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

Summary of findings

Overall summary

The inspection visit was carried out on 2 and 3 February 2017 and was unannounced.

Sholden Hall provides care for up to 27 older people some of whom maybe living with dementia. At the time of the inspection there were 20 people living at the service. Sholden Hall offers residential accommodation over two floors; has two communal areas and is located in the village of Sholden. There is a small conservatory on the ground floor for people to use; there is a secure garden at the rear of the premises. The registered manager's office is located in part of the dining area.

There was a registered manager working at the service. 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 and associated Regulations about how the service is run.

We carried out an unannounced comprehensive inspection of this service on 14 July 2016. We issued requirement notices relating to safe care and treatment, the provider did not have sufficient guidance and checks to make sure risks were mitigated. The provider had failed to have proper and safe management of medicines. The provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook a focused inspection to check that they had followed their action plan and to confirm that they now met legal requirements. During the focused inspection we identified other areas of concern within the service; we decided to complete a full comprehensive inspection to investigate these concerns.

There were two breaches of regulation identified at the previous inspection and at the time of this inspection the provider had complied with one breach and part of the other breach. The provider had not fully met the legal requirements. Risks to people's safety had not been consistently assessed and did not contain the information for staff to mitigate risks and keep people as safe as possible. This was a continued breach of regulation.
At the last inspection we reported that there was opportunity to improve some areas of the service including the plan to evacuate people safely at night, updating mental capacity assessments and completing risk assessments; some of the improvements had been made including the night evacuation plan but others had not.

At the last inspection medicines were not managed as safely as they should be. At this inspection improvements had been made. However, hand written instructions had not been signed by two members of staff to check that the instructions were accurate. This was an area for improvement.

Accidents and incidents had been recorded but had not been analysed to identify any patterns or concerns to reduce the risk of them happening again.

People said that they felt safe living at Sholden Hall. Staff received safeguarding training and they were aware of how to recognise and protect people from abuse. Staff knew about the whistle blowing policy and were confident to raise any concerns with the registered manager or outside agencies if needed. However, after the first day of the inspection, we found a person was a risk of neglect and this had been not been recognised by the registered manager. A safeguarding alert was raised with the local safeguarding authority about the care and treatment of one person.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people using services by ensuring that if there were any restrictions to their freedom and liberty, these had been agreed by the local authority as being required to protect the person from harm. At the time of the inspection the registered manager had applied for DoLS authorisations for some people and some had been granted. There were still other people within the service who were under constant supervision but DoLS authorisations had not been applied for.

Staff sought people's consent before giving care and respected their decision if they refused support; going back to them later, to offer support again. Staff knew people well and supported them in their preferred way, giving them choices about what they would like to do or eat and drink.

The registered manager completed checks and audits each month. The provider completed regular audits of the service; however, these checks did not include medicines or care plans and had not identified the shortfalls found at this inspection. Checks on the equipment and the environment had been carried out. The checks had identified the water temperature in two rooms were higher than recommended placing people at risk of scalding; no action had been taken. The provider adjusted the water temperature in the rooms on the second day of the inspection. There were emergency plans in place, in case of fire or flood; fire drills had been completed so staff knew what to do in an emergency.

Records were not accurate and up to date; documents were not always stored safely, as the registered manager's office was not secure. The provider and registered manager had not identified shortfalls within the service; they had not promoted and driven improvements within the service.

Before people came to live at Sholden Hall; the registered manager met them to ensure they were able to meet their needs. One person had recently moved into Sholden Hall, the registered manager had not completed an assessment of their needs and wishes to establish if the service could meet those needs. The care plan that was in place for the person was not complete so staff had very little information and guidance to care for the person safely.

There were sufficient staff on duty, however, the deployment of staff was not consistent. On the first day of our inspection there were long periods of time when there were no members of staff in the lounge with people and interaction between people and staff was limited. On the second day staff did spend time with people in the lounge enjoying conversations and activities. People were relaxed in the company of staff. People smiled and they were reassured with a hug when they were anxious.

On the first day of the inspection people's dignity and privacy was not always maintained; staff were not always available to support people.

Staff were recruited safely. Staff received an induction when they started working at the service, which included shadowing more senior staff and core training. There was an on-going training and refresher programme, however, there were gaps in training covering specific care areas such as diabetes and challenging behaviour.

