Handsale Limited

Handsale Limited - Shakespeare Court Care Home

Inspection report

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West Yorkshire
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 7 and 16 August 2018 and was unannounced on both days. There were 47 people living at the home at the time of our inspection.

Shakespeare Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Shakespeare Court accommodates 80 people in one building. Within the building there are four units. Rowan and Aspen on the ground floor and Cedar and Willow on the first floor. Aspen and Rowan provide personal care with Rowan dedicated to care of people living with dementia. Willow and Cedar provide nursing care; Cedar is dedicated to the care of people living with dementia.

All parts of the home are accessible by means of passenger lifts and there is a small enclosed garden area.

The last inspection was carried out in November 2017; the report was published in March 2018. Following that inspection, the service was rated requires improvement overall and inadequate in well-led. The inadequate rating in the well-led domain was because this service has consistently failed to meet the fundamental standards, it has been rated requires improvement or inadequate since the first rating inspection in October 2014. The provider was in breach of four regulations relating to person centred care, consent to care and treatment, dignity and respect and good governance. Two of these, consent and good governance, were continued breaches from the previous inspection. Following the November 2017 inspection, we took enforcement action and issued a warning notice to the provider in relation to good governance.

During this inspection we found that although some improvements had been made the provider was in breach of five regulations. These related to safe care and treatment (Regulation 12), the employment of fit and proper persons (Regulation 19), person centred care (Regulation 9), dignity and respect (Regulation 10) and good governance (Regulation 17). Three of these breaches, person centred care, dignity and respect and good governance were continued breaches from the last inspection.

The overall rating for the service remains requires improvement. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

People told us they felt the service was safe. Staff had been trained to recognise and report abuse. However, some staff needed more support in recognising the impact of poor working practices on people's wellbeing.

Risks to people's safety and welfare were assessed and care plans were put in place to manage these risks. However, care was not always delivered in line with these plans which meant people were at risk of not always receiving safe care and treatment. In addition, we found the risk assessments and care plans were not always put in place promptly when people moved into the home.

People were at risk of receiving care and support from staff who were not suitable to work in a care setting. This was because robust recruitment procedures were not always followed.

There were enough staff deployed to keep people safe. Staff received training and support and told us they enjoyed working at the home.

People's medicines were managed safely.

Overall the home was clean and there were good systems in place to prevent and control infection. However, there were unpleasant odours in some areas of the home. Some improvements had been made to the environment and the provider had plans for further improvements.

People's needs were assessed before they moved into the home. People were supported to plan for their end of life care.

People had enough to eat and drink. People's preferences and cultural and religious dietary needs were catered for. However, further improvements were needed to people's meal time experiences.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The service worked with other health and social care professionals to support people to meet their health

care needs.

Most people said the staff were kind and we saw many examples of good interactions between staff and people who lived at the home. However, we also saw a lot of interactions were task based and staff missed opportunities to support and encourage people in a positive way.

We found the provider had acted to deal with complaints about the service.

The provider and management team were committed to improving people's experiences. However, their systems for assessing, monitoring and improving the service were not being operated effectively.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not always protected from the risk of receiving unsafe care because staff did not always follow the plans of care.

People were not always protected from being cared for by staff unsuitable to work in a care setting because safe recruitment procedures were not always followed.

There were enough staff members deployed to keep people safe.

People's medicines were managed safely.

Staff had received safeguarding training. However, to ensure people were consistently protected from the risk of abuse some staff needed more support to apply this to their day to day work.

Overall the home was clean but, more needed to be done to manage unpleasant odours in areas.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Information about how to meet people's needs was not always made available to staff at the time of admission. This created a risk people would not receive effective care and treatment.

People had enough to eat and drink and their dietary preferences were catered for.

The home was working in line with the Mental Capacity Act which helped to ensure people's rights were protected.

The service worked with other health and social care professionals to support people to meet their health care needs.

Staff received training and were supported to carry out their roles.

