Bupa Care Homes Limited

Shelton Lock Care Home

Inspection report

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Tel: 01332690606

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 11 September 2017 and was unannounced. Shelton Lock provides long term and respite care for adults with a range of physical nursing needs, including palliative and end of life care and respite care for adults. The service is registered to accommodate up to 40 people. At the time of the inspection 31 people were using the service.

The last inspection took place in September 2015 before BUPA (The provider) changed their legal entity to BUPA Care Homes Limited. This was the first inspection of the service since the legal entity changed on 31 January 2017.

Shelton Lock had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's and staff comments found staffing levels were not always sufficient to consistently meet the needs of people using the service. We have identified this as an area of improvement as to how staffing levels are determined in the detailed findings of this report.

Staff were able to demonstrate a good understanding and knowledge of people's specific support needs, so as to ensure theirs and others safety. Staff understood the risks and signs of potential abuse and the relevant safeguarding processes to follow.

People's safety was promoted as potential risks were assessed and regularly reviewed. Measures to reduce risk were implemented which included the use of equipment to support people safely and promote their independence.

We observed that staff followed safe procedures when giving people their medicines. Medicines were safely stored, recorded and administered in line with current guidance to ensure people received their prescribed medicines to meet their needs. This meant that people received their prescribed medicines as they should and in a safe way.

The provider had robust recruitment processes in place. Staff understood their roles and responsibilities and would seek people's consent before they provided care or support. Staff received supervision and support, and had been trained to meet people's individual needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. We observed examples of good practice where staff offered people choice, and people told us they did not feel restricted.

The dining experience for people was positive and people were in the main complimentary about the quality of meals provided. Catering staff responsible for the provision of people's meals were knowledgeable about people's individual dietary requirements and their diets were catered for.

People's healthcare needs were effectively managed and kept under review. Staff were observed to refer to and speak with health care professionals on both urgent and routine health care matters. People told us they had access to health care services and people's records confirmed this.

People's needs were assessed prior to their moving into Shelton Lock and were used to develop care plans which were reviewed and updated. Assessments were also used to gather information about people's life histories. We found this information whilst gathered was not used to support people's social interaction and engagement. People's access to activities and stimulation was inconsistent, and further measures were needed to reduce the risk of social isolation. We have identified this as an area for improvement within the detailed findings of this report.

Systems were in place to seek and act on feedback from people using the service, which included the complaints policy and procedure. People referred to resident meetings; however they said these were not regularly held and that they would welcome the opportunity to take part. People's views about staff having insufficient time to talk with them and take part in activities were discussed with the area and registered manager. The area manager said they would take action, by considering an increase in hours made available so additional support could be provided to assist and engage people in activities.

The provider had a range of quality assurance audits which had taken place that focus on specific areas, such as medicine, health and safety and infection control. Audits as to people's care and support were also undertaken by the registered manager and area manager. The outcome of audits was used to develop the service and areas for improvement were recorded within an action plan.

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 not consistently safe.

People's views found staff were not able to consistently provide support to people in a timely manner. We have made a recommendation as to how staffing levels are calculated within the report.

People's safety was promoted through the through recruitment process of staff to determine their suitability to work with people.

Staff understood how to keep people safe and understood how to identify and manage risks to people's health and safety. People living at the home felt safe.

Staff had a good understanding about safeguarding and how to report concerns.

Medicines were given to people safely.

Is the service effective?

Good

The service was effective.

People's needs were met as staff had received the training to effectively carry out their role. Staff felt supported and had regular supervision and appraisals.

People were involved in day to day choices and decisions. People's rights and liberties were protected in line with the Mental Capacity Act 2005.

People received a diet that was appropriate to meet their nutritional needs.

People were supported to access health professionals where required to maintain their health and well-being.

Is the service caring?

Good

The service was caring.

People were cared for by staff who showed care and compassion.

Staff encouraged people to make decisions about their day to day lives and about the care and support they received. However some people said they were not involved in the development of reviewing of their care plan.

Staff respected the people they cared for and showed this through kindness and affection.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's views as to their opportunity to engage in social interaction and stimulation were mixed. We found improvements were needed to ensure everyone's well-being was promoted through social activities and inclusion. We have made a recommendation to the promote people's social inclusion.

