Barchester Healthcare Homes Limited

Shelburne Lodge

Inspection report

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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?	**Requires Improvement**

Summary of findings

Overall summary

We undertook an unannounced inspection of Shelburne Lodge on 8 and 9 March 2017.

Shelburne Lodge provides care and nursing care for up to 54 people. At the time of our inspection there were 44 people living at the service.

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

There were not sufficient staff to meet people's needs. Staff rotas confirmed planned staffing levels were not maintained. The management of people's medicine was not always safe and a number of concerns were identified at our inspection.

The service had safe recruitment procedures and conducted background checks to ensure staff were suitable to undertake their care role.

People and their families told us they felt safe at Shelburne Lodge.

Staff understood their responsibilities in relation to safeguarding people. Staff received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in place to notify the authorities where concerns were identified.

People benefitted from caring relationships with the staff. People and their relatives were involved in their care and people's independence was actively promoted. Relatives and staff told us people's dignity was promoted.

Where risks to people had been identified, risk assessments were in place and action had been taken to manage these risks. Staff sought people's consent and involved them in their care where possible.

People and their families told us people had enough to eat and drink. People were given a choice of meals and their preferences were respected. Where people had specific nutritional needs, staff were aware of, and ensured these needs were met.

Relatives told us they were confident they would be listened to and action would be taken if they raised a concern. The service had systems to assess the quality of the service provided, but these were not always effective. Systems were in place that ensured people were protected against the risks of unsafe or inappropriate care.

We had mixed feedback from staff about the support they received from the registered manager and all of the team at the home. Staff supervision and other meetings were scheduled as were annual appraisals. People, their relatives and staff told us all of the management team were approachable and there was a good level of communication within the service.

Relatives told us the team at Shelburne Lodge was very friendly, responsive and overall well managed. The service sought people's views and opinions and acted on them.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 always safe.

There were not always sufficient staff deployed to meet people's needs and keep them safe.

People had their medicine as prescribed. However, we found a number of concerns regarding administration of medicine.

People and their relatives told us people were safe. Staff knew how to identify potential abuse and raise concerns.

Risks to people were identified and risk assessments in place to manage the risks. Staff followed guidance relating to the management of risks.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the training and knowledge to support them effectively.

The Mental Capacity Act (2005) principles were followed by the provider.

People were supported by staff who were supported, supervised and trained.

People had access to healthcare services and people's nutrition was well maintained.

Is the service caring?

Good

The service was caring.

People told us staff were caring.

Staff were kind, compassionate and respectful and treated people with dignity and respect which promoted their wellbeing.

Staff gave people the time to express their wishes and respected

the decisions they made. We saw people's consent to care was obtained.

The provider and staff promoted people's independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed prior to moving into Shelburne Lodge to ensure their needs could be met.

Care plans were not always personalised and did not give clear guidance for staff on how to support people. People were supported in their decision about how they wished to spend their day.

Relatives knew how to raise concerns and were confident action would be taken.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service did not have effective systems in place to monitor the quality of service. People's records were not robust or complete.

People's views were sought on the quality of the service.

People, their families and staff told us there was mainly good management and leadership in the home.

Shelburne Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 and 9 March 2017 and was unannounced. The inspection was carried out by two inspectors and a specialist advisor (SpA). An SpA is someone who has knowledge in the care of people in a nursing setting and older people's care

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law. We sought feedback from the commissioners of the service and other stakeholders.

During the inspection we spoke with 13 people who used the service, two relatives of people and one visitor.

We looked at six people's care records, eleven medicine administration records, three staff records and records relating to the general management of the service. We spoke with the registered manager, the deputy manager, the Regional Director for the home, five care staff, two nurses, the chef and the activity co-ordinator.

We conducted a tour of the building with the manager to view the environment.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection on 30 June 2016 we found there was not always enough staff deployed to meet people's needs. This was a breach of Regulation 18 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan telling us how there were going to make improvements. They told us they would review people's dependency levels to ensure there were enough staff to meet people's needs. They also said the manager would monitor the care hours on a weekly basis.

We also found people's medicines were not always stored appropriately; there were gaps in recording of medicine; poor medicine hygiene and staff were not always following guidelines and care plans to ensure people received their medicine safely. This was a breach of Regulation 12 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's action plan told us how they were going to make improvements, for example, regular checking of the recording of people's medicine.

