

Sholden Hall Residential Home

Sholden Hall Residential Retreat

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Sholden Hall Residential Home is a residential care home providing personal care to up to 27 older people who may be living with dementia. At the time of our inspection there were 20 people using the service. The service accommodates people in one large adapted building.

People's experience of using this service and what we found

Relatives told us, they thought people were safe and happy living at Sholden Hall. People told us they were happy and felt safe living at the service. We observed people relaxed in the company of staff, smiling and laughing with them. People respond positively when asked if they were happy.

However, medicines were not always managed safely. People had not always received their medicines as prescribed and records were not accurate. Potential risks to people's health and welfare had not been consistently assessed. There was no guidance for staff about how to support people to minimise risks and keep them safe.

When incidents had occurred, action had been taken to keep people safe. However, the registered manager had not always recognised when these incidents needed to be reported to the local safeguarding authority. The registered manager had not consistently notified the Care Quality Commission of incidents as required.

There was a system of checks and audits in place, including regular provider visits, but these were not effective and had not identified the shortfalls found at the inspection. People and relatives had not been asked for their opinion of the quality of the service.

Some areas of the service needed redecoration and could not be cleaned effectively. Visitors to the service were required to provide a negative Covid-19 test before coming into the service.

Accidents and incidents had been analysed and action taken to reduce the risk of them happening again. Staff were recruited safely; people were supported by enough staff to meet their needs.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was Good (published 11 October 2018).

Why we inspected

This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. This included checking the

provider was meeting COVID-19 vaccination requirements.

We undertook a focused inspection to review the key questions of safe and well-led only. We have found evidence that the provider needs to make improvements. Please see the Safe and Well Led sections of this full report

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from Good to Requires Improvement based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Sholden Hall Residential Home on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to medicines management, mitigation of risks, checks and audits and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.
Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.
Details are in our well-Led findings below.

Requires Improvement ●

Sholden Hall Residential Retreat

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection was completed by one inspector.

Service and service type

Sholden Hall is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Sholden Hall is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 24 February 2022 and ended on 4 March 2022. We visited the service on 24 February 2022.

What we did before the inspection

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used information gathered as part of monitoring activity that took place on 9 February 2022 to help plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection

We spoke with three relatives about their experience of the care provided. We spoke with three people about their experience of living at the service. We spoke with four members of staff including the registered manager, deputy manager, heads of care and a team leader. We observed interactions between staff and people in the lounge and during the lunchtime meal.

We reviewed a range of records. This included four people's care plans and all the medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including checks and audits.

After the inspection

We continued seek clarification from the provider to validate evidence found.



Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Medicines were not always managed safely; people did not always receive their medicines as prescribed. One person was prescribed medicine to help manage their diabetes. They were prescribed two tablets twice a day however, they had only received the morning tablets on the previous two days before the inspection. Another person was prescribed medicine three times a day, to relax their muscles. They had not received any of the medicine on two days and not all the prescribed doses on other days. They had also been prescribed a new medicine; however, this had not been started when prescribed. Staff were unable to explain why this had happened.
- Records of the medicines given were not accurate. The medicines administration chart (MAR) had not been signed accurately for six people although the tablets left confirmed these medicines had been given.
- People had been prescribed creams to help keep their skin healthy or treat an infection. Carers applied these creams during personal care. The MAR's for the creams were kept with the medicines and had not been signed consistently to confirm application.

The provider had failed to ensure the proper and safe management of medicines. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people's health and welfare were not always managed safely. When people were prescribed medicines to thin the blood, this was recorded in the care plan but there was no guidance for staff about the side effects, such as excessive bleeding, and what action to take. Other people had displayed behaviour which could be challenging for staff and people. There was no guidance for staff about the triggers and how to manage the behaviour to keep people safe. Staff knew how to calm people, and this was observed during the inspection.
- When people had a catheter to drain urine from their bladder and they wanted to be responsible for the care of the catheter themselves, this was recorded in the care plan. However, there was no guidance for staff around how they should monitor the person's care of the catheter. There was no information about how people would present if they were unwell. Staff had not maintained records about when the catheter had been changed.
- When people had been prescribed medicine after they had experienced seizures, there was no guidance for staff about their condition. Though they had not experienced any further seizures, there was no guidance for staff about how the seizure may present and what action to take.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Checks had been completed on the equipment people used such as hoists and the service to keep people as safe as possible.

