Medicare Corporation Ltd

Shalom Care Home

Inspection report

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Date of inspection visit: 01 and 03 September 2015
Date of publication: 23/10/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 01 and 03 September 2015 and was unannounced.

Shalom Care Home provides accommodation and support for up to 25 people, some of whom may be living with dementia.

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

This inspection identified four breaches of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014. These breaches related to staffing levels, the safety of the premises, infection control practices, care planning and delivery and the governance of the service.

Summary of findings

Staffing levels were insufficient to ensure that people's needs could be met. Staff were usually able to meet people's physical needs in a timely way. However, many people living in the service were living with dementia and required emotional support throughout the day to enhance their wellbeing. This was not always being provided as often there were no staff in communal areas of the home. Given the already low staffing levels in the home current staff were unable to provide any social support to people. This may have been detrimental to people's sense of worth and wellbeing.

The staffing issues and levels had a knock-on effect to the manager's capacity to improve the quality of the service people received. Monitoring systems in the home were not robust and had not been regularly utilised.

The premises were in need of prompt remedial action to reduce risks to people's welfare and safety. Whilst the provider, their consultant and the home's management team had been involved in discussions about the improvements needed for several months, no substantive improvements had been implemented. Infection control practices needed improvement to ensure the environment was a pleasant and safe place for people. Some of the issues we identified were already known about, but again had not been actioned.

You can see what action we told the provider to take at the back of the full version of the report.

Staff recruitment, training and supervision processes were robust. Staff found the training effective and informative.

Whilst people and their relatives were very positive about the standard of care and support received from the staff they were aware of the staffing issues and wanted to be supportive of the staff team. They gave us examples of how they had been consulted in the planning their care. They had confidence in the staff team and the home's manager to sort out any concerns or complaints. Visiting healthcare professionals were also positive about the standard of care staff provided and that staff were quick to identify when people's health required investigation or their intervention.

We observed that staff were thoughtful and considerate and took time to ensure that people were not rushed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

Insufficient numbers of staff were deployed in order to meet people's needs.

The premises required improvements to reduce the risks to people's safety.

Risks to people's wellbeing had been identified and appropriate action had been taken to mitigate them.

Requires improvement

Is the service effective?
The service was effective.

Staff received the necessary training and support from the management team to ensure they had the skills to care for people effectively.

People had access to health professionals and other specialists if they needed them.

The management team and care staff understood their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Good

Is the service caring?
The service was caring.

People participated in the planning of their care and their views were acted upon.

People were treated with kindness and respect.

Good

Is the service responsive?
The service was not consistently responsive.

People's social and emotional needs had not been planned for and were not consistently met.

People had confidence that any complaints would be dealt with fairly and effectively.

Requires improvement

Is the service well-led?
The service was not consistently well led.

Where improvements were required the provider had not taken timely action to mitigate risks to the welfare of people or to improve the quality and safety of the service.

The home's management team had the support of people living in the home, their relatives and staff.

Requires improvement

Summary of findings

Staff knew the standard of care required of them and the manager took appropriate action when concerns were raised.	

Shalom Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 01 and 03 September 2015 and was unannounced. This inspection was carried out by three inspectors.

During this inspection we spoke with seven people living in the home, relatives of three people, the registered manager, head of care, provider's consultant, the visiting GP and community nurse, three care staff members, the cook and a housekeeping staff member.

We observed care and support being provided to people living in the home on both days of our inspection.

We looked at the care plans of four people including their medication records and at various records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

Our inspection identified that insufficient staff were deployed to ensure that people's needs were met. One person told us that they had to wait, "…very often when I need help" and that, "There's not enough carers on nights, there's only two and we need three." Another person said, "Some people living here argue with each other and there's no-one about to sort it out." A visitor told us, "It can be very hectic here." A health professional we spoke with told us that there never seemed to be many staff about and the staff they saw were always very busy. All staff members spoken with felt that more staff were needed. One said they had been told this was not possible due to funding. A summer fete had been planned but this had been cancelled as there were insufficient staff and not enough time available to organise it.

At the time of this inspection 23 people were living in the home. The registered manager told us that eight people always required two staff members to assist with mobilising or personal care and seven further people sometimes needed the support of two staff members. One staff member told us that more than 10 people had required the assistance of two staff to assist them that morning so they were quite behind and unable to give enough attention to those already up and this was quite commonplace.