Staff received support from the registered manager through supervisions and yearly appraisals to identify their training and development needs. There were regular staff meetings so that staff could discuss any issues or ideas they may have.

Each person had a care plan, these were detailed with people's preferences and choices; staff were able to support people in their preferred way.

When people became unwell staff contacted their doctors and specialist services and followed their guidance. Care plans had been reviewed but had not been consistently updated to reflect people's changing needs.

People told us they enjoyed their meals, at lunch time people were offered a choice of drinks. The meals looked appetising and the portions were adjusted for people's appetite.

People had access to organised activities during the week; people had one to one time with staff and enjoyed manicures and reminiscence.

People and relatives told us they knew how to complain and felt that it would be taken seriously by the registered manager, there had been no complaints since the last inspection. A quality assurance system was in place, the registered manager had asked the views of people, relatives and professionals; these had been analysed and action had been taken.

The registered manager had an open door policy. People, relatives and staff felt that they were able to approach the registered manager and would be taken seriously. People, relatives and staff were encouraged to express their views and suggestions.

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. This is so we could check that appropriate action had been taken. The registered manager was aware that they had to inform CQC of significant events in a timely way. Notifiable events that had occurred at the service had been reported.

We found four 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

Risks to people were not always assessed. There was not always clear guidance given to staff to keep people as safe as possible.

Staff were recruited safely. There were enough staff on duty but they were not consistently deployed to meet people's needs.

People had not been fully protected from abuse and harm. Staff knew the signs of abuse and had received training to keep people safe from harm but this had not always been put into practice.

People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received induction training and on-going training in relation to their role but not all staff had completed training related to people's needs.

Deprivation of Liberty authorisations had been applied for some people. There were other people with restrictions to their liberty that had not been actioned in line with the Mental Capacity Act 2005 and DoLS safeguards.

People were supported to ensure their health needs were met.

People were supported to eat a nutritious diet to stay as healthy as possible.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always communicate with people in a caring and dignified way.

People's dignity was not always maintained.

Staff knew people well and knew how they preferred to be supported to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Assessments of people's needs were not carried out consistently before they moved in.

Staff did not always respond to changes in people's needs. Care plans had been reviewed but were not consistently updated.

People were happy with the activities within the service.

People and relatives were able to raise any concerns or complaints with staff or the registered manager, who would listen and take any action that was needed.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a continued breach of a regulation.

Quality monitoring systems were in place but did not look at all areas of the service. The shortfalls within the service had not been identified and there were no plans of how improvements would be made.

Accident and incidents were recorded but had not been analysed to identify trends to reduce the risk of them happening again.

Records were not always accurate and complete.

Staff told us that they felt supported by the registered manager and that there was an open culture between staff and the registered manager.

Sholden Hall Residential Retreat

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Safety 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.

The inspection took place on 2 and 3 February 2017 and was unannounced. It was carried out by three inspectors.

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 included in the PIR along with other information we held about the service. We looked at previous inspection reports and notifications received by CQC. A notification is information about important events which the provider is required to tell us about by law, like a death or serious injury.

We looked around areas of the service, and talked with six people who live at the service. Conversations with people took place in people's rooms and the main lounge areas. We observed the lunchtime meal and observed how staff spoke and interacted with people. Some people were not able to explain their experiences of living at the service due to their dementia. We therefore used the Short Observational Framework for Inspection (SOFI) which is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed records including four care plans and risk assessments. We looked at a range of other records including staff files, staff induction records, training and supervision records, staff rotas, medicine records and quality assurance surveys and audits.

We talked with relatives who were visiting people, the provider, registered manager, care staff and domestic staff. We spoke with a health professional and social care professional.

The previous inspection was carried out in July 2016. At that inspection two breaches in the regulations were identified.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe at Sholden Hall. One person said, "Staff get what I need for me. They make me feel safe, they are always here."

At our last inspection in July 2016 the provider had not assessed all of the risks to people's health and safety and had failed to mitigate risks to people. The provider sent us an action plan telling us how they were going to improve. At this inspection the action plan had been implemented, but there were still shortfalls in managing risks to make sure people were as safe as possible.

