checked during January 2017and current certificates were available. Maintenance certificates for the gas appliances in the kitchen and on boilers indicated that work was required to ensure they were safe but there was not record that the work had been completed. The registered manager later obtained confirmation from the relevant contractors that the work had been completed. Certificates for the passenger lift also indicated that safety work was required. The registered manager was asked to provide confirmation that this work had been completed during the inspection and by email following the inspection but this has not been supplied.

At previous inspections we highlighted that wardrobes and other large pieces of furniture had not been fixed to walls and therefore there was a risk that furniture could be accidentally pulled over and injure someone. Items that we had previously highlighted had been attended to. At this inspection we found a large, glass fronted cabinet and two wardrobes that had not been fixed to the wall.

Also at previous inspections, there were concerns with items of broken furniture and equipment and various pieces of equipment being left in the garden. When this had been highlighted, action was taken. There were no concerns about this during the inspection in April 2017. At this inspection we again found various items had been left in the garden and tools and equipment, including ladders, a wheelbarrow, cement mixer and old metal railings were left out. In addition, we noted that there was a pond in the garden that was not protected or secure and a number of foot paths were uneven and posed a trip hazard. A specialist waste bin which should be kept secure was not locked. Access to the garden was not restricted and we saw people walking in the garden on a number of occasions. By the last day of the inspection the registered manager had taken action to tidy the garden and had filled in the pond.

Staff checked people's weights every month. At this inspection two people had been identified by staff as "at risk" and records of their food and fluid intake were being kept. There were no care plans indicating what the people's specific needs were or how they could be encouraged to improve the amount they ate and drank. One person had been prescribed a milk based food supplement to try to improve their calorie intake. Records showed that they were choosing not to drink the supplement. We checked their other care records and it was clearly recorded that they did not like milk. Staff had been recording that the person had declined the supplement but there were no records that any other action had been taken. At 11:15 am on the first day of the inspection, one of the people had drunk only 50mls of fluid. There was no indication on the fluid chart or in care plans what their usual intake was and any action staff should take if their intake fell below this.

During the two inspections in 2016, risk assessments had not been completed for people who had rails fitted to their beds or for people who had experienced one or more falls. At the April 2017 inspection we found that all assessments had been completed. We advised the registered manager to ensure that the form they were using for their bed rail risk assessment complied with guidance issued by the Health and Safety Executive (HSE). Recommendations are that, where possible, bed rails should be integrated rather than rails that need to be attached. At this inspection we found that most people had integral rails where they were needed. However, two people were using older style beds with rails that attached separately. There were large gaps between the mattress and the ends of the bed and the rails themselves were loose. Protective bumpers were placed over the bed rails. In one case these had not been properly secured and in another the bumpers were cracked and dirty. The HSE guidance clearly states the maximum and minimum dimensions for the rails, mattress heights and any gaps in order to try to prevent injuries to people. None of the records that we saw confirmed that measurements had been checked for these beds. We raised this issue with the registered manager during the second day of the inspection. They confirmed on the third day of the inspection that there had been spare beds in the home with integral bed rails and so these had been provided for the two people discussed.

Training records showed that none of the staff had completed Control of Substances Hazardous to Health (COSHH) training. A COSHH audit completed in July 2017 stated that all products were kept in their original containers. During this inspection we found that cleaning chemicals were not being stored and handled in a correct manner. On two separate occasions, cleaning trollies were left unattended and insecure. On each trolley were mop buckets containing dirty water which also contained bleach, spray bottles labelled 'detol', and a spray bottle that had the original label removed and 'pink spray' written on the bottle in marker pen. There was also a bottle of detol surface spray left in an ensuite bathroom.

A number of issues were identified at the last inspection and during an audit undertaken by the local Clinical Commissioning Group (CCG) in October 2016, regarding infection prevention and control. At the inspection in April 2017, we found that seven staff had completed a workshop on 'essential principles of infection prevention and control' training and six staff had completed the Skills for Care work book on infection prevention and control but there was no evidence that these had been checked to ensure that their answers were correct. The housekeeper, who was in overall control of cleaning, had not completed infection control training. At this inspection we found that three of the seven staff who had completed the training were no longer employed at the home. There were no records that additional training for other staff had been completed.