At this inspection we found improvements to staffing levels had not been maintained and although medicine concerns identified in our previous inspection had been actioned, further improvements were still required regarding the management of people's medicine.

People, staff and relatives told us there were not always enough staff to meet people's needs. Comments from people and relatives included; "Yes they are short staffed sometimes"; "They (staff) come eventually, sometimes it's three quarters of an hour, not usual though, but it does put me on 'tender hooks'"; "I am supposed to be up for two hours, but it doesn't happen"; "You do have to wait"; "You must not ask to go to the toilet at lunchtime, I had to wait half an hour once"; "On average I have to wait ten or fifteen minutes"; "I call my bell, but they are very busy, they need more staff"; "You have to wait your turn" and "There are generally enough staff, but sometimes not anybody (staff) that I can see".

Staff said "Lunchtime can be difficult sometimes with the staff we have"; "People can be kept waiting sometimes"; "Usually we are so busy, we are not able to stop and talk to people"; "Sometimes we are short due to sickness and it's too late to call agency staff in, which does have an impact"; "When we cannot get agency, it is difficult as we have to help on the floor. This means we are not always able to do our day job" and "Before it wasn't safe, but staff numbers are increasing. It would be better to have five care staff on duty on the first floor so that the fifth care staff member can do the 'single' care, which leaves two teams of two to help people that need two care staff to support them".

The manager told us it was difficult to recruit staff. They said they had vacancies for night care staff, day care staff and two nurses. They said they cover these shortfalls with agency staff and use the same staff where possible so that there is continuity of care for people.

We were told there should be two care staff on nights per floor, four staff on the ground floor and five on the first floor of the home throughout the day. We looked at the staff rota for March 2017. We saw that there were mainly four care staff on the ground floor and two care staff on nights. However, the first floor where there should be five care staff, we saw there was consistently four care staff and on some occasions only

three and half (a post) staff on duty. We looked at the dependency tool for March 2017 which the service used to calculate the number of staff needed to look after people. This confirmed that the required number of staff needed on the first floor was five. We also noted on the first floor that two staff went on their break at the same time. This meant only two care staff were left to meet people's needs. We raised this with the regional director for the home. They agreed with our findings and said they would ensure people's dependency is reviewed regularly to ensure enough staff are available. They also told us they would look at the deployment of staff and ensure staff breaks are not taken at the same time.

This is a continued breach of Regulation 18 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The areas of concern we identified at our previous inspection regarding people's medicine had been addressed. However, we identified further areas of concern regarding the management of people's medicine. For example, we found when checking stock that there was one case where the person's medicine did not match the records as there was one tablet more that there should be. There was a second case where the person received Paracetamol. The records showed there should be 232 tablets carried forward, however the amount in stock was 424 tablets. We spoke with the deputy manager and they confirmed the Paracetamol boxes had been missed when the counting of the medicine took place and this was an oversight by the nurse. However, the case where one extra tablet was still in stock, could not be explained.

We found further concerns of the management and recording of people's medicine. For example, we found instructions for nursing staff to follow were not securely recorded. We saw one person required to have Oramorph pain relief. The MAR sheet had a 'post-it' note attached stating 'give Oramorph 30-40 minutes before dressing is changed'. The nurse told us this was because they were not sure staff were giving this pain relief in time. These details were not recorded on the MAR sheet and the 'post-it' note could easily become detached from the sheet. This meant staff may not be aware of this instruction as it had not been recorded on the person's MAR sheet which may put this person at risk of pain. One person had swallowing difficulties and was under the care of the SALT (Speech and Language Therapy) team. Care staff knew the required thickener and type of food (puree food) this person needed which corresponded to the advice from the SALT team. However, the care plan stated different quantities and instruction for staff to follow. We saw a verbal message had been taken by two nurses from the GP which gave consent for another person to continue to receive their medicine. Although, the two nurses signed to confirm the message, the Management of Medicine Policy stated 'This will be followed by an instruction signed by the prescriber via fax or email, this will be stored with the MAR chart'. We found no fax or email was present with the MAR sheet. Therefore, staff were not following the provider's policy. We saw another person had allergies recorded on the front of their medicines file, however these were not on the MAR sheet for staff to be aware of when administering this person's medicine. We saw two people who had PRN (as required) medicine. In both cases there was no PRN protocol in these people's files to provide guidance for staff to follow to administer this medicine safely.