Some of the décor needed updating. The provider had an improvement plan in place.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Most people told us the staff were kind and treated them well.

We saw positive interactions between staff and people who used the service. However, a lot of interactions were task based and did nothing to enhance people's wellbeing.

People were not always supported to exercise choice and the meal time experiences could be improved.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had detailed care plans in place to guide staff on how to meet their needs. However, care was not always delivered in line with these plans.

More needed to be done to provide an engaging and stimulating environment for people.

People were supported to plan for their end of life care.

Complaints were dealt with in line with the provider's policy.

Is the service well-led?

Inadequate

The service was not well led.

Systems to check the quality and safety of the service were in place but were not always working effectively.

People were asked for their views of the service but this information was not always used effectively to improve the service.

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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.

The inspection took place on 7 and 16 August 2018 and was unannounced on both days.

On the first day of the inspection three adult social care inspectors, an assistant inspector and two experts by experience visited the home. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case our experts had experience in the care of older people and older people living with dementia. The second day of the inspection was carried out by two adult social care inspectors and an assistant inspector.

During the inspection we spoke with 12 people who lived at the home, six relatives and a visiting health care professional. We spoke with the clinical lead, five care staff, two housekeeping staff, two laundry staff, the chef, the administrator a quality assurance consultant and the care director.

We looked at nine people's care records and other records relating to the management of the home, such as six staff recruitment files, training records, maintenance records, meeting notes and audits. We observed people being cared for in the communal areas and looked around the home.

Before the inspection we reviewed information available to us about this service. The provider completed a Provider Information Return (PIR). The PIR is a form that asks the registered provider to give some key

information about the service, what the service does well and improvements they plan to make. We also reviewed safeguarding alerts; share your experience forms and notifications that had been sent to us. A notification is information about important events which the provider is required to send us by law. We also spoke with the local authority commissioning and safeguarding teams to gain their feedback about the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found the service was not consistently safe. The provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to shortfalls in risk management and failing to act on feedback from people. During this inspection we found that although some of these concerns had been addressed, further improvements were needed.

People were at risk of not always receiving safe care. People's care records showed risks to their health and safety were assessed and plans of care put in place for staff to follow. This included risks associated with choking, nutrition and pressure area care. These were detailed and informed staff of how to deal with a range of situations. However, we found care was not always delivered in line with these plans. For example, one person's nutrition care plan stated they had a fork mash able diet. The plan stated the crusts must be removed from their sandwiches. However, during lunch time, we observed the person being served sandwiches with the crusts on. In another person's records the care plan stated their food must be cut into small size pieces. However, we observed they received their meal without it being cut up. We discussed these concerns with the clinical nurse lead who took immediate action to make sure it would not happen again. Following the inspection visit the provider confirmed they had requested a speech and language therapy (SALT) review.

Another person's plan stated, "Staff need to check bedding on a regular basis. [Person] likes to eat in bed, crumbs could affect skin integrity". When we checked this person's room, they had a valence sheet on the mattress instead of a fitted sheet. The sheet didn't fit correctly and this could affect the persons skin integrity. When we checked the room again at lunch time the valence sheet was still in place.

Personal emergency evacuation plans (PEEPs) included information about the level of support people would need in the event of an emergency. These were kept in the fire safety box along with other information about the emergency procedures. On the first day of our inspection, we found the PEEPs information in the fire box was not accurate. We discussed this with the nurse in charge and it was dealt with immediately.

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

Recognised risk screening tools were used for pressure area care and falls. We saw specialist equipment such as pressure relieving cushions and mattresses were used to mitigate such risks. However, two people's skin integrity care plans did not state the setting for the pressure relief mattresses. Both plans stated, "Mattress setting should be set to body weight". There was no record of what this should be. Mattresses which are not set correctly may not be effective in reducing the risk of skin damage. As none of the people who lived at the home had sustained skin damage due to pressure we concluded this was a shortfall in record keeping.

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

2014.