Rooms and equipment were clean and we observed that staff wore disposable gloves and aprons as required.

At the last inspection, three of the six bedrooms visited did not have paper towels in them to enable hygienic

hand drying. The registered manager told us that this was due to staff not replacing them as required and this would be addressed with staff. At this inspection four of nine rooms visited did not have paper towels available.

This was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not ensured that the premises and equipment is safe to use and was used in a safe way, suitable equipment to meet people's needs had not always been provided and steps had not been taken to assess the risk of, prevent, detect and control the spread of infections.

During our inspections in September and December 2016 we found that the employment of staff had not always been undertaken in a way that meant people were protected against the risks associated with the unsafe recruitment of staff. At our April inspection one new member of staff had been recruited and all of the required checks and references had been completed and obtained.

At this inspection staff recruitment records for six staff who had been recruited since the last inspection were checked. The regulations require specific employment checks to be carried out for prospective staff to ensure people are safely cared for by appropriately recruited staff. These checks include, criminal record checks, right to work in the United Kingdom, appropriate employment references and fitness to work. These checks had all been properly completed for two of the six staff records. Three of the staff had started work without current, role specific references and a fourth member of staff was working in the home without an up to date criminal record check from the Disclosure and Barring Service. This meant that the provider had not taken suitable steps to ensure that there were effective recruitment procedures in place.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because recruitment procedures were not operated effectively to ensure that all staff recruited were suitable to work with vulnerable adults.

Staff confirmed that they had enough time to provide the care and support that people required and they felt staffing levels were satisfactory. People living in the home were satisfied that there were enough staff on duty to support them when required. Observations throughout the inspection showed staff were available to help and assist people when they were required. Alarm bells did not ring for lengthy periods and staff did not appear rushed when supporting and assisting people. However, a number of people spent much of their time in the lounge and there was no call bell available. Over the course of the inspection there were between one and six people in the lounge each time we visited it. We asked two people how they would get help if they needed it. They told us that they shout out and staff come to them. We were concerned that, if staff were not in the vicinity, they may not hear people calling. To ensure people's safety and comfort, they should have access to a means of summoning staff at all times. This was an area for improvement. The provider has stated, following the inspection, that there should be six call bells in the lounge.

The service had satisfactory policies and procedures in place to protect people from abuse. Information about safeguarding was included in the staff handbook, which was given to all staff and there were information posters displayed around the home. The registered manager had made safeguarding alerts to the local authority where possible abuse had been suspected. Staff told us they knew the different signs and symptoms of abuse and said they were confident about how to report any concerns they might have. However, training records showed that only 12 of the 17 staff on the rota had completed safeguarding training. This was an area for improvement.

Requires Improvement

# Is the service effective?

## Our findings

During the inspections in September and December 2016 we found that staff had not received adequate induction, training and supervision to ensure that they could deliver care and support to people safely and appropriately.

At this inspection we found that the service had improved their in-house induction for staff to familiarise them with the people living there, the premises and working practices. However, whilst seven of the staff had started work on the Care Certificate, none of them had completed this. The Care Certificate is a national qualification created by Skills for Care. Skills for Care is a national organisation that sets the standards of knowledge and competency that people working in adult social care need to meet before they can safely work unsupervised and the frequency they should undertake refresher training in these areas. Following the inspection the provider advised that some of the staff had been employed for a long time and had previously completed common induction standards. Therefore they did not need to complete the Care Certificate. Information about how many staff had completed this,and when, was not made available.

Skills for Care recommend that training in safeguarding adults, fire awareness, emergency first aid and basic life support, medicines awareness and moving and handling are updated every 12 months. Training in dignity, equality and diversity, fluids and nutrition, person centred care, communication, recording and reporting, food hygiene, health and safety, infection prevention and control and the Mental Capacity Act should all be updated every three years.

At this inspection, training records showed that of the 17 staff on the rota
12 staff had completed safeguarding adults training.
11 staff had completed emergency first aid and basic life support training.
3 staff had completed handling records training.
2 current staff and one of the registered providers had completed training in the Mental Capacity Act.

Some of the new staff may have completed some training with other providers but records were not clear. They had provided copies of certificates of previous training but this had been undertaken more than 3 years ago in some cases. No assessments of their knowledge and competence had been completed to establish whether further training and development was required.