Systems and processes to safeguard people from the risk of abuse

- The registered manager understood their responsibility to report concerns. However, they had not always recognised when incidents needed to be reported to the local safeguarding team. There had been an incident where a person had become friends with another person and had been found in their room was trying to kiss them without consent. This had been reported to the person's care manager but was not reported to the local safeguarding team. Action had been taken to reduce the risk of this happening again, the person had asked for a gate in their doorway, and this had stopped further incidents. We signposted the registered manager to guidance on their reporting responsibilities under safeguarding.
- Staff had received safeguarding training. They were able to describe what signs they would look for if people were being abused and what they would take. Staff knew and understood the whistle blowing policy. Staff had used this policy to raise concerns previously.
- Relatives told us they had been told about any incidents that had happened and were aware of the actions taken. People told us they felt safe at the service.

Preventing and controlling infection

- We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service mostly looked clean; however, decoration was poor and the flooring in places was worn and coming away from the skirting board making it hard to ensure these areas were clean.
- We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. When people had tested positive, staff had not been allocated to provide their support. We discussed this with the deputy manager, it was agreed that staff would be allocated to support anyone in isolation, including cleaning the room. During the inspection, a rota was put in place for staff to support one person in isolation.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes

People were supported to have visitors, they were asked to arrange an appointment and provide a negative Covid-19 test, to keep people as safe as possible.

Care homes (Vaccinations as Condition of Deployment)

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Learning lessons when things go wrong

- Accidents and incidents had been recorded and were analysed to identify any patterns or trends. There was information about what had happened and if there had been any injuries. Staff had taken appropriate action following falls. Action had been taken to mitigate risks where possible such as using pressure mats to alert staff when people got up or moving bedroom furniture.

Staffing and recruitment

- Staff were recruited safely. There were effective systems in place to recruit staff, checks were made to make sure staff were suitable to work with people. Staff completed an application form with an employment history and references about their conduct in their previous employment. Disclosure and Barring Service (DBS) checks were made before staff began working at the service. DBS checks identify if prospective staff have a criminal record or were barred from working with adults.
- There were enough staff to meet people's needs. The registered manager did not use a tool to calculate how many staff were needed. They aimed to have four care staff on duty during the day and two at night. However, vacancies had not been recruited to and there were only three care staff on duty during the day. Staff told us, with three staff they could support people and meet their needs, but they did not have time to spend with people. The registered manager worked as care staff to make sure the minimum staffing level was always met. Relatives told us, there was enough staff when they visited. We observed people being supported when they asked or needed assistance. The activities co-ordinator spent time with people in the lounge.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Checks and audits had been completed but these had not identified the shortfalls identified at the inspection. The registered manager completed audits on all areas of the service. There was an action plan in place when shortfalls such as poor decoration were identified. Audits of care plans and medicines had not identified the shortfalls found.
- The provider visited the service regularly. They completed a visit form checking areas of the service such as care plans and decoration but did not audit medicines. On recent visits the provider had not spoken to people to receive feedback. The provider had recorded they had spoken to staff but not what had been discussed or action taken. The reports had not identified shortfalls with the care plans.

The provider had failed to assess, monitor and improve the quality of the service. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had not submitted notifications to CQC in an appropriate and timely manner in line with guidance. The service had not consistently submitted notifications to CQC when there had been incidents between people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and relatives had not been asked for their opinions on the quality of the service formally during the pandemic. The registered manager told us; they were planning to send out quality assurance surveys in April 2022 to relatives. We will check this on our next inspection. Relatives told us they knew how to complain and raise concerns and were confident action would be taken.
- Staff attended regular staff meetings. They discussed people's care and changes within the service and national guidance. Staff told us they were asked their opinion about the service and were asked to make suggestions. Staff told us they were supported by the registered manager.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Relatives told us, they thought there was a positive culture within the service. They told us they thought staff were supportive of people.
- Staff explained how they supported to maintain as much independence as possible. People were supported to take part in activities they enjoyed and were introduced to new ideas. One person told us they were supported to go out and visit their family.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- There was an open culture within the service. Relatives knew the registered manager and told us they were contacted if there were any incidents or concerns. Relatives had been informed when there were incidents between people and were kept up to date with any developments.

Working in partnership with others

- The service worked with the local commissioning authorities to make sure people received joined up care and support.
- The registered manager was part of local groups and received updates from national organisations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the proper and safe management of medicines.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. The provider had failed to assess, monitor and improve the quality of the service.