People's individual care had been assessed and planned for and regularly reviewed.

Systems were in place to ensure people were able to raise concerns and provide feedback on the service they received.

Is the service well-led?

Good

The service was well-led.

People's views as to their ability to share their views on the service were mixed. People's and those of staff were regularly sought.

The registered manager and deputy manager were clear about their roles, responsibility and accountability. We found staff felt supported by the registered manager.

Appropriate arrangements were in place to ensure that the service was well-run. Suitable quality assurance measures were in place.

Shelton Lock Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to 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.

This inspection took place on the 11 September 2017 and was unannounced.

The inspection team comprised of two inspectors, a Specialist Advisor and an expert by experience. The Specialist Advisor had experience working and caring for people within health care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in older people living with dementia.

Before the inspection we reviewed notifications we had received from the provider. Notifications are information about key incidents and events within the service that the provider is required by law to tell us about. We also reviewed the provider's statement of purpose. A statement of purpose is a document which includes the services aims and objectives.

We contacted commissioners for social care, responsible for funding some of the people that use the service and asked them for their views. We contacted Healthwatch Derby who shared with us their findings following their visit to Shelton Lock in July 2017. The feedback we received was used to inform our inspection judgements.

We spoke with 13 people who used the service and 1 family member who was visiting their relative. We spoke with a doctor from a local practice who was at the service to review people's health care needs.

We spoke with the regional manager, the registered manager, deputy manager, three registered nurses, a housekeeper, the chef manager, the cook, four health care assistants and the activity organiser.

We looked at the records of 10 people, which included their plans of care, risk assessments and daily notes. We looked at three people's medicine records. We also looked at the recruitment records of three members

of staff, staff training records, quality assurance audits and the minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

Our observations showed people's call bells were answered in the early morning within several minutes. We noted the ability of staff to respond to people's needs timely was affected, dependent upon the needs of other's. For example, the availability of staff to support people in a timely manner was made more difficult as people began to request help in getting up and when a person's health deteriorated and urgent medical support had to be requested. Our observations of the availability of staff to support people consistently were supported by their comments.

People views about their being sufficient numbers of staff to meet their needs and to respond request for help, including answering call bells were mixed. "It's the help, not as instant as a lot of people feel it should be but can't complain at all. If I have to say anything about this place – it's understaffed. There's such a tight budget if a staff member is off sick, then its agency staff." "I won't say they come quickly but they do come. It's different, sometimes they (staff) are available and sometimes they're not, can be very different." "I've not really waited too long really." And. "Not bad, I've not had to wait too long but its like 'I'll be with you in a minute' or 'I'll be with you in a second'". "At night I go on the toilet and have to wait for them (staff) to come back."

We recommend that the service re-evaluates the current dependency tool used. To ensure there are consistently sufficient numbers of staff available, to safely and responsively meet the care needs of people using the service in response to the comments we received and from our observations.

Whilst staff were occupied in supporting people to go through to the dining room for the lunchtime meal, we saw a person sitting in a wheelchair in the lounge, who appeared distressed. The person did not have access to a call bell and was therefore reliant on staff walking by so that they could attract their attention. The person asked us how long they would need to sit in their wheelchair as their back was causing them discomfort. We sought the help of a member of staff on their behalf. The person received the support they needed.

Staff said there were usually two nurses and six or seven care staff on duty, who were supported by an activity co-ordinator, house-keepers, laundry staff and kitchen staff. This was consistent with the number of staff on duty on the day or our site visit and the staff duty roster.

Staff spoken with felt staffing levels were not always adequate. Staff comments included: "Night staff sickness is an issue so we have agency staff." "……but no one goes without the care they need." "We've raised the staffing issue at meetings. [The registered manager] is dealing with it I'm sure." The registered manager told us the issue regarding staff sickness was being managed consistent with the provider's policies and procedures. The registered manager said staffing levels were regularly reviewed and the needs of people were considered as part of the review.

People we spoke with said they felt safe. "Oh I feel safe here yes, I think it's all about the place, I'm looked after." "Oh god Yes, I do feel safe, the home, it's got a comfy feeling to it." And. "It's nice here and yes, I do feel

very safe because there are a lot of people around looking after me."