The usual staffing arrangement was for one senior and three care staff plus either the registered manager or the head of care. At night two staff were on duty. Often the registered manager or the head of care was required to help out on the floor which we saw on several occasions during our inspection. Sometimes the head of care was required to work shifts as a senior carer. We reviewed staffing rotas for the four weeks prior to our inspection. The service had maintained the staffing levels determined by the provider, but were frequently reliant upon agency staff and ancillary staff who had been trained to provide care to do so. The registered manager told us that they did not use dependency assessments to help determine staffing levels and did not have the authority to alter the number of staff on duty.

A few of the people who were mobile required a high degree of emotional support. Throughout both days of this inspection people repeatedly approached us seeking re-assurance and asking for assistance, for example, to get a drink, because there were often no staff in the main communal areas of the dining room and the lounge. Both rooms had a selection of cold drinks available at all times for people to help themselves to, but most people did not have a drink nearby. Some people would not have been able to help themselves and would have required assistance or encouragement. There were not enough staff in these areas to ensure an appropriate level of support for people.

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

The registered manager was also the registered manager of a domiciliary care agency owned by the provider which had separate premises on the same site. This agency was supporting over 120 service users which meant that often the head of care was in day to day charge of the home. The registered manager told us they had taken a decision to prioritise people's 'hands on' care. Both the registered manager and head of care were often on call and occasionally could be required to come in at night because night staff had not been trained to administer 'as required' medicines. The registered manager told us they were working in excess of 60 hours a week and had decided that they could not manage both sites effectively and would be stepping down from managing the home to concentrate on the care agency. The head of care advised that when the new manager commenced duties they would then be returning to a senior carer role.

We were told that five new care staff had recently been employed and they were due to commence work in the next few weeks and that a new manager would be commencing work at the home on 05 October 2015.

Some areas of the premises were unsafe and required attention in order to reduce the risks to people's welfare. The lounge carpet was threadbare in some areas. The carpet in the main corridor was rucked up in places and posed a trip hazard for people when moving around the home. Several handrails were not secured firmly to walls. This presented a risk that they would come away from the wall if people needed them for support. On a wall directly behind a wobbly handrail on the large staircase was a radiator. This was not a safe place to have a radiator without a radiator guard. People using the handrail were at risk of a scald if the radiator was on full. Some radiators, particularly in corridors, required covers to ensure that people were protected from the risks of scalding.

Requires improvement

Is the service safe?

One person's bathroom lino had a large hole in the centre area. Another person's bedroom carpet was ripped and rucked in the area directly leading to their en-suite bathroom. We were told that a substantial refurbishment was due and saw correspondence from the provider's consultant to the provider about these matters going back to February 2015. Quotes had been received in respect of replacing the flooring throughout the home. However, no action had been taken.

The smoke alarm in the downstairs bathroom was broken. This meant that if a fire broke out here, no alarm would sound. A fire exit staircase was partially obstructed by piles of clothes on the stairs. In the lounge a stool was placed in front of the lounge door which meant that were a fire to occur the door would not automatically close.

One person's room had a strong smell of urine but looked clean. The room was unhygienic and unpleasant for people to be living in. The manager was aware of this problem and told us that the maintenance man was due to replace the floorboards in another room due to the same issue and they would look to see whether this was also required in this room.

In the upstairs bathroom we saw cleaned and upturned commode pans in the bath. There were several cleaned re-usable urine bottles on the floor behind the door which was not a safe way to store cleaned and decontaminated equipment. We were told that this bathroom was used by staff to clean these items, but the bath wasn't being used by people. However, the door was unlocked so people would have been able to use the toilet in this bathroom. The sink had a shower head instead of taps and was used when the hairdresser visited. The mixed functionality of this bathroom posed a risk of cross-contamination. We were told that plans had been made to install a sluice room as part of the refurbishment of the premises, but no action had been taken at the point of our inspection.

After our inspection the provider contacted us to advise that they would bring the refurbishment forward.

Our findings constituted a breach of Regulation 12(1)(2)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks associated with the premises had been acted upon. For example, in August 2015 a fire risk assessment identified that some fire doors had excessive gaps. An evaluation of fire doors was carried out and the necessary repairs had been made. Equipment was regularly serviced and regular checks in relation to risks associated with legionella and gas and electricity servicing were in place.