Staff confirmed that the training they had completed had been helpful and they felt it had improved their knowledge and understanding. All of the staff confirmed that they would like to complete more training.

At previous inspections, training to meet people's specific needs had not been provided. People receiving care from the service were living with conditions such as dementia, Parkinson's disease and diabetes. At this inspection training in these areas had still not been provided. This meant that staff may not always be able to deliver care and support to people safely and appropriately.

This was a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014 because staff were not supported with appropriate induction, regular training and supervision

The registered manager advised that they had recently invested in an online training package for staff. This contained all the required training topics and they anticipated that staff would complete one course every two months. At the time of the inspection none of the staff had completed any of the courses.

Staff had not received adequate supervision and support. A system to ensure supervision happened had not been established until August 2017 although the need to provide this had been highlighted to the registered manager since the inspections in September and December 2016. One of the new senior staff had completed 10 supervision sessions with staff in August 2017 and a plan had been put in place to ensure that all staff received regular supervision and support in the future.

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's rights were not always protected because the staff did not act in accordance with MCA. Some people told us they made their own choices and that staff listened to and acted upon their decisions. Consent was sought by the service with people signing agreement to things such as the use of photography and equipment such as bed rails.

During the inspections in September and December 2016 we found that that there was not always a sufficient understanding of the processes to assess capacity, make decisions in people's best interests where necessary and to accept that people have the right to make unwise decisions. Mental capacity assessments and best interests decisions had not been carried out and documented where people lacked the capacity to make decisions for themselves.

At this inspection we found that two of the current staff group and one of the registered providers had completed a workshop on the Mental Capacity Act and Deprivation of Liberty safeguards. Two of the new senior staff were able to demonstrate knowledge and understanding of this area gained from previous employment. However, we found that the principles of the Mental Capacity Act were not always being followed. A pressure mat had been placed in one person's bedroom to alert staff when the person was moving around their room. This had been done because the person was assessed at being at risk of falls. The person did not have the capacity to agree to this restriction. Care plans did not reflect that the mat was in use or the reason for it. There was no evidence that staff had tried to explain the reason for the sensor mat to the person or that a mental capacity assessment and best interests decision had been made. Three other people had bed rails fitted to their beds. This meant that people may not be able to get out of bed without assistance. The potential restriction to the people's freedom had only been assessed and documented in accordance with the MCA for one of the people. There were no records relating to these decisions for the other two people.

This was a repeated breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because suitable arrangements were not in place for acting in accordance with the Mental Capacity Act 2005.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS)

which applies to care homes. 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). The registered manager understood when DoLS applications would be required and had a system in place to ensure they were aware when DoLS authorisations expired and any conditions had been adhered to.

Some people were not able to leave the home because exit doors were locked and connected to an alarm that sounded unless the person leaving the building knew how to turn it off. Where people lacked capacity to consent to this, DoLS applications had been made. Senior staff were aware which people this applied to and whether any special conditions had been placed as part of the authorisation.

The main meal of the day was served at lunchtime and the evening meal was a lighter meal such as snacks including sandwiches, beans on toast, and salads. The lunchtime meal consisted of three courses, the first of which was a homemade soup. During the inspections in September and December 2016 people had been served their soup in a plastic insulated mug and no choices or alternative dishes were offered to them. Staff told us that alternatives were available to the main meal if people requested this. However, the people that we spoke with told us that they did not know until they went to the dining room what the meal was going to be and most people were not certain that they could request something different. The registered manager pointed out that there were printed menu cards placed on each table and also on two of the walls in the dining room which detailed alternative dishes which people could request.

Lunch service started from 11:20 in the morning. The registered provider told us that this was because some people had an early breakfast and other people needed support at mealtimes so they started meals earlier to ensure staff were available to help them as necessary. Staff supported people to eat and drink in a relaxed way and at their own pace. Some records contained information about food people liked or disliked. The registered provider and cook were also aware of some people's preferences. At this inspection we found that there had been no changes to the management of meals and no steps had been taken to make people more aware of any choices that may be available. This was an area for improvement.

Two people were not wearing their dentures at meal times. Staff were aware of this and were clear that this was the person's own decision to make. They told us that the people still ate well and there were no concerns about their diet or nutrition. The cook had provided softer meals for one of the people. None of this information was reflected in their care plans.