Risks to people had not been consistently identified and assessed; guidance was not in place to reduce risk and keep people safe. One person had been identified as being 'unsafe on the stairs' there was no guidance for staff on how the person was to be supported to reduce the risk and remain independent and as safe as possible. Another person was prescribed blood thinning medicine; there was no guidance for staff to recognise or manage the risks to the person when taking this kind of medicine. There was one person living with diabetes; their care plan stated that their blood sugar was to be monitored regularly. There was no guidance for staff about how often their blood sugar should be checked or what level the blood sugar should be and what to do if the level was too high or low.

One person had not been weighed since November 2015 because the scales could not be taken to them; the person was at risk of weight loss; food charts showed that the person was not eating all their meals and there were no records of alternatives being offered. The staff had not sought advice on other ways of checking that the person was maintaining a healthy weight. Since the inspection, the person has been weighed and maintained a healthy weight.

On the first day of our inspection, we observed one person alone in their room on the first floor. There was an emergency call bell in the room but the person was unable to reach it if they needed to call for assistance. Staff had positioned the person with their feet up and a table placed over their lap so that their movement was restricted. Staff told us the person was unable to use the call bell and that they were at risk of falls; there was no guidance in the care plan for staff to manage these risks safely. The deputy manager said that staff regularly checked on the person but staff did not record these checks. There was no evidence that the person was checked by staff to see if they were safe or needed anything. The registered manager was unaware of how the staff had left the person. At the end of the first day we raised a safeguarding alert with the local safeguarding authority because of the risk of neglect.

On the second day of the inspection, the registered manager had made changes to manage the risks. We went to see the person again. The person had their feet down, there was a pressure alarm mat in place by the person's feet to alert staff if they got up. Their table was now by their side and there was a chart in place for staff to sign to document that they checked the person hourly. However, when we checked at 3.30pm the chart had not been completed since 12.30pm. This was brought to the registered manager's attention. The registered manager reminded staff that the person needed to be checked and this needed to be recorded. Staff then completed the form retrospectively.

Checks had been completed on the environment and equipment and had identified shortfalls. These shortfalls had not been consistently addressed, the water temperatures had been recorded in September 2016, and they had not been recorded again until January 2017. In January 2017 two bedrooms had water temperatures that were higher than the recommended safe level to protect people from scalding. No action had been taken. On the second day of the inspection; adjustments to the water temperature had been made by the end of the day. The fire risk assessment had identified that the steps leading from the back hall were too steep for people, staff and visitors with mobility problems to use to evacuate the building. There was no plan in place to make changes so that the steps were safe for people to use.

Other risks identified at the last inspection of July 2016 had been addressed. This included checks to ensure the specialist mattresses were working effectively and that catheter care plans were in place. The provider had failed to provide clear guidance to staff to mitigate other risks to keep people as safe as possible, this continued to be a breach of regulation.

Care and treatment was not provided in a safe way for people because the provider did not have sufficient guidance and checks to make sure risks were mitigated. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they knew what to do if they suspected any incidents of abuse. Staff said "I would report anything to the manager, if needed to yourselves (Care Quality Commission). I wouldn't think twice about it." Staff said they felt confident that the registered manager would take action if needed. The provider had a policy and procedure that staff could refer to. Staff had completed training about how to keep people safe and this was confirmed by the training record. However, staff had not recognised that a person was at risk of neglect which is a type of abuse.

Staff were aware of the provider's whistle blowing policy and the ability to take concerns outside of the service if they felt they were not being dealt with properly. Staff were confident the registered manager would listen to their concerns and take appropriate action to ensure people were protected.

At the previous inspection a box of medicines did not have a pharmacy label and staff were not given guidance on how to administer medicines that were prescribed on an 'as and when' basis for pain relief and anxiety. Staff were signing records before giving medicines to people rather than signing the record after the person had taken the medicine. At this inspection there had been improvements. There was now guidance for staff to give medicines to people on an 'as and when' basis, there were records that this guidance had been followed by staff. All boxes of medicines had pharmacy labels in place. Staff were now signing the medicines charts after they had ensured the person had taken the medicines. However, other shortfalls were identified.

Some instructions on the medicine administration records (MAR) had been handwritten by staff. These instructions should have been signed by two staff to confirm the instruction was correct, this had not been completed. Bottles of liquid medicines are effective for a limited period of time once opened, there were some medicine bottles that did not have an opening date on them, there was a risk that the medicines could be administered and not be effective.