Safe recruitment procedures were not always followed to ensure only staff suitable to work in the caring profession were employed. In two staff files there was no record to show gaps in the staff members employment history had been explored and in a third there were no details of the staff members previous employment. One staff member's criminal record check showed they had a previous non-care related conviction. The provider had not completed a risk assessment to support their decision to employ this person. One staff member had an unsatisfactory reference and another had no references. In a third case we found that although references had been obtained they were not from the staff members previous employment in the care sector.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were enough staff deployed to keep people safe. The home was registered for 80 people and there were 47 people living there at the time of our inspection. The provider told us they had not reduced the staffing levels to take account of the reduced occupancy. Going forward they told us they would be using a dependency tool to make sure they had enough staff to meet people's needs.

The service used agency staff where necessary to maintain safe staffing levels and skill mix. Nursing and care staff were supported by separate housekeeping, catering, activities, maintenance and office staff. We observed that although there were enough staff on duty, their interactions with people were mostly task based and they missed opportunities to engage with people.

The registered manager was supported by a residential care lead and a clinical lead nurse. The management team took it in turns to provide on call support outside of office hours. In addition, the service had two night managers who between them provided management cover seven nights a week.

Most of the people we spoke with felt the home was safe. One person said, "Yes, I feel safe, if I had a problem I would ask [name of staff member]." Another person said, "Yes, I feel safe here."

Staff we spoke with told us they knew how to recognise and report concerns about people's safety and welfare. One staff member said, "If I thought someone was at risk of abuse I would report it to the nurse in charge or the manager. If I thought it wasn't dealt with, I would use the whistle blowing procedure." Staff said they knew the whistleblowing procedures and would immediately report poor practice if a person was at risk of harm. 'Whistleblowing' is when a staff member reports suspected wrongdoing and unsafe practice.

Staff had received safeguarding training. However, while some staff clearly knew how to recognise and report concerns, others needed more support to ensure their training was applied to their day to day work. For example, a relative shared with us a concern about poor practice which staff had not identified and reported as a safeguarding concern. We discussed this with the nurse in charge and they took immediate action to deal with it. They made a referral to the local authority safeguarding team and started an investigation.

People's medicines were managed safely. Medicines were stored securely and medicine administration records (MARs) were well completed. We checked the stock of five medicines against the MARs and found for one person their medication didn't balance. We discussed with the with quality assurance consultant. They later told us they had found it was due to a staff error and assured us this would be dealt with.

There was clear guidance for staff to follow about the administration of medicines prescribed to be taken 'as required.' Some people were prescribed medicines, which had to be taken at a specific time in relation to food. There were suitable arrangements in place to enable this to happen. Audits of medication took place which covered temperature checks, administration records, controlled drugs and medication stock. However, the audits did not always show what actions had been taken when errors had been found. This was discussed with the consultant who assured us they would deal with it.

People had separate MARs in place for topical medications such as creams. The MARs included a body map of where the cream should be applied. The MARs were kept separately and were completed by staff when a cream was administered. Staff received medication training and regular competency checks were carried out to make sure they were following the correct procedures.

Accidents and incidents were recorded and monitored. The accident and incident forms showed people's relatives were informed and action was taken to reduce the risk of recurrence. For example, we saw examples of people being provided with sensor mats or crash mats following falls. At the last inspection relatives told us they were not always kept informed about accidents and incidents involving their family members. During this inspection we found the provider had changed the accident and incident reporting forms to prompt staff to inform people's relatives. This showed the service learned lessons when things went wrong.

People's moving and handling care plans had detailed instruction for staff. This included how to support the person and which sling type to use. We observed staff supporting a person to move from their wheelchair to a chair using a hoist. They spoke to the person throughout, explaining what they were doing and reassuring the person. When the person was in their chair, staff checked they were comfortable and helped them to adjust their clothing.