People were supported to access the health care they needed. People told us that staff sought medical help quickly when they were poorly. Records confirmed this showing that people had seen their GP, nurse or dentist, and other professionals such as hospital consultants, dieticians and chiropodists.

Requires Improvement

# Is the service caring?

## Our findings

During this inspection we received positive comments from people about the staff and the care they received. We observed staff chatting to people whilst supporting them to eat or mobilise around the home. During the three days of the inspection there were many occasions where people were in the lounge with the television playing but they did not appear engaged either with the television programme or with one another. When staff came into the lounge people became more alert and responded to greetings from staff and chatted with them.

However one person was sitting alone in the lounge and calling out that they felt unwell. We spent time with the person and chatted to them. Staff explained that the person always said they were unwell but there was no problem. We observed this person during the course of the inspection and saw that they rarely did anything that engaged them or provided any form of occupation. There was no information in their care plan about how they presented or actions that staff could take to reassure the person and redirect their thoughts and behaviours.

There were two occasions in the lounge where people were sleeping in their wheelchairs. Staff woke people up and told them that they were going to be hoisted to an armchair. Staff did not seek permission from the person to do this or ask if this was what the person would like or if they would prefer to go elsewhere in the home. This was an area for improvement.

Senior staff had a good knowledge and understanding of people, including their current support needs, and information about their lives, family, career and other things that were important to the person concerned. This meant they were better able to have conversations with the person and support them in the way they wanted. Other staff were learning from this example but records still lacked detail and did not reflect the knowledge that individual staff had about people living at Shalden Grange.

People were smartly dressed, clean and comfortable. People who used aids such as hearing aids or glasses were wearing them and people had their watches or jewellery, such as a necklace or earrings, on where they chose to. Bedrooms were personalised with items of their furniture, ornaments, pictures and photographs of people who were important to them.

Requires Improvement

# Is the service responsive?

## Our findings

During previous inspections in September and December 2016 we found that people's care needs were not always fully assessed, planned for and met. For example, people with conditions such as diabetes, dementia and Parkinson's disease did not have care plans outlining what the condition meant to the person, how it affected them, how it may progress and any risks or possible complications that may occur.

At this inspection, a new member of senior staff had taken on the responsibility for reviewing and updating care plans. There had been a number of staff changes since the last comprehensive inspection in December 2016 and each change had meant the structure and content of people's assessments and care plans had changed. This had meant that care plans were always in a state of change and no one system had been fully embedded for staff to adopt and become used to.

The registered manager had introduced new processes which included printing the most recent care plans from the computer to enable all staff to access them for reference and a programme to ensure that each person's care plans were reviewed at least once a month or sooner if required. On the first day of the inspection we viewed the hard copies of some care plans. Discussions with senior staff later revealed that there was more up to date information on the computer but this had not been printed. This meant that staff may not always be able to access the most recent information about people.

At this inspection we found that care plans were more up to date than at previous inspections and contained more information about people's needs. For example, there were care plans for people who lived with diabetes or epilepsy. However, other care plans still lacked important details about people's needs and how they were met and some contained contradictions. For example, care plans did not include the type of pressure relieving equipment being used, whether the equipment was self-regulating or should be set according to weight or how frequently a person should be supported to reposition themselves. Another person had a catheter. There was no care plan to indicate what support the person required to manage this or any specific issues that staff should be aware of and report to health professionals. A care plan for a person living with diabetes stated that their condition was controlled by diet and prescribed medicines. A review of their medicines records revealed that they were not prescribed any medicines for diabetes.

During the inspections in September and December 2016, we highlighted that there was little or no information about people's wishes for end of life care and no information about whether people had a Do Not Attempt Resuscitation (DNACPR) orders in place. This means that people have chosen not to receive cardio pulmonary resuscitation (CPR) if their heart stops beating. At this inspection there was clear information about which people had chosen to refuse resuscitation and this information was readily accessible to staff in the event of a medical emergency. However there was still very little information about people's wishes regarding end of life care and support if they should require this whilst at Shalden Grange.