We recommend that the provider take into account The Royal Pharmaceutical Society of Great Britain Guidelines with regard to the safe storage and recording of medicines.

Medicines were stored safely, the medicine trolleys were clean and tidy and not overstocked. The fridge and room temperature were recorded daily to ensure medicines were stored at the correct temperature. The

staff recorded accurately and consistently when people had creams and sprays applied to help keep their skin healthy. The registered manager had recognised that staff needed more day to day support with medicines and had started the process to change to another medicines system. Staff had attended training for the new system and the deputy manager had started to complete new supporting paperwork to improve the management of medicines.

The registered manager based the staffing levels on people's needs, activities and appointments. The staffing levels had been increased to manage new admissions to the service. Staff were not consistently deployed to keep people safe and meet their needs. On the first day of the inspection, there were long periods of time when there were no staff members present in the lounge to support people. There were two occasions when the inspectors had to intervene and protect people's dignity as no staff were present. There had been eight falls recorded in January 2017 and the majority had been unwitnessed by staff so people had been alone. Staff looked rushed and at times paced quickly through the lounge without talking to or engaging with anyone. One staff member told a person "You had better eat extra (lunch) for me as I won't have time to eat."

We observed one person trying to stand from their arm chair, they looked off balance and anxious. Another person looked worried and approached them asking them to sit down. They told us "I am worried about (person's name), she keeps trying to get up." There were no staff present to intervene. People confined to their rooms were not regularly checked on by staff. On the second day of the inspection there was a member of staff present in the lounge at all times, the atmosphere was relaxed, people were chatting with staff and involved in activities.
The provider had failed to deploy sufficient numbers of suitably qualified, competent and experienced staff to make sure that people's needs were met. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents had been recorded but had not been analysed to identify any patterns or concerns to reduce the risk of them happening again.

There were emergency and contingency plans in place, there was an evacuation plan in each room. Staff took part in fire drills and knew what to do in an emergency; there were arrangements in place for people to be taken to a nearby residential home. At the last inspection each person had a personal emergency evacuation plan (PEEP) in place for the day but not for the night. At this inspection the PEEP covered the person's needs both during the day and night. Safety sockets and plugs had been installed since the last inspection so that pressure relieving mattresses could not be switched off.

Staff were recruited safely. Recruitment checks were completed to make sure staff were honest, trustworthy and reliable to work with people. These checks included written references and a full employment history. Any gaps in people's employment history were discussed at interview and recorded. Disclosure and Barring Service (DBS) criminal record checks had been completed before staff began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services.

Requires Improvement

Is the service effective?

Our findings

People and relatives felt that they were supported by staff, one person told us, "They know what I need and help me to keep independent." One relative told us, "Resident's interests are top of the tree. I can't praise them enough."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation Of Liberty Safeguards (DoLS). We checked the service was working within the principles of the MCA.

The registered manager had knowledge of MCA and DoLS and was aware of their responsibilities in relation to these. However, these principles had not been consistently applied. The registered manager had applied for DoLS authorisations for some people within the service, there were other people under constant supervision where DoLS had not been applied for. On the first day of the inspection, the care plan for one person, who had been admitted recently, stated that a lap belt should be used while the person was in their wheelchair and that the person did not understand what the strap was for. The care plan noted that staff were to use the lap belt as the person 'would undo the straps' and try to get out of the wheelchair. The registered manager had not recognised that this was a restriction and had not sought advice. The person's capacity to consent to this restriction had not been assessed although the registered manager told us that the person had capacity so their decision about the lap belt should have been respected. On the second day the registered manager had completed a DoLS application for the person without considering the person's ability to consent to the restriction and whether there was any alternative.

Most people's capacity to consent to care and support had been assessed and assessments had been completed. When people lacked capacity to make decisions; staff understood that decisions must be made in the person's best interests. However, one person was refusing healthcare treatment. The registered manager told us that the person had capacity to make decisions. When a person has capacity their decision must be respected even if others feel it is unwise. The registered manager had contacted the person's doctor, who prescribed a sedative to be taken before the required treatment. Although this decision had been made in the person's best interest, they had not been involved or asked, nor had their loved ones. Staff sought consent from people before giving support; if people refused support this was recorded and respected. People were supported to make day to day decisions; staff offered people options in ways they understood and gave them time to choose what they wanted. During the inspection people were able to move about the building with support as they wished.