The provider had arrangements in place to make sure installations and equipment were maintained in safe working order. This included electricity, gas, water, passenger lifts, hoists and slings and fire safety systems. In two of the bathrooms we found the temperatures of the hot water in the baths exceeded the recommended safe limit of 44 degrees Celsius. We raised with the nurse in charge and the bathrooms were immediately taken out of use. The provider arranged for the thermostatic valves which are used to regulate the water temperature to be replaced.

The home was visibly clean with few malodours. However, on the first day of our inspection there was an unpleasant odour on Cedar unit even after the cleaning staff had completed their tasks. On our return visit there was an improvement to the overall malodour, however, there was a strong malodour in the lounge which was present throughout the day. We spoke with the cleaner who informed it was difficult to clean the carpets due to people's needs. The carpets in the hallway and lounge were sticky. We discussed this with the provider who told us they had arranged for an external cleaning company to carry out a deep clean of all the carpets.

An infection control audit was carried out by the local authority in January 2018. The service scored 94.5% which showed they had good systems in place for the prevention and control of infection. Infection control policies and procedures referenced good practice guidance from the Department of Health and the Royal College of Nursing.

Shakespeare Court was awarded a Food Hygiene Rating of 5 (Very Good) by Bradford Metropolitan District Council on 16 August 2018. This is the highest score which can be awarded.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found the service was not consistently effective. The provider was in breach of Regulations 11 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to failing to ensure decisions about people's care and welfare were only made by those properly authorised to act on their behalf and shortfalls in people's care records.

A pre-admission assessment was carried out to make sure the home had the right resources to meet the person's needs. When people moved into the home, a more detailed assessment of their needs was carried out and this information was used to develop their care plans.

For one person who had recently moved into the home, we found there was very limited information on the care planning system. There was an initial assessment from the local authority. However, this was in the office and not readily available to staff. This person had complex needs. There were no care plans or risk assessments in place to guide staff on how to support the person. The absence of care plans and risk assessments informing staff how best to support the person created a risk they would not receive appropriate care and treatment.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the service was working in line with the requirements of the MCA and DoLS. The care staff we spoke with said they had received training on mental capacity and consent. Their answers demonstrated an understanding of the legislation and how it had to be applied in practice.

A Lasting Power of Attorney (LPA) is a legal document that allows someone to make decisions for you, or act on your behalf, if you're no longer able to or if you no longer want to make your own decisions. LPA's can be put in place for property and financial affairs or health and welfare. Since the last inspection the registered manager had put together a list of everyone who had a LPA in place. Where an attorney was appointed it was clear what decisions they were authorised to make. This helped to make sure decisions about people's

care and welfare were only made by those properly authorised to act on their behalf. When people lacked capacity, and did not have a LPA in place we saw the best interest decision making process was followed.

People were offered a variety of food. People told us the food was good, one person said, "The food is very fine." Another person said, "The food, yes, they do something special now and then." The chef knew about people's dietary needs and preferences. They attended daily meetings with the care staff team which helped to ensure they were kept up to date with changes to people's dietary needs.

The service used a recognised risk screening tool to check if people were at risk of poor nutrition. Where weight loss had been identified, we saw the service had involved the persons GP or made a referral to the Speech and Language Therapy (SALT) service.

People had nutritional care plans in place. These were detailed, for example, they showed where people required a soft or blended diet and where people needed their diet to be fortified with additional calories.

When people were at risk nutritionally their dietary intake was recorded. However, it was not always clear from the records when people had received their dietary supplements or fortified milk shakes. Although we saw people were offered plenty of drinks throughout the day their care plans did not record their personal daily target for fluids in line with national guidance.

The service worked with other agencies to ensure people received effective care and treatment. Where staff were concerned or had noted changes in people's health we saw they had made referrals to health professionals. Care records showed people had access to a range of health and social care professionals such as GP's, district nurses, dieticians, opticians and dentists. We spoke with a visiting health care professional who told us they had seen improvements in the service since our last inspection. They said, "Communication has improved to help more effective collaboration between the service and other agencies."