We saw the provider used agency nurses to cover shifts which meant they may not be familiar with the individual care needs of people at Shelburne Lodge. This meant people could be at risk of receiving incorrect medicines as records were not accurate or up to date for staff to follow.

People's medicines were being kept when no longer required. We were told that one person's eye drops were no longer needed. However, there were four bottles of eye drops still stored and another one which was opened and had gone beyond its expiry date. When medicine is given there are set codes to indicate whether the person had received their medicine. We found there was inconsistent recording as some staff used the 'A' code and other had used the 'N' code when medicine had not been given. We also found the

completion of the MAR charts to be unclear as the entries were not always legible. There was another person who was on a pain relieving medicine. We saw they had three bottles of 100mls of Oramorph. Two of these bottles had been opened on 22 February 2017. There was no explanation why both bottles were open and it was not clear which bottle the nurse should be using. Having two bottles open made it difficult to calculate the correct amount of Oramorph was held in stock for this person.

We discussed our findings with the manager and deputy manager. Although they were able to take action in some of the cases, the number of concerns found demonstrated people's medicine was not managed safely.

This is a continued breach of Regulation 12 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw good practices were in place for controlled drugs, medicine fridge temperatures and where PRN protocols were in place, these were well written and the guidance was very clear for staff to follow. The system was clear and well understood by the registered nurse. The medication room had a temperature check and a secure controlled drugs (CD) cupboard. We saw a CD book was in place which listed people's individual medicine. Two nurses signed for each entry and the disposal of CD was also signed by two nurses. We saw daily temperature checks were undertaken of the medication room and the fridge to ensure people's medication were stored at the right temperature to keep these effective.

We observed the medication round with one of the nurses at Shelburne Lodge. The registered nurse was diligent and approached people in a calm manner. For example, we saw them approach one person and say "Alright my dear, can I give you your tablets now?" The person nodded in agreement. One person told us "My medication is ok, I am not in pain". Specific medication management was in place. For example, one person's warfarin drug had been safely recorded with notation of when the next blood test was due.

People and their relatives told us they were safe. Comments included; "You're safe, they make sure that the windows are locked at night"; "Oh yes, I feel safe"; "I am safe and very happy" and "No concerns with safety, none at all".

People had equipment to enable them to move around the home safely and staff were aware of when this equipment should be used. We saw people were transferred safely, for example, from their wheel chair to a lounge chair by care staff. We saw evidence that equipment checks were carried out to ensure they were safe to use, for example, bath hoists.

We saw most people had call bells in their bedrooms to enable them to call for assistance if needed. However, we saw some people did not have a call bell or were unable to use one. We asked the manager how people called for assistance if they needed help. They said, "They will shout" and we have put some people near the nurse station so that they can be monitored. They told us there was only one person who could not use the call bell, but staff told us of another person who was also unable to use their bell. They said "Some people can't, like [name]. When we were on the first floor we heard one person calling out for help. We went to this person and saw they were distressed. They told us "I have been waiting for ages for help, please find someone". We tried this person's call bell and found it was not working. We alerted the nurse on the floor, who spoke to the person immediately. We raised the call bell issue with the manager, they later told us they had checked this person's call bell and found the connection had come away from the wall. They said they would get the maintenance person to check everyone's call bells to ensure they worked. Comments from people included "They're unreliable those things" and "Its ok when it works".

One relative told us when their family member first arrived their call bell had not worked on three occasions. They said this had concerned them, and eventually the bell was in working order. The manager told us, as an interim, the person was given a pendent alarm which was connected to the call bell system to enable them to call for assistance.

Staff had completed safeguarding vulnerable adults training. Staff we spoke with were able to tell us about the different types of abuse and the signs that might indicate abuse. Staff had a clear understanding of their responsibilities to report any concerns and were aware of which outside agencies they could report to as well as their own management team. Staff said, "If I had a concern I would report it to a nurse or another care staff member"; "If I have concerns I would report them" and "I would notice the change in a person if something was wrong". We saw systems were in place for safeguarding referrals to be recorded and appropriate referrals had been made to the local authority and the Care Quality Commission.