Steps were in place to reduce the risk of people being abused. Information and leaflets about safeguarding and the procedure were displayed and available at the entrance to the service. Information about external agencies including their contact details were available should people wish to raise concerns or make a complaint. There was a policy that covered whistle blowing, known as the 'Speak Up' policy which made clear that staff had the right to whistle blow to outside agencies if appropriate.

We were made aware of a person with a large bruise on their hand. When we spoke with the person, they said, "Staff didn't hurt me or hit me." They explained the bruising was caused by their health condition and as a result of how treatment was administered. The person was clear that staff supported them to stay safe. They said staff understood their health condition and how best to support them when they were feeling low in their mood. They said staff asked them how any bruises they noted had occurred.

Staff confirmed they had been trained in safeguarding adults and were confident to report concerns and if required use the providers' whistle-blowing procedure. Staff had a good understanding of safeguarding procedures and were clear about what action they would take if they witnessed or suspected any abusive practice. When we asked a staff member if they knew what abuse looked like, they said, "Any unusual marks or bruising, neglecting themselves, withdrawn and not eating, I would report it to the nurse." Another staff member said, "[The registered and deputy managers] take issues seriously and would look into the concerns."

People's safety was supported by the provider's recruitment practices. We looked at recruitment records for staff. Staff recruited by the provider underwent a robust recruitment and interview process to minimise risks to people's safety and welfare. Prior to being employed, they had an enhanced Disclosure and Barring Service (DBS) check, two references and health screening. (A DBS is carried out on an individual to find out if they have a criminal record which may impact on the safety of those using the service). The records of nursing staff showed that the provider had made checks to ensure they were registered with the appropriate professional body, which meant they were registered to provide nursing care safely.

A staff member who had not worked within the field of care prior to working at Shelton Lock described their recruitment process. They told us that it had included the completion of an application form; interview and that checks were carried out, for example DBS and references. The staff member stated they had a mentor who supported them as part of their induction who had worked alongside them.

Upon our arrival at Shelton Lock at 6am we found the premises were secure. The outside of the service was well lit and side gates to the garden were locked and small windows were closed or had restricted openings. CCTV was fitted at the entrance only.

Potential risks to people had been identified and measures put into place to manage them. We found risk assessments were up to date, detailed and personalised. These had been completed when it had been identified people's safety might be compromised.

People's records contained a PEEPS, (personal emergency evacuation plan). These stated the level of support required and the equipment, if required, that should be used to evacuate and the level of support from staff. These were reviewed regularly and took account of people's mobility, cognition and sensory impairment.

We saw appropriate actions had been taken to promote safety. For example, sensory mats had been placed

in people's rooms where they had been assessed at high risk of falls. This meant staff would be alerted when the person got out of bed, so they could provide the appropriate assistance and promote their safety. Where people had been assessed as being at risk of developing pressure sores, then appropriate equipment to promote healthy skin was used, for example pressure relieving cushions and mattresses. A person was provided with a wheeled rollator (walking frame) to enable them to move around safely and their care plan identified they were at risk of falling at night. To reduce the risk staff ensured the call bell and rollator was within reach, to promote both the person's independence and safety.

Everyone had a profile bed which could be raised / lowered as required. Some people had bumpers on their bed rails to reduce the risk of trapping their limbs. Where people did not have bed rails then beds had been lowered and a crash mat placed next to the bed, to reduce the risk of injury should the person fall out of bed.

A person identified at risk of choking had been assessed by SALT (speech and language therapist) and prescribed a thickener to be added to their drinks. The care plan included information and guidance on the texture of their food and how to prepare drinks. We observed a staff member prepare the drinks using the prescribed thickener correctly. The texture (fork mashable) of meals prepared for the person was consistent with the guidance provided by the SALT. We saw another person was provided with a similar meal and used an adapted cutlery so that they could eat independently. These were further examples of how risks associated to people's health were managed, whilst promoting their independence.

A person told us about their medicine. "I have seven tablets in the morning, one at teatime and several at bedtime. Staff put them in my hands and I take them with a hot drink of tea or coffee. "People's care plans included information about the medication they were prescribed. We observed the nurses administering medicines throughout the day. The medicine trolley was locked when left unattended. The nurse checked the person was happy to take their medicines; and those people who were prescribed medicine to be taken as and when required were asked and offered this. For example, people who were prescribed medicine to manage their pain. The nurse signed the medicine records once the person had taken their medicine.