Staff were supported to carry out their roles. Staff told us they received individual supervision and appraisals. They told us they felt they had enough support through supervision and training, to do their work effectively. They said there was always someone to approach if they needed to discuss any issues. One staff member told us, "Supervision every month, they are useful, we talk about changes and training, as well as opinions. We are supported to progress and develop. We work as a team. I would recommend this as a place to work."

There was a training matrix in place which showed when staff training was due. The matrix showed most staff were up to date with training on safe working practices. When training was overdue this was being addressed.
Adaptions had been made to the parts of the home to make it more 'dementia friendly'. For example, on two of the units we saw points of interest, reminiscence boxes and memory boxes were in use to help provide people with stimulation and occupation. On Rowan unit there were picture signs to help people living with dementia find their way around independently.

Some of the décor was tired and needed updating to ensure a consistently nice living environment. We saw people were encouraged to furnish their bedrooms with personal possessions such as ornaments, pictures and photographs. The service had a patio area that people could access safely. This meant the service had incorporated the needs of people who enjoyed spending time outside. The provider had an environment improvement plan in place.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we found the service was not consistently caring. We found improvements were needed to enhance people's dining experience to make sure their dignity was respected and they were supported to make informed choices. We judged the provider to be in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found further improvements were needed to enhance people's meal time experiences.

On Willow unit we observed the meal service at lunchtime on the first day of our inspection. Two people were helped to go from the lounge to the dining at 12.15. A third person was helped into the dining room and asked where they would like to sit. They were offered a protective apron for their clothing which they declined. The staff member respected this. Approximately five minutes later another member of staff came into the dining room and put an apron on this person. The person looked uncomfortable and when the first member of staff came back into the dining room they noticed this and asked the person if they wanted the apron removed. The person indicated they did and the apron was removed. However, the scene was repeated when a different member of staff entered the dining and put an apron on the person. Again, when the first member of staff came back into the dining room they intervened and removed the apron, telling the other staff to leave it off as the person had said they did not want it.

People had to wait a long time for their meals, the two people who had been helped into the dining room at 12.15 did not get their meals until 13.10. Another person who had asked to go to the dining room at 12.15 stood up and left at 12.30 without having had any food, at 13.15 we noted they had still not received any food.

On Cedar unit on the first day our inspection we found the dining room was noisy at lunch time due to music playing. One person's care plan explained that noise caused them to become anxious which led to them shouting. However, no consideration was given to trying to create a calm environment during this the meal service. This affected other people trying to eat and we heard them shouting at the person who struggled with noisy environments to 'shut up'.

We observed staff telling people to eat their food, no positive and caring encouragement was provided. One person refused their meal all together, another meal option was offered, but the person also refused this. No encouragement was provided to motivate the person to eat and they left the table having had nothing to eat.

One staff member who had been supporting a person to eat had to leave them half way through their meal to provide additional support to staff in the lounge. This left the person sat at the table and no one in the dining room observing what was happening.

On the second day of our inspection we observed the meal service at breakfast on Rowan unit. This unit

supports people living with dementia. People were asked what they wanted, but were not offered a visual choice to help them decide. People were sitting in the dining room for 25 minutes before breakfast was served. One person was sat hunched over the table, no one spoke to this person and when other people were offered a drink at 08.55 this person was not.

We concluded the provider remained in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us they had carried out meal time audits and we saw evidence of this. However, there was no evidence to show how the information gathered had been shared with staff to help improve people's experiences.

We looked at whether the service complied with the Equality Act 2010 and how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. We saw examples of the service being responsive to people's diverse needs. For example, one of the staff explained they addressed one person who used the service as 'uncle' because within the person's culture it was not respectful for younger people to address elders by their name. However, we also saw an example of a member of staff not being respectful of a person's cultural needs. We observed one of the people who used the service whose first language was not English. We heard one of the staff say, "speak English" to the person. This was discussed with the clinical nurse lead who agreed it was not acceptable and said they would deal with it.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visitors generally felt welcome. However, one person's relatives said they felt excluded by the home's protected meal times policy. Protected meal times are used to create a calm environment, free of distractions which allows people to focus on their meal. This was explained on the notice about visiting times displayed in the home. The management team told us it was not their intention to exclude family members who might like to support their relatives at meal times. However, they accepted this had not always been made clear to people's relatives and said they would address it.

