

Borough Care Ltd

Shepley House

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

Shepley House is a residential care home providing personal care to up to 43 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 38 people using the service.

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

Systems to ensure people were safe were not always being used effectively and people's needs, and risks were not always readily identifiable in care records. Staff were not always recruited in line with safe recruitment policies and feedback about staff and their visibility within the home was mixed. We have made a recommendation about this. Medicines were not always managed in line with good practice in relation to storage and medicines people were being given covertly, hidden in food or drink. We have made a recommendation about this. Details about how to manage risk was not always clear and records did not demonstrate that people's assessed needs were being met. We have made a recommendation about this.

Records of accidents and incidents were not always identified in the systems for oversight but, when identified appropriate action was being taken. The service was clean and tidy, and people were encouraged to receive visits from friends and family. People felt safe and relatives generally spoke highly about staff.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support good this practice.

There was no registered manager in post, and we found the service had not submitted a notification of a serious injury to CQC in a timely way. Systems for oversight were not always used effectively as areas for improvement we identify such as medicines, and accidents had not been identified. Families and staff spoke highly of the new manager and felt confident to raise concerns with them. Staff and families felt improvements were being made within the service.

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

Rating at last inspection and update

The last rating for this service was good (published 31 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.

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 Shepley House on our website at www.cqc.org.uk.

Enforcement and Recommendations

We have identified breaches in relation to the recruitment of staff and the systems for oversight in place to ensure the service was safe.

We have made recommendations about the systems in place for the monitoring and management of risk staffing deployment and training and management of medicines administration.

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 ●

Shepley House

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 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

This inspection was completed by an inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Shepley House 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. Shepley House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A manager was in post but had not yet begun the process of registering with CQC.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. This included any information of concern and notifications the service is required to submit regarding any significant events happening at the service. We sought feedback from the local authority, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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 all this information to plan our inspection.

During the inspection

We reviewed staffing levels and walked around the building to ensure it was clean and a safe place for people to live. We observed how staff supported people and provided care.

We spoke with 2 people who use the service, 10 relatives and 12 members of staff, including the manager, senior care workers, care workers, auxiliary staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records including 5 people's care records. We looked at 4 staff files in relation to recruitment, training and support. We reviewed several people's medicine administration records and looked at medicines related documentation and management arrangements. A variety of records relating to the management of the service, including policies and procedures were examined.

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.

Staffing and recruitment

- Recruitment records did not always demonstrate that robust recruitment processes were being followed. It was not always evident that suitable references were obtained from relevant previous employers and that gaps in employment, reasons a person may have left previous roles, or conflict in information given were fully explored.

The provider had failed to ensure safe and robust recruitment processes were being followed. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was responsive to feedback and had taken the necessary steps to address oversight of gaps in employment prior to this inspection. However, for the recruitment files we reviewed this process had either not been in place or had not been completed as part of the interview process.

- Feedback about staffing was mixed. Some people and families felt there was enough staff, but others felt there was not always enough staff.
- Staff fed back they felt there was enough staff to meet people's needs. However, during the inspection, the inspector had to seek staff to help people, as no staff were present or nearby in communal spaces. This included when people needed to use the toilet or wanted to move from where they were sat.
- Staff were not always suitably deployed across the home to be available to support people in the various communal areas available for use. We observed some shortfalls in how people were supported with pressure relief, for example some people who had been assessed as needing two hourly pressure relief were not receiving this. We also found that some people who required prompting and support to eat, did not receive this initially, meaning their meals sometimes got cold before they received the support they needed.

We recommend the provider review their staffing levels to ensure staff are suitable deployed to ensure people's needs are met in a timely way.

- People spoke very positively about the staff employed at the home. Staff were described as kind and caring. There was a consistent team of staff, and most staff knew people and their needs well. The home had a bank of casual staff who were available to cover shifts as needed.

Assessing risk, safety monitoring and management

- People's moving and handling risks were not always safely managed. People had moving and handling care plans in place. Observations of staff practice were mixed with some moving and handling done with care and consideration. However, other observations identified the process had not been planned for, as the equipment was not in the right place or suitably secured to ensure smooth transfer.
- We discussed with the manager one person who we observed being transferred in a wheelchair without the use of a lap strap or footplates, which help reduce the risk of a person becoming injured. The manager told us this person would refuse the footplates at times and there was a care plan to mitigate this risk in place. However, staff were not following this process and we were unable to find a care plan which detailed how to manage the risk as described by the manager.
- People had appropriate assessments relating to their need for pressure relief and management of skin integrity, and care plans developed in relation to this. However, it was not always evident that people were receiving pressure relief in line with their assessed needs. This was fed back to the manager who was responsive and agreed to review people's needs and discuss this further with staff.
- People's nutritional and hydration risks and needs were assessed, and care plans were developed to guide staff on action to take in these areas. However, records did not always show people's meals or drinks were modified to their assessed needs, and records of people's fluid intake levels were at times very low. This meant the service could not demonstrate it was consistently meeting people's needs in this area. We also found that for people who chose to eat their meals in lounge chairs, equipment to support good food intake such as a table set at the correct height and in a suitable position was not always in place. This was discussed further with the provider.

We recommend the provider review the system in place to monitor and manage risk.

Learning lessons when things go wrong

- The provider had systems in place to ensure oversight of when things went wrong, such as accidents and incidents. Where records of incidents were maintained, meetings and audits ensured that appropriate action had been taken. However, we found not all records of accidents or falls recorded on the electronic system were being identified within the falls audits.
- Areas of risk were not always updated and easily identifiable on the summaries within people's care records. Individual records did not always reflect people's level of risk and did not consistently demonstrate care plans were being reviewed in a timely way.