People's medicines were kept safely and storage facilities were clean and tidy. The temperatures of rooms and refrigerators where medicines were stored were monitored and recorded to ensure that medicines were safe to use. Medicines audits were regularly completed.

Good

Is the service effective?

Our findings

People's comments as to staff having the necessary knowledge and skills to meet their needs were positive. "Yes, I do. It's just from the way they act and we have a laugh with them as well." "The majority of them (staff) have, yes." And. "Oh yes, sometimes you get new ones (staff) come in who have to be taught."

A staff member, who was relatively new, said they had a mentor who had supported them through the induction training. This included a range of theory and practical training in fire safety, manual handling, safeguarding, and infection control, dignity in care and health and safety. They worked alongside the mentor who supported them in providing people with personal care and support, for example bathing and maintaining privacy, dignity and promoting independence. They said, "I learnt from [mentor] how you have to work together to move someone who needs to be hoisted."

Staff spoke positively about the training and support. "Training is pretty good. We have regular training updates and told in advance what training is due." "I'm a nutrition champion. That means making sure people have had enough to drink; look for signs that indicate that someone's not drinking enough such as dry lips, behaviours, and water infections." They went on to say that they would report concerns to the nurse who would assess them. "There's one person whose intake is being monitored. An intake chart is kept and record how much they've eaten and drank."

Staff told us how they put their training into practice. "I know how to use the whistleblowing procedure to report concerns." Another staff member said they had a better understanding of how dementia affects people. They said, "For example, [person's name] will keep asking the same question over and over again, so I just repeat the same answer. I won't get annoyed at her because it's the dementia."

Training records showed staff received on-going training, which covered a range of topics to provide staff with the knowledge and skills required to meet people's needs. A report of training was completed each month, which identified gaps in staff training. This enabled the registered manager to have a plan of training in place. Staff we spoke with told us they were happy with the training and development provided and said it equipped them with the required skills to offer effective care and support.

A system of formal supervision and annual appraisal was in place which included discussions on goals, development needs and conversation about individual performance. Staff told us these were a good opportunity to discuss any concerns, extra training requirements or career aspirations.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and training records showed they had attended courses on this. 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 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. We found eight people had an authorised DoLS in place with no conditions. All records containing information about people's care and support were reflective of the principles of the Mental Capacity Act 2005.

People's capacity to make decisions about their care had been assessed. Care plans demonstrated people were involved in decisions made about all aspects of their care from times they liked to get up and retire to bed, meals, and preference as to being supported by male / female staff. Care plans were signed by people to confirm they agreed to the care and support to be provided. One person's care records showed that they had a regular independent advocate to support them to make decisions about their care. People's records in some instances included a Lasting Power of Attorney (LPA) agreement, which detailed the person who had the legal authority to make decisions on behalf of the person, with regards to their financial and or health needs.

In some instances people had made an advanced decision about their care with regards to emergency treatment and resuscitation, which meant they had a DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) in place. This had been put into place with the involvement of the person, their relative or representative and health care professionals. This showed that people's choices and decisions were supported and would be acted upon when needed as agreed by all parties involved.

We observed staff sought consent before they assisted people. For example we heard staff ask the following questions. "Would you like me to help you to the lounge?" "Would you like me to help you to the dining room?" "Where would you like to sit (for breakfast)?"

Staff spoken with said, "I would always ask whether they would like me to help. This morning I asked [person's name] whether they wanted to get up, he said, no but wanted a cup of tea which I took to him."

When we asked staff what they would do if they felt some people was unable to make decisions, they said, "Some people can make some decisions or I'd help them. Like show them two outfits, or jewellery that would look good and let them choose" and "If I thought someone's struggling then I'd report it to the nurse."

People were generally positively about the meals. "Its fine, it's lovely, it's all right – better than my own what I used to do". "They just come and ask you what you want." "A tea trolley comes round twice a day'. "They help me (to eat) I'm not very good, cutting and that I can't cope with it so they do it for me." "It's not horrible, that's not the word, just not very good' 'You have to decide what you want to eat the day before." "You can have something to eat (between mealtimes) but I don't want it, I'd feel full if I did." "At the moment the food is marvellous, top class and we can ask what we want there's always a choice." And "Yesterday we had New Zealand Lamb, it was tender."