Discussions with staff, and records, showed that some people in the home could exhibit behaviours that were challenging to others. Records noted that people had been 'aggressive', 'agitated' and 'shouting out'. There was no evidence that referrals had been made to specialists for advice and support. Care plans were

in place for dementia care, behaviour that can challenge others and mental health. However, these had not been fully completed and did not contain any analysis of events to look for possible triggers or find successful management strategies. For example, one person's care plan stated 'agitated and shouting out, may be pain' but there was no further information to advise staff what they should do to support the person.

An activities programme was posted on the lounge door and listed activity sessions for each afternoon except Sundays. Activities included bingo, colouring and painting, exercise, music therapy and word games. These were all group based activities and senior staff advised that they hoped to introduce some individual sessions for people who preferred to stay in their rooms or who did not like to join in with groups. No organised activities were observed taking place during this inspection and there were no records of previous activities that had taken place or who had participated in these.

This was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because proper steps had not been taken to ensure that people received the care, treatment and support they required to meet their personal, social and emotional care and welfare needs.

One person was cared for in bed and a senior member of staff had recently discovered that the person enjoyed watching cartoons. They had checked the television guides and made a point of ensuring that channels showing cartoons were selected for the person.

During previous inspections in September and December 2016 the service did not have an effective system for identifying, receiving, recording, handling and responding to complaints had not been established. At this inspection there was information about how to complain on a noticeboard by the main entrance to the home. Details about how to make a complaint were also included in the information pack given to people and their relatives when they moved into the home. The information was detailed and set out clearly what an individual could expect should they have to make a complaint. There was a procedure to ensure that complaints were responded to within specific timescales and that any outcomes or lessons learned were shared with the complainant and other staff if this was applicable. Records of complaints that had been received and investigated showed how the concern had been investigated, the timescales this was done within and the outcome for each complaint.

Regular meetings were held for the people living in the home to enable them to contribute to the running of the home and raise concerns. Meetings were also held for relatives. Records of the meetings showed that recent topics for discussion had included menu plans, activities and staffing.

Inadequate

# Is the service well-led?

## Our findings

Previous inspections in September and December 2016 found that arrangements to monitor the quality and safety of the service provided were not effective. Nine breaches of regulations were identified. The service was rated inadequate and placed in Special Measures. Specific conditions were placed upon the registration of the service with regard to the provision of person centred care, safe care and treatment and good governance.

Following these inspections the registered provider engaged two consultants to support the registered manager to make the necessary improvements to the service. A follow up inspection focussing on the questions of is the service safe? And is the service well led? was carried out in April 2017 and it was found that improvements were being made. At that inspection our assessment was that the service was no longer in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because recruitment procedures were had been improved and were operated effectively to ensure that all staff recruited were suitable to work with vulnerable adults and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 because notifications were being made as required.

The first day of this inspection was unannounced. The registered manager was not in the home upon our arrival and was unable to come to the home when staff contacted them. The second and third days of the inspection were arranged with notice and the registered manager was available to support the staff and provide information for the inspectors.

People living in the home told us that they felt cared for and that there was always someone they could speak to if they had concerns. All of the staff we spoke with confirmed that a number of improvements had been made since the last inspection; they were enthusiastic about the training they had undertaken.

However at this inspection we found seven breaches of the regulations. Breaches of regulation 9, 12, 17 and 18 relating to person centred care, safe care and treatment, good governance and staffing had been identified at the previous three inspections, as well as at this inspection. Regulation11, relating to consent had been in breach at the two previous comprehensive inspections and also at this inspection. It was not checked at the focussed inspection in April 2017. Two other regulations relating to the safe recruitment of staff and notification of events and incidents to CQC had been breached at the two previous comprehensive inspections. At the focussed inspection in April 2017, systems had been put in place to ensure the regulation was complied with. The actions taken had been satisfactory and no breaches were found. However, these improvements had not been maintained and these regulations were again in breach at this inspection.

The provider and registered manager had not taken appropriate action to meet these regulations or make and sustain the necessary improvements. This meant people were at risk of not receiving safe and effective care. There were a number of areas where sufficient progress and improvements had not been made. For example, there were continued shortfalls in the management and administration of medicines, the premises, risk management and health and safety. Staff induction, training and supervision had not been completed and people did not always have their rights protected because the service did not operate in

accordance with the Mental Capacity Act. Care planning was still lacking in detail and contained inconsistencies and there was little activity and occupation for people living in the home.