Using medicines safely

- Medicines were not always being managed in line with best practice. We found shortfalls in how temperatures were being monitored in the room and fridge and advised the fridge be reset to ensure that it was working effectively.
- Medicines were being securely stored in locked cabinets, with the exception of thickening powders which we found stored in unsecured cabinets on the first day, which was identified and addressed by the manager that day.
- Staff maintained records of medicines administration. Records of the administration of creams were maintained with relevant information and body maps in use. Improvements to the use of descriptors used to describe thickened fluids given to people were needed to ensure these were accurately recorded.
- People's medicine care plans contained detail about what medicine people had and why. People had protocols for medicines they needed occasionally, such as paracetamol to manage pain. However, these were not always personalised to the person and their specific circumstances and were not always available at the point of administration.
- Covert medicines were not being managed in line with best practice and the Mental Capacity Act (MCA). Some people were receiving medicine covertly but the principles of the MCA regarding best interest and

least restrictive options had not been followed and advice from a pharmacist was not in place. Care plans did not always contain enough detail to guide staff on how to give these medicines and some care plans were inaccurate about medicines being given covertly. The manager was responsive and took immediate action to contact relevant services and arrange for best interest meetings where this was appropriate. However, systems for oversight were not robust enough to have identified these issues.

We recommend the provider review their systems for training and oversight of medicines management.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- The service was not always working within the principles of the MCA. Consent to care was requested from people or their legal representative and we saw that staff offered choice and requested consent when providing support. However, records did not always demonstrate best interest decisions were being made in line with the MCA.
- The manager had completed work to ensure DoLS applications were made where needed and records were up to date.
- Tools to promote choice, for example pictorial menus, were not used although some people living at the home may have benefitted from this.

Systems and processes to safeguard people from the risk of abuse

- People spoke very positively about staff support and felt safe being cared for at the service. One person told us, "They can't do enough for you. They really look after you here." Relatives shared these views.
- The manager maintained records of accidents, incidents and safeguarding concerns. Relatives told us that they were kept informed if anything had happened to their family member. One relative commented on how proactive staff were. They said, "They have been so supportive in managing [family members] needs and as their health has declined. They have tried everything to keep them at Shepley and manage their distress."

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- 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 responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

The service had no restrictions on visiting during the inspection. People enjoyed visits from friends and family and were supported to access the community. The manager told us they would follow any guidance from the local health team in the event of an outbreak of an infectious disease.

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

- The provider had not ensured that a registered manager was in post as required as part of their condition of registration. We are reviewing any possible enforcement action in relation to this breach of regulation outside of this inspection. There was a manager in post and they advised that they intended to begin the process of registering with CQC.
- Quality assurance checks and audits were in place. However, these were not robust enough to have identified some of the issues we found in relation to care records, medicines management and management of accidents and incidents.

The provider had failed to embed robust systems for oversight to ensure best practice was followed, safety was effectively managed, and improvements made across the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Families generally spoke positively about the care and outcomes for the people living at Shepley House. One relative spoke highly about the support and efforts staff had made to manage their family member's needs as they increased. Another relative told us, "We were a bit concerned a while ago but this has improved since [manager] took over."
- People and families spoke positively about how kind and caring staff were. Staff generally knew people well and interactions were kind. However, we observed times where tasks were not completed as thoughtfully as possible, for example with moving and handling, and supporting people to eat their meals.
- People and relatives told us they had noticed the absence of the activity worker and the impact of the lack of activities and stimulation when this post was vacant. During the inspection we found people who did not wish to engage in the communal activities on offer were often bored and lacked stimulation and it was not clear how people who chose to stay in their bedrooms were supported. The manager was keen to address this and make care within the home more personalised.

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

- People and families told us they felt able to raise concerns or make complaints. Records showed that complaints were recorded and investigated with the provider responding and offering an apology to people

where this was required.

- We reviewed accidents and incidents and found one incident where a person had injured themselves following a fall the previous month for which we had not received a statutory notification. The manager explained this had been an oversight due to a delay in the fracture being identified. We requested the manager submit a notification about this injury as soon as possible. Other notifications appear to be submitted to CQC as required and the provider was also providing information to the local safeguarding services as needed.

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

- Communication with the service worked well. One relative told us, "They always keep us up to date if [family member] is unwell and we know about the events going on. However little things aren't shared as well as they use to be. We use to have newsletters before the last activity worker left." There was evidence of newsletters and relative meetings prior to the last activity worker leaving, but when this post was vacant these had not been happening. A new worker was in post, and this would be an area of their responsibility.
- Staff spoke positively about the manager and felt able to raise concerns. They consistently spoke highly about how supportive the new manager was and the impact they had already made to improve the home. Staff all worked well as a team and one person told us, "It's sweet to see how the staff are with each other."

Continuous learning and improving care

- The provider and manager were responsive to feedback. The manager told us they were committed to improving the service and spoke about the improvement journey at Shepley House, and areas which had already been addressed.
- Feedback from families was positive in relation to staff and the new manager. They told us they found the manager very approachable and responsive to any questions or concerns they had. They felt confident the manager and staff team would take any action needed. One relative told us, "It's much more organised now [manager] is here. We can always get hold of them."

Working in partnership with others

- Staff and the manager had good working relations with visiting professionals and records indicated people were accessing a range of services when needed. Opticians came and completed their checks, and people who did not have a dentist had been referred for dental input where this was needed.
- The service worked with other organisations including a local preschool activity group. During the inspection we saw people living at the service attend a music and movement group with young children, which everyone in attendance appeared to enjoy.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to embed robust systems for oversight to ensure best practice was followed, safety was effectively managed, and improvements made across the service.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure safe and robust recruitment processes were being followed.