Some staff told us they were aware of the provider's whistle blowing policy, but other staff were not always clear. Whistleblowing is where someone can anonymously raise concerns about standards of care. We saw the lack of understanding by staff had also been identified by the provider in their audit in January 2017. An action had been set to refresh staff through team meetings. Following our inspection the manager provided us with a copy of minutes from October 2016 which showed the topic had been raised. However, no further evidence was available which showed whistle blowing had been discussed following the providers audit.

People's risks were recorded and monitored. For example, one person was at risk of fainting when being hoisted. We saw a risk assessment was in place and the daughter of this person had been involved in the assessment. There was clear guidance for staff to follow, 'monitor [name] when being hoisted and avoid sudden movements'. Another person had an aortic aneurism; there was a clear risk assessment which guided staff on how to manage this person's condition.

Accidents and incidents were recorded and actions to be taken were recorded. For example, there had been a recent outbreak of influenza at the home. This had been clearly recorded and reported to the relevant health authorities.

Arrangements for emergencies were in place. We saw people had individual personal emergency evacuation plans (PEEPS). These were stored securely next to the fire panel in the reception area. We saw a box which contained people's PEEP's, emergency equipment and a copy of the up to date fire assessment. This ensured details were available to emergency staff when needed.

Records relating to recruitment of staff contained relevant checks that had been completed before staff worked unsupervised in the home to ensure they were of good character. These included employment references, the right to work in the UK and disclosure and barring checks (DBS). DBS checks enable employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. The provider also had processes in place to check all staff employed as registered nurses were registered with their professional body. This ensured they were qualified to work in the capacity of a registered nurse.

Records showed staff had completed a job application form and we saw there were no gaps in a person's employment record. Interviews had been completed; photographic identification and health checks were present in staff files.

There were effective systems to monitor the safety of the environment and equipment. For example, we saw checks were regularly carried out on fire doors, the fire alarm system and regular fire tests were carried out.

The records were accurate, complete and up to date in relation to monitoring these systems.

Good

Is the service effective?

Our findings

Staff had the skills and knowledge to meet people's needs. Staff had completed training which included; safeguarding, moving and handling, food safety, infection control and 90% of staff had completed the Care Certificate. The Care Certificate is a recognised set of standards and national qualification for care staff. We saw staff training was monitored and triggers were set to remind the manager when individual staff training was due. A training plan was in place for 2017 for staff to attend.

Staff were complimentary about the training provided and were able to request any additional training they felt would improve their skills and knowledge. Comments included, "My training is good and is all up to date"; "I have done training in infection control, fire safety and control of substances hazardous to health (COSHH)" and "I have done e-learning units on health and safety and prevention of choking. There was E learning training for staff available in the home.

People and their relatives said they were happy with staff competence. Comments included, "Yes all the staff are competent in their work" and "You've got to trust them I suppose".

New staff completed an induction and were supported by more experienced staff until they felt confident to work alone. We saw on the day a set of new care workers were going on their induction training. The manager told us new staff would go to a 'hub' away from the home to complete their induction. This also included refresher days for current staff. Staff told us they 'shadowed' another staff member before working alone. Staff felt the induction process was thorough and we were told that staff could return to repeat any element they were unsure about.

We saw communication processes were in place to keep staff up to date. Handover meetings took place and we saw staff were provided with updates regarding individual people's needs. For example people's risk areas, wound management and mobility needs.

Staff were supported by the management at Shelburne Lodge. Staff had regular supervision and an annual appraisal. This was confirmed when we looked at staff files. They told us it was an opportunity to discuss any concerns and development needs. Comments from staff included, "Good support, advice and team work here".

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA). 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.

We saw people's capacity had been assessed in their care plan, but these were not always person specific. People were mainly supported to make decisions on their day to day care. Care plans outlined whether people had capacity to make decisions on care and treatment, and where appropriate a Lasting Power of

Attorney was in place which had been authorised in accordance with the MCA. The deputy manager showed us the work they were doing on changing the recording and assessment of people's capacity. We saw people's assessment was now broken down into specific areas so that people's individual decisions could be assessed. For example, personal care and medicine. There was a checklist which identified which decisions the person was able to make. This made it a lot clearer for staff to follow and concentrated on specific decisions for people.