Peoples' nutritional and hydration needs were assessed and recorded and where healthcare professionals, for example, the dietician or a member of the Speech and Language Team [SALT] were needed, appropriate support was provided. To promote people's safety who were at risk of choking, meals were provided in the form of 'soft diets' or 'fork mash able' diets and staff were seen adding 'thickeners' to people's drinks.

People were provided with a diet which met their needs and were given a choice of meals which were freshly

prepared and menus rotated on a seasonal basis. The chef manager showed us the information they were provided with, which included recipes with a breakdown of information as to the calorific value, salt and fat content of each serving. Where specialist diets were required these were catered for. The chef manager and cook spoke to us about the individual diets people required, which included a low potassium and phosphate diet, low sugar diets to support people with diabetes and diets which promoted weight gain or weight loss.

Dining tables were set with placemats, napkins and condiments. Equipment to support people to eat their meal independently was provided where required. Staff supported those people who required additional support by sitting with them and helping them to eat, or cutting up their food so it was easier for them to eat independently. We also observed staff encouraging people to support themselves; intervening only where it was evident they were struggling.

Hot drinks and snacks were regularly served throughout the day. Communal areas had a tray with glasses and a range of flavour drinks and water for people to help themselves.

A person told us they were trying to lose weight. They had had discussions with staff and had attended a medical appointment whereby they were given advice about healthy eating and diet. They showed us the dietary recommendations of suitable food and drinks to manage their diabetes, weight loss and low phosphate foods.

We asked people as to whether they had access to health care. "Yes, I can and I'm going to see a dentist next week." "I think they're marvellous for the doctor here, I have one in twice a week." Records showed staff appropriately referred people to health care professionals when required to ensure people's health needs were met, for example people were referred to the 'falls clinic' where they experienced falls or to the 'memory' clinic to monitor people's dementia.

The monthly evaluation of people's care plans took account of healthcare professional's visits and any treatment prescribed and, where required, care plans had been amended. For example, encouraging [person's name] to drink more and an intake chart put in place so that staff could monitor the quantity of fluid the person drank. However we found charts were not in place to record a person's fluid output. This meant action could not be taken as records were incomplete. Records showed people's weight had been measured monthly or weekly if there were any concerns. This was information was taken into account with evaluating care plans each month and if required advice was sought from healthcare professionals.

We spoke with a visiting GP, who had been requested by a nurse to visit as they had concerns about a person's health. The nurse briefed the GP as to the changes in two people's health condition and also requested banana flavoured fortisips (nutritionally enhanced drink) for a person with a nutritional risk whose was enjoying the drink. The nurse told us, "He drinks it all, so we need more of that flavour."

The GP raised no concerns about the care of people at Shelton Lock. They told us they regularly visited people at the home, to review their health needs. They said nurses contacted the surgery to request a visit by a GP where they had concerns about people's health.

Good

Is the service caring?

Our findings

We asked people if staff had time to talk with them. "No, I wouldn't mind if they did, that would be good and I think it would really help me." "The time I see the staff is at mealtimes and they don't really have time to chat but they would if they did have time."

All staff knew the people they cared for well and had built up positive caring relationships with them. Staff were noted to have a good rapport with the people they supported and there was much good humoured banter during the inspection visit, which many people appeared to enjoy and welcome. Staff were attentive to people's needs, whether it was supporting a person with their personal care needs, supporting someone to eat and drink, supporting people to mobilise within the service or just talking to people. We saw that staff communicated well with people living at the service by listening to them and talking with them appropriately. A member of staff told us. "I got to know people by talking and leaning about them. Most will tell you how they want you do things [care] for them."

Upon our arrival at Shelton Lock, a person continued to call out for staff. The housekeeper responded and spent time chatting with the person. When the housekeeper went to leave, the person asked them to stay. They stayed a little longer speaking with them. We heard the person thank them for spending time with them. The person asked for a cup of tea, which staff brought to them, the member of staff stayed with them, talking with them whilst they drank their tea.

The housekeeper told us how they enjoyed spending time with people, and how this had a positive impact on people. For example they told us the person they had been chatting with earlier, had lost their appetite recently and that by spending time with them at meal times, had resulted in the person eating their meal. They told us person enjoyed having company whilst they ate.