The provider had not acted in accordance with the Mental Capacity Act 2005 when a person lacked capacity to make a decision or had capacity to withdraw or refuse consent. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who knew them well. Staff received essential training to support people and keep them safe. Staff currently watched a DVD and answered questions on a topic. The registered manager said they planned to introduce a booklet system where staff read a booklet and answered test questions on a topic and some face to face training. Staff had completed adult social care vocational qualifications, these are worked based awards that are achieved through assessment and training. To achieve these qualifications staff must prove they have the ability to carry out their role to the required standard. Records of staff training showed that not all staff had received training for specific areas of care related to people's needs including behaviours that challenge, nutrition in older people and diabetes. The registered manager had a plan in place to provide additional training in the coming year. This was an area for improvement.

New staff completed an induction programme; this included 'shadow shifts' where they worked with established staff to get to know people and understand their choices and preferences. New staff completed a probation period and the Care Certificate, which is a set of standards that care staff achieve when they are deemed competent.

Staff received regular one to one supervisions with the registered manager; when their practice and any support they needed could be discussed. Staff had a yearly appraisal when their progress and future development could be discussed and personal objectives could be set. The registered manager had asked an outside professional to assess staff's competency in administering medicines, this was to start in the next month. Staff knew how people liked to take their medicines and spent time with people so they did not feel rushed.

People were supported to remain as healthy as possible; staff monitored people's health and involved health care specialists when needed. People had been supported by the community psychiatric nurse, district nurse and podiatrist. When people had problems swallowing and were at risk of choking; they were referred to the Speech and Language team for assessment. Staff followed guidance from the health professionals to keep people as healthy as possible. When people were unwell their GP was contacted; when people required emergency care; staff had recognised this and contacted the emergency services.

The lunch time meal was a social occasion. People were offered a drink to go with their meal, some people decided to have a beer or lemonade. People had a choice of healthy and nutritious meals, one person liked to eat their main meal in the evening so staff prepared a snack for them at lunch time and saved their meal for later. People could choose where they wanted to eat; some people stayed in the lounge or their room. People enjoyed their lunch; and people told us that they had enough to eat and that the food was good. Some people were at risk of losing weight; staff monitored their weight and referred them to a dietician when required. People had drinks within reach when in the lounge and in their rooms. One person said "The food is alright, I have no complaints."

People were offered snacks and drinks throughout the day, the chef knew about people's likes and dislikes and what portions they preferred.

Requires Improvement

Is the service caring?

Our findings

People and relatives told us that the staff were kind and caring. Another person said, "The staff are very friendly and helpful." However, we observed that people's dignity was compromised and some staff spoke abruptly to people. These issues were observed on the first day of our inspection, on the second day people's dignity was supported.

On the first day of the inspection there were no staff available in the lounge for long periods of time. Before the inspection a health professional had also made this observation during their visits, that there was a lack of staff presence and interaction. People were alone in the lounge, one person became distressed and started to remove their clothing, there were no staff available to support the person so an inspector had to intervene to protect the person's dignity. This had also happened earlier in the dining room. The person had no shoes on and appeared anxious. A staff member supported the person after they had been alerted by the inspector. Another person was sitting in an armchair with their feet dangling and they looked uncomfortable. The inspector asked the person if they would like a footstool as there were two nearby and the person said yes. As there were no staff present the inspector asked the housekeeper to help, and the person said they were more comfortable with the footstool.

Staff did not always speak respectfully to people. When offering medicines, staff said to a person "Sit, open (your mouth), tablet, drink." This was said in an abrupt manner.

On the second day of the inspection the atmosphere was different and there was a member of staff in the lounge, there were people chatting and laughing. Staff were massaging people's hands and talking to them about their past, prompting them to share their memories. People were asked what they would like to do. Staff encouraged and supported them to join in with activities if they wanted to. On the second day of the inspection the hairdresser was visiting, staff assisted people to have their hair done, respecting their decision if a person decided not to.

Some people decided they wanted to spend time in their rooms, staff respected this, supporting them to their rooms when asked by the person. There were no systems in place for staff to record that they checked people who stayed in their rooms. The deputy manager said she expected staff to check that people were alright but these checks were not recorded so she could not be sure they were happening. Two people, who were in their rooms, had no means of calling staff if they needed support. There was one person in their room and they were happy playing cards. The person required assistance with their personal care and was able to call staff by using a call bell. When the staff were alerted they supported the person immediately.