At this inspection we found that sufficient improvements had been made with regard to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, promoting dignity and respect and to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 receiving and acting on complaints. Staff were more confident and there were improved interactions between staff and people living in the home.

The staffing and management structure had been developed further. There was one deputy manager, one assistant manager and five senior carers. The registered manager reported that the staff worked well together. Staff told us that there was always someone available for them to seek advice from. However, people told us that they had seen a number of new staff come and go which they had found difficult. There were no clear records to tell us how many staff had joined and left the service and there were no exit interviews to establish the reasons for their departure. From training records and previous rotas we established that five staff who were employed at the last inspection had left and there were a further seven names of staff who had not been employed at the last inspection and were no longer employed at this inspection.

People living in the home believed that the new deputy manager was the manager. They reported that they felt able to approach any of the staff with any concerns or difficulties they may have.

The registered manager did not have the same level of oversight of the service as had been demonstrated during the inspection in April 2017. Regulations that had previously been met were found to be breached again at this inspection; this included the safe recruitment of staff and the requirement to notify CQC of incidents and events. Audits that had previously been completed by the registered manager or consultants had been delegated to senior staff.

Initially, daily "walk the floor" audits had been introduced to ensure that improvements and new systems that had been introduced were properly embedded and sustained. The audit form had been created to ensure that people living in the home were seen to be engaged and feeling supported, staff were available to people when required and working safely, record keeping was monitored, medicines management and equipment were satisfactory and the environment was checked to ensure that there were no cleaning or safety concerns.

Analysis of the completed audits showed that the senior carers and assistant manager had been completing the daily checks. The form contained instructions to visits five bedrooms a day rooms including empty bedrooms. In each room pressure relieving equipment, bed rails and bumpers should be checked, the auditor should check all medicines were stored securely and water outlets (taps and showers) in vacant rooms should be run for a minimum of two minutes as part of the steps taken to prevent legionella. From 1 August 2017 until 26 September 2017 daily walk the floor audits had been completed on 32 out of a total 57 days. There had been no plan to guide staff which rooms to check. Consequently some rooms had been checked up to nine times, three rooms had been checked once and four rooms had not been checked at all.

The records of the checks that were carried out were very brief and rarely highlighted any issues to be addressed. On one occasion it was noted that there were no paper towels in a room, twice there were notes that the shift had been short staffed because staff did not arrive for their duty, twice there were comments that records had not been properly completed, once a note that one person did not have a drink in their

room and once that there was no call bell in an ensuite. None of the issues that we noted such as medicines left out, cracked bumpers and loose bed rails had been picked up. There was no evidence that anyone had checked or analysed the audits although on the final day of the inspection the registered manager reported that they had realised that the rooms were not being checked in rotation and they would address this.

At the previous inspection we found that the leadership of the home was becoming proactive, risks were being identified and addressed and the quality of service was improving. During this inspection we found that little progress had been made in many areas including care planning and assessment, staff training, record keeping and the standard of accommodation. Some bedrooms had been redecorated and this had improved these rooms but furniture was not always in a good condition. At each inspection we had requested a plan for the refurbishment and maintenance of the home but this, together with other documents that were requested, was not provided.

The culture of the service has, again, been found to be reactive rather than proactive in ensuring that a good standard of care and accommodation is provided for the people living in the home. Steps to ensure people are kept safe and provided with good care from staff who have been trained to work to current standards and good practice guidance have not been completed.

Before the inspection, we asked 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. They did not return a completed PIR to us.

Records again lacked detail and current information as well as containing errors and contradictions. Some of the records we requested were not provided. In addition, a new office area had been created within the dining room. Records containing personal information were held within cupboards in this area and we could not be certain that records were being created, amended, stored and destroyed in accordance with current legislation and guidance.

This was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because effective systems and processes had not been established to assess, monitor and drive improvement in the quality and safety of services provided and because accurate records were not maintained.

During the inspections in September and December 2016 we found that the service had not been submitting the required notifications to CQC regarding specific incidents and events. We provided the registered manager with guidance about this requirement and the service was found to be compliant with this regulation at the inspection in April 2017. At this inspection we found that one person had passed away and two people had sustained significant injuries but notifications had not been made.

This was a repeated breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 because the registered manager had not notified us of all incidents.