A person was seen sitting in the garden having a cigarette. The chef approached the person saying. "I knew I would find you here." The person responded saying. "Here or inside reading my paper." They both laughed. We heard someone singing and we saw a staff member go into the person's room and sang along with them. As we walked by the room the person was seen smiling at the member of staff.

We asked people for their views as to the atmosphere within the service. "Very good, just everything really." "Quite good really, not bad." "Oh it's very pleasant but don't you think it's the people who make the atmosphere, don't you think so?" And. "Its friendly, close knit, its friendly."

People were asked as to their involvement in making decisions about their care, including their care plan. We found people's understanding to be mixed. "Occasionally, when they're updating, apart from that no. It will be in the office. If I have one and no, I don't remember signing one." "No, not really and I presume I have a care plan."

One person's care records showed that they had a regular independent advocacy to support them to make decisions about their care. Care records viewed showed people had signed to confirm they were happy with

the agreed care and support to be provided. Individual preferences, as to morning and night time routines, food, and how they spent their day had been documented. A person's care record stated their religion and that they took Communion at the home.

People were supported to maintain relationships with others. People's family members and those acting on their behalf visited at any time. Staff told us that people's friends and family were welcome at all times. This was confirmed by comments received from people at Shelton Lock and their family members.

Information within people's care plans provided information for staff as to how to respond to people's needs. For example, a person's care plan stated they wanted their family members to be involved in making complex and long term decisions, when there were feeling low in mood.

People in the main felt staff were mindful of their privacy and dignity and felt they were respected. "Yes, they do – knock on the door and do all that." "Oh yes, definitely."

We observed two staff using a stand aid and belt to support a person to stand up from the wheelchair and be seated into an armchair in the lounge. This manoeuvre was safely undertaken and care was taken to maintain the person's dignity. Staff took the lead, explained how they were going to move the person and gained their consent. Throughout the move staff ensured the person was safe, comfortable and their dignity maintained.

Throughout the inspection we saw people were clean and dressed in clothing of their choice. We noted people's nails were clean which showed staff paid attention to people's appearance and cleanliness. We observed when someone was assisted to move using a stand aid, staff adjusted the person's clothing which maintained their dignity.

The tone and language used by staff when they spoke with people was personalised. They addressed one person by their preferred name. The banter between a staff member and another person was humorous and friendly as they were supported to be seated. This showed a positive and trusting relationship had been developed.

Requires Improvement

Is the service responsive?

Our findings

Appropriate arrangements were in place to assess the needs of people prior to their admission to Shelton Lock. This ensured people's needs could be met and provided sufficient information for the person's initial care plan. Staff told us that they were given relevant information; an overview of the care needs of a new person when they moved to the service. A staff member said, "We're told who the person is, like their name and room they're in, what help they need, any moving and handling issues and equipment used."

Social isolation and loneliness is known to have a detrimental effect on people's health and wellbeing. Initial assessments included information about people's life history. For example, information about peoples pets, family life, work and hobbies. However the information was not fully used to support people's well-being. For example, where people's physical and nursing needs meant they were cared for in bed, the information about their, family life, hobbies and interests had not been considered as to how it could be utilised to support them in social engagement and prevent social isolation. We spoke with the registered manager who listened to our comments. They said following our feedback they felt energised to make changes to support people's social engagement. The registered manager spoke of an idea they were considering, involving the setting up of an evening group, to support the large number of men who were at Shelton Lock, to take part in activities of their choosing.

People shared with us their views about social interaction and activities. "There's an activity lady here now, she comes every day – sometimes weekends as well. I just join in when I want to and I ask them if I want to go out into the garden." "Yes there are and I joined in. There are not really any trips." "Not really for me. I would like to be taken out." And. "I'm not one for that sort of thing but I joined in for a quiz the other night and enjoyed that. I don't get bored I've got my stamp albums." Care and food and cleanliness I think are good. The staffing again, it's down to needing more staff. The staff are always busy and I feel like I'm intruding to ask for anything. It would be nice if they'd got some form of transport to go out now and again on trips."

We recommend that the provider considers how it further develops the service to promote people's wellbeing by enabling them to follow their interests and take part in social activities within the service and community.