Staff knocked on people's doors and waited to be invited in before entering. Staff knew people well and referred to them by their preferred name. Staff ensured that people's preferences were continued, for example, one person liked to wear jewellery, staff had helped them to put on their necklace.

One person liked to spend all their time in their room, staff ensured that they had all they needed to remain as independent as possible. Each day staff made sure that the person had what they needed and were

content. The person said, "I am quite independent and don't use the call bell that much, but know there is someone there to help."

People and staff seemed comfortable in each other's company, at lunch time; there was laughter and people talking together. Staff talked with people in a discreet way and encouraged people to be as independent as possible, offering support when a person was unable to do something for themselves. One person looked anxious and appeared to be confused, staff approached them and spoke to them discreetly, they took the person's hand and led them to the bathroom, the person returned to the lounge much calmer and settled.

People could choose where they wanted to spend their time, some stayed in the communal lounge, but others liked to walk around the building and spend time in quieter areas. Relatives and visitors were welcome at any time and people were encouraged and supported to contact their family and friends.

The registered manager had recently moved their office from the conservatory in to the dining room; the office was not a solid construction, there were gaps at the side and above the walls. There was a risk that confidentiality could not be maintained during telephone calls and conversations with relatives and visiting professionals. Confidential documents were being stored in the space, the documents were locked away however, the office could be accessed easily. On the second day of the inspection, the provider stated that a more permanent structure would be provided.

Requires Improvement

Is the service responsive?

Our findings

People told us that they received the support they needed. One person told us: "Staff are very helpful and friendly, they come when I need them."

The registered manager told us that they completed an assessment of people's needs before they came to live at the service. We looked at an assessment for a person who moved in recently. The care needs assessment document, had not been completed. There were no documents, including assessments, from other health professionals available to give staff guidance about the care and support the person needed. The person's family confirmed that they had met with the registered manager and had given them information but this had not been recorded. The person had a specific health need affecting their balance and mobility that needed supporting and could become anxious.
The person had a care plan but this information was not recorded so staff had no guidance on how to support the person in safest way. We asked the registered manager how staff, who did not know this person, knew how to support them. The registered manager told us that staff relied on what the registered manager had told them. This placed the person at risk of not receiving the support they needed and wanted. Staff told us that they knew how to support the person and this had been discussed between them. On the second day of the inspection, the registered manager showed us an assessment they had completed the previous afternoon for another person who might move in.

Some people had a care plan in place that provided staff with details of people's preferences and choices. Plans contained information for staff on how to support people effectively. One person was hard of hearing and did not like to wear their hearing aids; the care plan gave staff guidance about how to communicate effectively with them by using a white board to write on. Care plans gave details about people's daily routines, continence, skin care needs and eating and drinking. There was guidance about how to keep people's skin as healthy as possible and how to use any specialist equipment such as special mattresses and cushions.

Care plans were reviewed monthly but had not always been updated to reflect people's changing needs. One person had refused to have their nails cut by staff and the chiropodist. Staff told us that they gave the person a tablet to relax them when the chiropodist visited and then they cut the person's nails. This information had not been included in the person's care plan.

Before the inspection there had been concerns raised by a health care professional about the management of people with behaviour that may challenge. They were concerned that staff may be using medicines to manage people's behaviour. There were people who were prescribed medicines to calm them, the care plans gave guidance on when the medicines should be given and staff had completed behaviour charts to show how the decision had been made to give the medicines. Records confirmed that medicines had been given when all other behaviour management had failed.

Staff supported people to keep occupied. One person enjoyed folding laundry, so staff encouraged the person to help them when they were doing this; the person was smiling and looked to be enjoying the

activity. On the second day of the inspection, staff sat and chatted to people about their lives and past events. People chose an old movie that they wanted to watch that brought back memories for them. This was in contrast to the first day of the inspection when no activities were provided and people sat in the lounge with the television on or in their rooms.

There was an arts and crafts coordinator employed one morning a week. There was a different activity each week for people to be involved in. People enjoyed playing bingo and joining in with the singing. Each afternoon staff supported people with Namaste care, a programme that has been designed to improve the quality of life for people living with dementia, including hand and foot massage using creams and scents that remind people of their youth.