We saw positive interactions between staff and people who lived at the home. Many of the staff showed kindness and compassion towards the people in their care. However, we also observed a lot of the interactions which were task based and neutral and did nothing to enhance people's sense of wellbeing.

The level of detail in the care plans indicated people and their relatives had been involved in writing them. However, people's involvement was not always clearly recorded.

At the last inspection we found staff were not wearing name badges. The use of name badges is widely accepted as being of benefit to people who use services and essential to providing compassionate and person-centred care. During this inspection, we found that although staff had been provided with name badges they were not always wearing them. One staff member said they didn't wear it because it kept falling off.

We asked people who lived at the home and relatives if they felt the service was caring. Feedback was mixed, one person said, "Yes the girls are kind." Another person said," I can do what I like. I spend a lot of time in the garden. The staff are very kind and caring." A third person said, "I feel independent. They are very caring and respect my privacy and dignity." A fourth person said, "They don't really ask me about how I

need caring and I just let them get on with it as the regulars seem to know what I want."

A relative said, "The staff are very kind. [There is] a really nice atmosphere." Another relative said, "The staff are really caring. [Relative] is not clean or well dressed, [relative is getting the wrong clothes even though all [relatives] clothes are labelled." A third relative said, "I think they do their best and [relative] always seems clean but like I said there's a lot of staff who aren't regulars."

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found the service was not consistently responsive. We found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's care was not always delivered in line with their care plans. During this inspection we found further improvements were needed.

Since the last inspection, people's care records have been transferred to an electronic care planning system. The care records were person centred, detailed and reflected people's individual care and support needs as well as personal preferences, history, likes and dislikes. For example, one person's plan explained, "I used to be a whacky dresser, some might say eccentric. I wore bright colours and different patterns. I like to dress comfortable now, I wear leggings t-shirts and cardigan." We observed the person wearing this type of clothing on the day.

However, we found care was not always delivered in line with people's care plans. One person's behaviour plan informed staff how to distract a person when they became agitated and shouted. The plan stated, "[Person] uses key words, these are included in the care file, staff to respond quickly to prevent [person] becoming more agitated." We observed the person becoming agitated and staff did not use the key words to calm the person down. Staff informed us that noise and the vacuum cleaner caused the person to become agitated. On two occasions we saw the person was not supported to go to a place where they could not hear the vacuum cleaner or offered any other distraction when cleaning was in progress. This lead to the person becoming more agitated and shouting.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at what the service was doing to meet the Accessible Information Standard (2016). The Accessible Information Standard requires staff to identify record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it.

People's communication needs were assessed and people had communication care plans setting out how staff were to communicate effectively with them. Information was personalised for example, one person's plan stated, "[Person] can understand English, due to health conditions no longer has the ability to form speech. [Person] has impaired ability to understand the spoken word."

Another person's stated, "[Person's] expressions change, breathing changes and becomes clammy, demonstrating that [person] is scared when moving and handling. [Person] is very tactile and will hold face and follow you with her eyes. Staff to communicate with [person] at all times, explaining tasks completing. Staff to look through magazines with [person] and speak about family and [place of birth]."

However, we found the way people were supported to meet their communication needs was inconsistent.

Some people whose first language was not English were well supported by staff who spoke their language while others were not. Staff did not have any basic words or phrases they could use to support people whose language they did not speak. This meant that people whose first language was not English did not always have access to equality of care in terms of communication comparison to those whose first language was English. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw care and support needs were regularly reviewed. Reviews that had taken place were detailed and reflected any changes in people's needs and behaviours.