We spoke with staff about their understanding of the MCA. One staff member told us, "The MCA is legislation in place for people who cannot make a decision. It is there to protect people as some people get confused".

The management team demonstrated a clear understanding of their responsibilities in relation to MCA and Deprivation of Liberty Safeguards (DoLS). DoLS applications had been made to the supervisory body where an assessment had identified the person lacked capacity to consent to the deprivation. There was a mental capacity assessment which identified the person lacked capacity to understand risks. DoLS applications had been made to the local authority and best interest decision meetings had been held with the appropriate professionals, relatives and management at Shelburne Lodge. For example, one person was put on a specific medication for their behaviour. A mental capacity assessment had been carried out and a best interest decision meeting held which included the person's GP. DoLS applications were kept under review to ensure that people were being supported in the least restrictive way. We spoke with a staff member and they were able to tell us which person was subject to a DoLS. This meant people's individual needs were known to care staff.

We saw people's care plans included consent details. For example, consent to pneumonia vaccine and life decisions. Where appropriate a "Do not attempt resuscitation" (DNAR) forms were in place for individuals. Where people did not have the capacity to make these decisions we saw professionals and staff were involved and had authorised these decisions. However, we saw one care plan where it was not clear if consent was obtained. We saw there were two forms in this person's file, one saying they do want to be resuscitated and one saying they did not. There was no DNAR form on this person's file which indicated they did wish to be resuscitated. We raised this with the manager and deputy manager immediately. On the day of our inspection the deputy manager checked the person's wishes. They confirmed they did want to be resuscitated and the records were removed from the care file to ensure only the correct guidance was there for staff to follow.

People had enough to eat and drink. Comments included "I get plenty of what I need"; "Food is good"; "Food is good and there is always a choice"; "Food is excellent" and "I make my order from the menu and eat what I want". We saw tea, biscuits and fruit were available to people throughout the day.

We saw records which showed people's nutrition was monitored. People were regularly weighed to monitor their weight and actions were taken to address any risks.

We saw menu boards were displayed on the wall in the dining room. Before lunchtime staff came to people and asked their food choices, this included the starter, main and sweet options. We observed the lunchtime experience for people. Staff were very caring and knew people's individual needs. Tables were laid up with napkins and condiments. Overall people's experience was positive. People who required support to eat their meal were supported by staff who were patient and caring. People were offered protective clothing and a choice of fruit juice. Staff knew people's individual needs and when assisting people with their meal they took their time and were attentive to people's needs. They sat at the person's level and explained the food they were assisting the person with. Where needed staff cut people's food up for them so it was easier to eat.

Comments were "Thank you for cutting my food up, I like that Dear". Staff encouraged people to eat by saying 'well done' and the person appreciated this. Staff interacted with people well, they made sure people were happy and asked "Enjoying your lunch [name]?" and "Are you alright [name]?". There was music playing in the background.

People who had their meal in their bedroom were supported in an unhurried way and they were encouraged to eat and drink. Again we saw staff were attentive, for example, they recognised the person was not in the right position to eat their meal. The staff member called for assistance and closed the door to ensure privacy whilst they moved the person to a more suitable position to eat their lunch.

We spoke with the head chef. They knew people's individual preferences, including health needs and allergies. They knew people who needed their food pureed and those who's diets needed fortifying to maintain their nutritional intake. They said "I fortify food with double cream to maintain people's weight. I make milk shakes with full fat milk also". We saw the head chef regularly checked fridge and freezer temperatures. This meant the chef recognised the need to keep the food for people at the right temperature and to keep people safe.

People had access to health professionals when required. People's care plans showed people had been supported to see health professionals, for example their GP and each visit was clearly recorded with details of how to look after the person. Visitors told us they were kept informed of any health concerns regarding their relative. Comments included, "They always phone me and make me aware of [name] health" and "They get the health professional in if needed".

We saw some corridors had people's mobility equipment stored. We raised this with the manager and they told us a new storage system would be in place when the refurbishment of the home took place. At the time of the inspection we did not see these items caused a risk to people.

Good

Is the service caring?