The activity organiser spoke with enthusiasm about their role and what they hoped to achieve. "For people to have a good time and to improve their quality of life." They spoke of their plans for the future. "I'm starting an allotment for the next season, it's about keeping as happy and normal life isn't it – or you lose your identity." They spoke of their day to day role. "I see residents in their rooms in the mornings, then have an activity, then write up notes, then activities in the afternoon. I do like to integrate a lot of physical activity as much as I can." They went onto tell us about a recent event organised in the evening. "Friday just gone the local fish and chip shop donated 24 meals, I try to get community involved and they're very good. It was a fun night for family and relatives and it didn't cost anything – all money raised went to the home." When asked if they were able to provide sufficient activities and stimulation, they said that the service in their view could be improved, by additional activities being made available across all days of the week.

The activity organiser was seen encouraging people to take part in a game of skittles. Other people were seen to occupy themselves with jigsaws or by reading the newspaper. The room next to the dining room had a piano, shelves with books, jigsaws and games; however this space was not utilised on the day of our inspection. The registered manager told us, previously the room and its activities had been well used, however due to the changing needs of people; this was no longer the case. We spoke with the area manager and registered manager about using information in people's assessments as to their interests, and taking the activities to people who spent their time in their room. The registered manager said the number of hours funded to provide activities was limited, the area manager said they would take action by reviewing the funding made available.

The garden was well managed and had areas for people to sit along and an aviary for budgerigars. A person we spoke with said. "In the summer it's pleasant to sit outside and watch the birds. We also have a couple of rabbits."

A person who was at Shelton Lock for respite care, said they been asked about the help they needed. They said, "I was asked what I like to have for breakfast, what time I liked to get up and go to bed, how I spend my time (when at home), if I had any hobbies or interests." They went on to tell us that they preferred their own company and said, "My friend will be coming later and I like to talk to her." We later saw the person and their friend sat in the conservatory and staff had provided them with drinks and a biscuit.

People's care plans provided guidance for staff as people's needs and how to support them. For example, a person's care plan stated how staff should intervene and support the person when they were feeling low in their mood, by talking about films, music and fashion, which were of interest to them. Whilst for some people it reflected their preferences about their day to day lives. For example, what time they go got up and went to bed. A person spoke to us about this, telling us they preferred to get up in their own time. They described how staff supported them in the morning and at bedtime which was usually around 10pm. Discussions with those using the service, staff and our observations showed people were supported to get up and go to bed at a time they suited them.

Staff we spoke with were aware of people's individual preferences, which were recorded within people's care plans. For example some people's care plans stated that they liked to have an alcoholic drink with their meals, which staff were aware of. We asked staff how they ensured personalised care was provided. "Read the care plan and ask the person how they [staff] can help them." And "We're given an update on everyone at the handover meetings, like of someone's not well, changes to their needs for example."

We observed staff handover meetings. Information was discussed in a respectful manner. For example a person who was receiving end of life care, information about their deteriorating health was shared. Where people had had an unsettled night, this information was shared so staff during the day could encourage the person to rest if they were tired. Information as to how people spent their time and occupied themselves was limited, and supported our observations that preventing social isolation and loneliness was not a primary consideration. The registered manager said they would review the content of information shared within handovers.

There was a complaints policy in place, this was clearly displayed on the notice board and people were informed of their right to make a comment or complaint. The notice board displayed information about the local authorities' advocacy service. A complaint that had been made had been dealt with promptly and in line with the provider's policy. Clear action had been taken following the complaint investigation and the complainant informed as to the outcome.

When people were asked what they would do if they had any concerns or were unhappy about any aspect of their care or stay at the service, they told us. "I would talk to the staff or matron"
"Staff are good here. I don't have any complaints about them."

We asked staff what they would do if people or their visitors had expressed concerns about their care or had a complaint. They all confirmed that if possible they would address the issue if it was minor issue or would report it to the nurse or a manager.

Good

Is the service well-led?

Our findings

The registered manager confirmed that the views of people who used the service had been sought prior to changes to the provider's legal entity in January 2017. The report reflected satisfaction in the service people received in December 2016. Staff's views were sought through an on-line survey three times a year and the results made available to the registered manager. The report produced in response to the staff survey found staff to be positive about their place of work, with specific comments as to the positive and friendly atmosphere of Shelton Court.