At the last inspection, we found there was a lack of recorded information about people's end of life care needs and wishes. The registered manager was addressing this and was in the process of implementing advanced care plans with detailed information about people's end of life wishes. They had sought advice from the local NHS end of life educator to ensure they were working in line with current best practice guidelines.

We saw one persons advanced care plan which included detailed information about the support they wanted in the last days of their life. The clinical lead nurse told this was the standard they were aiming to achieve for everyone who used the service.

Activities co-ordinators were employed. However, one was on leave, which left one on duty. Information about planned activities was displayed, there was a weekly plan and an annual plan showing important dates and people's birthdays. We saw the service had held a summer fair in July 2018 and raised over £500.00 which was to be used for activities. Staff told us about different activities they supported people to take part in such as pamper sessions and trips to the local shops. However, throughout the inspection we observed most interactions with people were task based. Staff spent little time chatting with people and providing people with social interaction during the morning period. This meant people were sat unoccupied and were not engaged.

Feedback from people also suggested improvements were needed in this area. One person who lived at the home said, "[There are] no activities really other than nails and feet and that's nice. I have my TV and I've said they should get Sky. I have no problem complaining and [name of clinical lead] will always sort it out. I have my phone so that keeps me in touch with friends. I get visits from chiropodist and the district nurse comes every Wednesday. I have a call bell and they are generally very good at answering."

Another person said, "There's no activities though and I wish there were, well no one comes in here to see what I'd like to do and there's never any meetings, well not that I've been asked to anyway." A relative said, "Well, no I don't really see many activities."

Information on how to complain was displayed throughout the home. There had been three complaints since the last inspection. We saw complaints were taken seriously and investigated. People were given feedback about their complaints and there was evidence of action taken to reduce the risk of recurrence. For example, a relative had complained about the laundry service. As a result, their relative, who lived at the home, had been given their own laundry basket and their laundry was dealt with by a designated member of staff.

The service also kept a record of compliments. One visiting social care professional commented, "Person centred care planning, so much thought and detail catering for preferences, staff are brilliant, caring environment." Another had commented, "I have reviewed [name] care plan which I found to be very

thoroughly completed with all information up to date. The care plan provided a good history of [name] past life experiences, family, likes and dislikes including an overview of their physical and mental health needs. The care plan was very easy and simple to follow."

A relative had written, "I would like to thank everyone at Shakespeare Court for taking really good care of [person's name], I am so pleased that [name] ended their life here, you have all been amazing once again thank you, keep up the good work."

Inadequate

Is the service well-led?

Our findings

At the last inspection we found the service was not well led. We rated the well-led domain inadequate because the overall rating for the service has been inadequate or requires improvement since October 2014 when we carried out the first rating inspection.

During this inspection we found that although some improvements had been made, the overall rating for the service remained requires improvement. We found the provider remained in breach of regulations 9 (person centred care) and 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition, we found the provider was in breach of regulation 12 (safe care and treatment) and regulation 19 (fit and proper persons employed). This led us to conclude the providers quality assurance and monitoring systems were not being operated effectively. Therefore, we judged the provider to be in continued breach of regulation 17(good governance) and the rating for this domain is inadequate.

Audits and checks were carried out to assess and monitor the safety and quality of the service. These included audits of medicines, nutrition, falls, accidents and incidents and people's dining experience. However, when shortfalls were identified it was not always clear what action had been taken. For example, the records of meal time audits carried out in July 2018 stated people had not been offered a visual choice of food, people were not asked where they wanted to sit, there was not enough equipment and staff had to go to the kitchen to get spoons half way through the meal service and people were not given enough encouragement to eat. There was nothing recorded to show what action had been taken in response to these findings. During our inspection our observations of people's meal time experiences showed these issues had not been addressed effectively.
In another example, we saw medication audits took place which covered temperature checks, administration records, controlled drugs and medication stock. However, the audits did not always show what actions had been taken when errors had been found.