Our findings

People told us staff were caring. Comments included, "They're very good actually"; "The staff are very good to me. I'm very lucky really"; "I've got friends come and see me when they want, I'm very happy"; "I am well looked after"; "I'm fine thank you and the staff are pleasant enough"; "On the whole staff are very nice"; "Very kind lasses"; "Love my caring girls"; "There's good and not so good sometimes, but most of them are very good" and "If I need help I let them know and they are good".

Staff members told us caring was important to them. One care staff member said "It's important to me, I laugh and cry with them (people)". Relatives comments included "Mum loves it here" and "Care staff are caring and very nice".

People and their relatives were mainly involved in their care and reviews of their care. The care files we viewed showed they were written with the involvement of the person and their relatives who mainly told us they were involved in the reviews. We saw consent was obtained from people when using specific pieces of equipment, for example, bed rails and details of their consent was present in their care plan.

Care staff understood consent for people and their choices. They said "[name] choses her own clothes, washes herself and makes the bed in a specific way" and "The person with dementia may be able to make some choices, for example, what they would like to eat but not what to wear". People and visitors commented, "I probably won't get up today, it's my choice"; "I'm an early riser and can have my breakfast, it's my choice"; "I can always choose what I want" and "They (staff) do leave choice to the person".

Where people needed further support, for example, advocacy, this was arranged by the home. For example, there was one person who had recently come to live at Shelburne Lodge and had struggled to get access to their flat due to their condition. The manager had arranged for an advocate to work on behalf of the person to move their belongings to the home.

People's rooms were personalised, they were able to bring in their own furniture and belongings to ensure their room was homely. One person said, "I like my room, it's clean and tidy and a really nice room".

People's dignity and privacy was respected. When staff spoke about people they were respectful and they displayed genuine affection. The language used in care plans was respectful.

Staff explained how they promoted people's dignity. We saw they knocked on people's door before entering their bedroom, even when the door was open. They told us how they promoted people's dignity by ensuring the person is covered during personal care, taking their time with people and explaining how they were going to support them. They also said they ensured people's doors were closed when they delivered personal care to people. People were dressed appropriately on the day of our inspection. Their clothes were clean and staff made sure people had their glasses on and wore jewellery of their choice.

We saw people's confidentiality was maintained. When nursing staff were not at their nurse station, they

ensured the door was always locked to keep people's files secure.

Requires Improvement

Is the service responsive?

Our findings

People were assessed prior to moving to the home and assessments were used to develop personalised care plans.

In the care plans we viewed we saw there was detailed information relating to people's life histories, what and who was important to them, their likes and dislikes and there was a photograph of the person on the front of the file. We saw a document called 'All about me' was completed for people. The information enabled staff to know about people's past and tailor people's care to meet their specific needs. People's specific needs were recorded and acted upon. Care plan reviews were regular, including risks and involved people or their relatives, who were encouraged to make comments or amendments to the care plan. One relative said "I am here all the time and although I have not seen the care plan, I know they will involve me and mum". However one person and their relative told us they had not been involved in their care planning. Where people required further support from health professionals, this was arranged. For example, a tissue viability nurse was arranged for one person who had a grade 3 pressure sore. Another example was where the person had a chest infection and they were at risk of choking. The Speech and Language Therapy (SALT) team were involved in their care.

We saw reviews of people's care was regular, however, records of how people were on the day were not always person centred. For example, one person who we were told suffered from depression did not contain a description of their mood for the day. This detail is needed by staff to understand the mood state of the person and how best to manage their needs. The same person's review on 3 December 2016 was very brief and did not give much detail of the person's care needs. As this person had complicated needs more information about their current state of health would enable staff to ensure this person's needs were met.

One person had a cardboard 'star' on their bedroom wall which said 'Please use soft flannels and towels and pat dry only' and this provided staff with a reminder of the individual care needs. The manager told us they were responsive to people's needs. For example, if a person was at 'end of life' they would, where possible, ensure they were placed close to a nurses station to ensure they were monitored and received the best care at this stage of their life.

We saw the provider had systems in place to carry out an in depth review of people's care. This was called 'resident of the day'. This meant staff would concentrate on one person's care plan for the day to ensure it was complete and up to date. We saw following the review of one person's care plan on 7 March 2017 identified this person did not have advance care plan in place. The manager told us that they would put a note in the diary and follow up the details with the relative when they next visited the home.