People we spoke shared their views as to their opportunity to attend resident meetings and influence the service they received. "No, there aren't any but it's a good idea. Yes, I would like them." "I've never heard of one, if there were I'd certainly try to go but it's just us and them really'. And. "There was one a while back but none since." The registered manager informed us meetings involving people using the service were not held, as many of the people using the service were unable to take part. Therefore informal discussions were held with people to seek their views. The registered manager advised us meetings involving people and their family members were scheduled quarterly and that they had an open door policy to encourage people to share their views.

Events were organised at Shelton Lock to encourage family members and involvement of the wider community. This had included a quiz night, where local business had contributed to the event, which included providing food. Whilst others had provided prizes for a raffle.

Staff meetings had taken place, and were used an opportunity to discuss the outcome of internal audits undertaken within the service. Staff told us issues raised by staff were listened to by the registered manager. A member of staff said. "We did raise concerns about the sickness levels of the night staff and how it affects the day staff." They said the registered manager was dealing with the issue by using regular agency staff to provide continuity of care. Newsletters were available for staff, which provided them with information on services provided by BUPA, which included counselling.

Prior to our inspection a television programme had been aired and this showed poor care practices adopted by some staff in a care home run by the same organisation. The area manager and registered manager told us that following the programme being shown on television, meetings with the senior management team and managers of services to discuss the findings and outcomes of the programme. Subsequent discussions had also been undertaken with staff. The registered manager told us this was to ensure staff were aware of how to raise any concerns, for example through whistleblowing.

The provider's policies and procedures were stored electronically and included key policies on medicines, safeguarding, MCA, DoLS, moving and handling and dementia care. Policies were updated at provider level; this meant that the most up to date copies were always available. Staff told us they had access to these and had their own username and password so they could access them securely. This meant staff could seek advice and guidance as required.

People's knowledge as to who the manager and management team were; were mixed. "Don't know all of them but yes I do find them approachable." "Yes, I do. Oh yes, she is approachable, she goes around, she comes in and say hello." "No, I don't know." "Oh I do and very much find her approachable."

People we spoke with shared their views about the management of the service. "Yes, it is." "Well managed to a point." And. '"Yes, yes, I do but it's like your told things will happen but they never happen, so better not to say they will happen then you're not disappointed."

There was a clear management structure in place. The registered manager was supported by a deputy manager. The area manager visited the service on a regular basis. The service was supported by staff with dedicated areas of responsibility, which included nurses, health care assistants, housekeeping and staff who worked in the kitchen.

We asked people for the overall views of the service. They told us. "Care and food and cleanliness I think are good. The staffing again, it's down to needing more staff. The staff are always busy and I feel like I'm intruding to ask for anything. It would be nice if they'd got some form of transport to go out now and again on trips'. "I think the staff who look after me could be better really and I think the meals could be better." "It's friendly." And. "Just everything is good really, I'm happy." The registered manager told us trips when they had been organised were often not well attended, however further trips were being planned. The area manager said they would look to increase the number of hours allocated to the service for activities.

The provider used a range of systems to assess the quality and effectiveness of the service. The provider had a filing system in place called 'operational essentials', with a large proportion of the files linked to a specific area of auditing, monitoring or governance. The system ensured every area of care provision was being monitored and audited, with issues identified and action points generated.

We saw monthly compliance inspections were carried out. Each area received a rating of red, amber or green along with feedback on positive areas of practice observed and issues which needed to be addressed. Action plans arising from audits were in place, and showed the action being taken by the registered manager to bring out improvement. For example, improvements had been made to the environment.

Clinical 'walk rounds' were completed each day by the registered manager which allowed them to observe the provision of care within Shelton Lock. Each 'walk round' was documented and looked at a number of areas including a review of the handover, any people with clinical concerns such as falls issue or safeguarding concerns, medication administration and documentation, nursed in bed checks and also ensured the 'resident of the day' process had been completed and documented correctly. For any issues identified, we saw an action plan had been generated with details on who was responsible for completing and when.

Audits undertaken by external stakeholders showed no significant concerns and had identified compliance with regards to health and safety, including medicine management and food hygiene.