The service had meetings for people who used the service. Notes of meetings showed the topics discussed included activities and the menus. However, some of the people we spoke with were not aware of these meetings. One person said, "I've not been asked on my opinion for how it should be run." Another person said, "The manager is good and she will always sort things out, but I don't get asked about menus or activities."

Similarly, relatives we spoke with did not feel they had been offered the opportunity to have a say in how the service operated. One relative told us, "I can't say I have ever been asked really. I know the manager and I wouldn't hesitate to ask her anything but I have never been asked about [relatives] care since [relative] arrived." Another relative said, "Yes, I like the manager but I don't get asked how it should be run. I've spoken to her about the care and she says she will take it up but I am not convinced." We saw the service had planned meetings for people's relatives and the registered manager advertised surgery dates when they set time aside to meet relatives. One relative had attended a meeting and none had attended the managers surgery.

The provider sent surveys to people's relatives to give them the opportunity to share their views of the service. We saw "You said, We did" notices displayed in the home dated January 2018. The notices showed people had asked for a better entry system for visitors when the reception desk was unattended and for improvements in the laundry service. The notices stated the provider was looking at different intercom systems however, this had not yet been addressed at the time of our inspection. Regarding the laundry service the notice stated people's concerns had been discussed in staff meetings. However, some of the relatives we spoke with told us there were still issues with the laundry, such as people not getting their own clothing back.

There were shortfalls in record keeping in relation to people's care and treatment. For example, two people's skin integrity care plans did not state the setting for their pressure relief mattresses. Mattresses which are not set correctly may not be effective in reducing the risk of skin damage.
In another example, we found it was not always clear from the records when people had received their dietary supplements or fortified milk shakes.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the last inspection the provider had put a new management structure in place. The registered manager was supported by residential lead and a clinical lead nurse. The residential lead was in overall charge of Aspen and Rowan units on the ground floor. The clinical lead nurse was in overall charge of the nursing units Willow and Cedar. Both the residential and clinical lead had time allocated for management duties when they were not included in the staffing numbers. The service had also appointed two night managers and between them they provided management cover seven nights a week.

The provider told us the new management structure had improved the leadership of the service by putting clear lines of accountability in place. In addition, the provider had employed a quality assurance manager who would be working closely with the service. The quality assurance manager would support the homes management team in achieving and sustaining compliance with the fundamental standards of care.

Since the last inspection the service has been working closely with the local authority commissioning team to improve the service. The feedback we received from the local authority commissioning team was positive. They found the service was working to address the shortfalls identified at our last inspection. They reported the registered manager was responsive to feedback and open to suggestions about how to improve the service.

We found the clinical lead nurse who was in charge at the time of our inspection to be open and honest. They acted immediately and appropriately to address any concerns we raised with them and showed they were committed to ensuring people experienced good care.

A range of staff meetings were held. There were also daily 11am meetings for heads of departments, nursing and care staff to share information about the day to day running of the service and changes to people's needs. The provider also carried out staff surveys. In response to a recent survey the provider had started a staff newsletter. At the last inspection the provider told us they were introducing a reward scheme for staff to recognise staff who went over and above what was expected of them to enhance people's quality of life. During this inspection the provider told us the implementation of the scheme had been delayed and they now planned to implement it later in 2018.

Staff we spoke with were positive about their role. They told us they enjoyed working with the people living

at Shakespeare Court, which gave them lots of satisfaction. Comments included, "I love working here, I worked for an agency before and came here. I liked it that much I applied for a job." Another member of staff told us, "We have good banter with people we care for, makes it nice to come to work. I like working here, we are a good team, we listen to each other work together."

The service was working on developing links with the local community. For example, the registered manager had contacted two local schools. Plans had been made for children to visit the home and for some people to go to the school to read when the school term started again in September. Plans had also been made for two separate groups of young people to help the home with gardening projects as part of the National Citizen Service scheme. When this had been discussed at a recent meeting, one person who lived at the home had said, 'I love children, it will be lovely to read to them."