We saw where people had specific needs, for example wound care, details of the care needed was displayed on the board in the medicine room and there was a 'wound' file on each floor for staff to refer to. We saw some good evidence of detailed and accurate recording of people's health needs. For example, one person was at risk of skin tears. Their care plan stated 'skin is very fragile, try to encourage them to have fewer items on their bed as prone to skin tears'. This meant, the team did recognise people's individual needs.

People were supported to spend their day as they chose. They were encouraged and supported to participate in activities that interested them. We saw a group of people playing with a balloon on the day of our inspection, people enjoyed this and we saw people who had limited mobility were encouraged to use different parts of their body. People enjoyed the session and we saw people who could not communicate verbally, were smiling. Weekly activity options were displayed in the lounges at Shelburne Lodge. The activity co-ordinator told us they did one to one therapy with people. For example, they would read the national newspaper to people or have a chat about things that was important to the person. We saw, and the manager and activities co-ordinator told us how they were introducing individual 'rummage boxes' for people. They asked family members to bring in items for people to reminisce, for example photographs. This meant staff had items to enable them to strike up a meaningful conversation with people and could relate to people's past history. There was also a 'happy tree' for people and families to post comments about the home and staff. The manager told us they reviewed this regularly and we saw a number of positive comments and 'thank you' notes from family members. Comments from people and relatives included "We had a singing and dancing event and it was really nice"; "They (staff) are always organising things to keep people's minds occupied" and "We had Hoopla this morning and had really good fun".

The activities co-ordinator told us how they were planning to take people out in the mini bus to the Eden Centre in High Wycombe. This is a shopping and entertainment complex. We saw the activities co-ordinator maintained detailed records of their communication and work with people on an individual basis. They recorded the person's mood, what interactions had taken place, their communication ability and whether the aims of the activity had been met. This enabled them to monitor and change the needs of people on an individual basis.

There was a complaints policy and procedure in place. Relatives told us if they had made a complaint and that it was well managed and they had confidence their concerns would be listened to. One relative said "I am confident the manager will act, I raised a concern and all of these were followed up". We saw systems were in place to manage complaints and details were recorded along with actions following the complaint. We saw when complaints were escalated to senior management, these were well managed and clear communication had taken place, along with actions, with the complainant.

However, one person told us of a complaint they made. They said "We are only allowed one shower a week, I insisted on seeing the manager…eventually I got it sorted and had my shower when I wanted it". Other comments received were "I've asked to see the manager several times and the response they got was 'she is on the telephone or talking to somebody'" and "They don't like you and you get spite for that. Sometimes it's best not to disclose". We asked this person if they felt they could raise a concern, they told us "No, I'm a bit afraid; they can use it against you".

Providers are required to comply with the duty of candour regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity.

At the time of the inspection, the service had an appropriate duty of candour policy. The document provided clear steps for the management to follow if the duty of candour requirement was triggered. The manager demonstrated a good understanding of the Duty of Candour.

Requires Improvement

Is the service well-led?

Our findings

Where people needed specific care needs monitoring we found these were not always being completed. For example, we saw two people who had details of the frequency of when they should be repositioned in bed recorded in their care plan. A 'turning chart' was in place, but the repositioning of people was not consistently recorded. One person's care plan stated, they should be repositioned every three to four hours. But records showed on the 7 March 2017 that no recording of repositioning had been made between 17.30 and 22.40 hours. Another person's care plan stated they should be repositioned every two hours; however between the period from 5 to 8 March 2017 records did not confirm this frequency was maintained. There was a third person who chart stated 'on her back'. We raised this with the manager and they told us this was the person's usual position. However, this was not clear in the person's care plan. We saw another person who was known to be at risk of constipation and they had a bowel chart in place. However, this had not been completed since 19 February 2017. This meant people's care records were not up to date to ensure people's care and health needs were appropriately managed. Some people who required to be repositioned had cardboard stars cut outs on their bedroom walls. Whilst this could be a good way of prompting staff, it was not clear why some people had these and others who needed repositioning did not.