The provider had a written complaints procedure, this was not displayed in the service; it had been moved but it was available. The complaints procedure was available in a format that was more meaningful for people. The registered manager had not received any recent complaints; they were aware that complaints needed to be recorded, investigated and responded to. People told us that if they had any complaints they would raise them with the registered manager and they were confident that they would deal with it promptly.

Requires Improvement

Is the service well-led?

Our findings

People told us that they thought the service was well led. One relative said, "There is a happy atmosphere, comfortable feel. The manager is easy to talk to."

The breach of regulations found at the last inspection had not been met. There were further breaches of regulations found at this inspection. Some areas for improvement detailed in the last inspection report to improve the service, had not been acted on including updating mental capacity assessments and completing risk assessments.

There were systems in place to monitor the quality of the service provided. Checks and audits were completed regularly by the registered manager and the provider; these audits had not identified the shortfalls in risk assessments, Deprivation of Liberty Safeguards and Mental Capacity Act, medicines and care plans that we found.

Systems were in place to analyse accidents and incidents to reduce the risk of them reoccurring but these had not been completed since November 2016. Accidents and incidents should be analysed to look for any patterns or trends for example, if they happened at a certain time of day or in a certain place. As this analysis had not been carried out incidents and accidents could continue.
The provider visited the service every two weeks and completed audits on a monthly basis. The audits did not cover areas like care plans, recruitment and medicines. The provider did not have oversight of the whole service and had not monitored the care being given to people to identify shortfalls and prompt the registered manager to make improvements. After the inspection the provider informed us that they had arranged for an in-depth audit by a consultant.

Staff carried out checks on the environment and equipment; these checks were not always up to date. When shortfalls were identified the provider had not taken the action required to keep people safe. For example, when water temperatures in people's bedrooms were too high these had not been adjusted to reduce the risk of scalding.

Accurate and complete records in respect of each person were not maintained. Risks relating to people's care and support had not been consistently assessed and documented. Clear guidance had not always been provided to staff about how to mitigate risks to people. Care plans had been reviewed but not updated to reflect people's changing needs. These issues had not been picked up by the provider's audits.

The provider had not ensured that they were compliant with continued breaches of the regulations identified at the last inspection. They had not fully adhered to and completed their action plan.
The quality assurance audits were not effective to ensure that all shortfalls in the service were identified and acted on. The systems to identify and assess risks to the health and safety of people were not detailed to show what measures should be taken to mitigate risks. The provider had failed to ensure that records were accurate or fully completed. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The registered manager had sent out a quality assurance survey in April 2016 and was preparing to send out another in April 2017. The survey was sent to people, relatives and other professionals such as GP's. The results from April 2016 had been analysed and had been published for people and their relatives to read. The results had been positive and people had been satisfied with the care and support they received. The registered manager produced a newsletter each month to keep people and their relatives informed of what was happening at Sholden Hall. Staff had been asked to complete a survey to give their views on the service.

There was an open and positive culture between people, staff and the registered manager; people looked comfortable approaching staff, joining in with conversations. The registered manager knew people well and people responded to them in a positive way, by smiling and laughing.

People, relatives and staff appeared comfortable with the registered manager; people approached them and they responded with warmth, asking if they were alright and touching their arm. We observed relatives chatting with the registered manager, one relative said, "I can always come to the manager and talk anything over." The registered manager had an open door policy, they encouraged people and relatives to come and see them, this happened regularly during the inspection.

Staff understood their roles and responsibilities and had a good understanding of people's needs. Staff met with the managers for supervision however, the registered manager had not received supervision and support from the provider to develop their skills and improve their knowledge. Staff told us that they felt supported by the registered manager and deputy manager. They said they were able to discuss any concerns with them and felt that they would deal with them. The staff said that they worked as a team; the deputy manager and registered manager worked alongside side staff and knew people well. The registered manager organised regular staff meetings, staff were able to express their views and make suggestions about the service.

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 submitted notifications to CQC in line with CQC guidelines.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not acted in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for people because the provider did not have sufficient guidance and checks to make sure risks were mitigated

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 assess, monitor and improve the quality of the services provided and assess and monitor the risks relating to the health, safety and welfare of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient numbers of suitably qualified, competent and experienced staff to meet people's needs.