Systems were in place to monitor the quality of the service. Audits were carried out and included audits of: risk assessments; medicines; infection control and people's weights. These audits were reviewed by the manager and senior management at Barchester Care. We saw an action plan was in place to address areas of concern identified through the providers audit system. There were a number of tasks on the action plan for the manager to follow. For example, repositioning charts, the action stated 'general manager (GM) and deputy home manager (DHM) to review fluid and repositioning charts daily and sign off if completed in full. If gaps are identified, GM to investigate and take the appropriate action'; medicine management, the action stated 'residents MAR sheets to be audited….including detailed checks if the expiry dates of medication on a monthly basis' we also saw an action which indicated it had been achieved, 'The file containing all MAR sheets and information pertaining to the administration of individual medication has been overhauled ensuring that all information is clear and well presented'; Dependency tool, the action stated 'The care needs and dependency of each resident is reviewed on a monthly basis and the tool updated. Rota's are also updated to reflect an increase in dependency' and Involvement of people in their care planning, the action stated 'All residents to be consulted when their care plan is being reviewed. Care plan to be discussed with them. Monthly review sign off to reflect that residents have been consulted and are happy with their plan of care'. These actions had not been taken as all of these areas were identified at our inspection. The completed dates recorded on the action plan were 21 June 2016 for repositioning charts and all of the other areas were 31 October 2016. However, this shows the systems in place to monitor quality were not fit for purpose.

We spoke with the manager and deputy manager and they told us, that at times, due to staff shortages, this impacted on their ability to remain supernumerary and this led to areas not always being effectively monitored.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

The manager, deputy manager and the team provided us with the documents required which demonstrated an open culture.

Relatives' comments on the workplace culture included; "It's run alright"; "Listens and was helpful"; "Service is run well"; "Communication is very good" and "The service satisfies me".

Staff told us they were mainly supported by the registered manager. They said, "Yes I feel supported by the manager"; "We have meetings on how to improve, we get together and talk to see how we can make improvements for people" and "Support is good and manager really helps you". However, other comments received included "No I am not supported"; "She (manager) is not very approachable" and "If I want to speak to the manager they tell me, I'm very busy'".

We saw policies were in place which showed consideration was given to people's personal preferences. For example, there was a policy on 'sex, sexuality, intimate relationships and friendships'. This demonstrated diversity and equality was recognised by the provider.

We saw an annual survey was sent to people and their families. The last one was October 2016; however, details of the findings were not available at the time of the inspection. However, overall comments about the service were good.

We saw the provider held a general managers meeting on a six monthly basis. The manager told us a person who lived in one of the Barchester homes were invited to provide feedback and ideas to the management. This showed people's involvement and enabled managers in to share good practice. Other meetings included Heads of Department meetings where topics included the forthcoming refurbishment of Shelburne Lodge and details of actions for each head of department was shared. There were also 'carers' meetings. We saw at the last meeting on 27 February 2017 that there was a clear two way discussion of people's needs. For example, reminders for staff to complete people's documents and staff made requests for further battery chargers for hoists in the home. These tasks were allocated to the respective department, for example, maintenance.

We sat in on the 'Daily Department Stand-up Meeting' we saw areas discussed were maintenance plans for the day and week, housekeeping issues, entertainment preferences and recruitment.

There were regular resident meetings and topics discussed by people were food, entertainment and spiritual needs. In the meeting on 17 February 2017 we saw people commented, 'Happy I am home once again' and 'I am happy with the care and support'. It was also mentioned about the selling cakes for Comic Relief. This demonstrated people were encouraged to keep in contact with community based events. However, not all people or their families were aware of these meetings.

Comments about the overall management at Shelburne Lodge include "There is an 'open door' policy here"; "Mum loves it here"; "We all get on fine"; "Overall I am quite happy with the management" and "Its fine here, it's alright and I like it".

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. The provider was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.

Throughout our visit management and staff were keen to demonstrate their practices and gave unlimited access to documents and records.

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 Appropriate arrangements were not in place to check the expiry date of medicine. The accuracy of medicine records were not effectively monitored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured robust systems were in place to identify where quality and or safety had been compromised. The provider had not identified the risks to people's health, safety or welfare of people. The provider had failed to maintain accurate contemporaneous records in respect of each service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not always effectively deployed to meet the needs of people using the service at all times.