Staff had received training on how to identify abuse and what action to take. Those staff we asked about this told us what actions they would take if they had any concerns. Staff were also aware they could report concerns to external agencies such as the local authority or the CQC. People and their relatives we spoke with did not have any concerns in relation to their or their family member's safety.

Staff were aware of risks posed to the wellbeing of individuals and took appropriate action to minimise these risks. We saw a variety of equipment used to help minimise the impact of falls from bed. For example, we observed some people had low level beds and crash mats and some had bed rails. The risks of using bed rails had been appropriately assessed.

Some of the risk assessments in use were not fit for purpose. For example, one person had sustained several falls but the falls assessment tool still scored them as at a low risk of falls. However, the service had sought professional guidance at an early stage in relation to this person. It had been determined by the occupational therapist that the service was taking all reasonable precautions and they hadn't fallen in recent months. We were satisfied that the service identified risks to people in relation to the care provided and took appropriate actions to mitigate these risks.

Recruitment checks were robust. The registered manager ensured that staff recruited had verifiable backgrounds, references were taken up with previous employers. Criminal record checks were carried out to ensure that the risks of recruiting unsuitable staff were minimised. One relative told us they had faith in the management team to, "….only employ staff they would trust with their own family."

The systems in place for the management of people's medicines were safe. They were stored safely in locked trolleys and storage cupboards. Keys were kept with the senior staff member on duty who administered medicines. We noted detailed instructions to guide staff when it was appropriate to administer people's prescribed medicines or

Requires improvement

Is the service safe?

homely remedies on an 'as required basis'. For example, we saw detailed information and directions for staff on when and how to administer a person's medicine spray which was used to alleviate the symptoms of angina.

We reviewed the medicines records for people who had been assessed as not suitable for solid medicines by a speech and language therapist due to swallowing difficulties. All medicines currently required were given in a suitable form. However, one person's medicines administration record (MAR) showed that they been prescribed one medicine on an 'as required basis' in a tablet form. The person had not required this medicine for two months. The head of care advised us that they were unsure whether the person still needed this medicine and that they would query this with the GP and request a more suitable form for the medicine if necessary.

One the first day of our inspection we found that the stock levels of boxed medicines were not always recorded and room temperatures were not being recorded where medicines were stored Topical cream application records need improving. These did not provide guidance for staff to show when people's creams needed applying. There were also considerable gaps in application records. These issues meant we could not be sure that people were administered creams when they needed them. By the second day of our inspection improvements had been made in these areas.

Good

Is the service effective?

Our findings

Staff received comprehensive training and support from the management team. The service's ancillary staff had also been providing care and support to people and we saw they had received the training to enable them to do this effectively. The training officer from the agency, operated by the same provider, and the registered manager provided the 'hands on' training. One staff member told us they had attended training on dementia. They told us this had given them a good understanding of what people might be experiencing and how they could better support them. Staff members told us they had supervisions which included being observed providing care and annual appraisals. The service's induction programme was arranged in line with the standards of the new Care Certificate and newer staff confirmed that they had been required to 'shadow' experienced staff until they were assessed as competent to provide care to people on their own.

There were plans to train night staff to administer medicines, but with significant changes in night staff in recent months, this had not been possible. Most people were able to make decisions about their everyday life and were asked for their consent before care and support was provided. For example, we observed people being asked where they wanted to sit or whether they wished their food to be cut up.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The registered manager demonstrated a good level of understanding of the Mental Capacity Act (MCA) 2005 and DoLS requirements. They had identified people living in the home who were potentially deprived of their liberty in order to protect them and keep them safe. The manager had submitted the required applications to the local authority. They understood that this did not apply to everyone living in the home, because some people had capacity to make their own decisions. Mental capacity assessments were in place for those whose ability to consent to the care they received was in doubt.

People and their relatives were positive about the food. One person said, "If you don't like what is being offered then you can have something different." We observed the cook speaking with people individually about what they wanted for lunch or tea. One person did not want the options on offer for tea time but had decided to have a cheese muffin when this was offered as an alternative. Those requiring specialised diets, for example a diabetic diet, or to aid swallowing, received their food prepared as necessary. During the lunch period we saw that people were offered second helpings of food and drinks were topped up.

People had the choice of where they wanted to eat their meals which was managed on an individual basis. When the person had finished their main course their plate was cleared and then their dessert course was brought out. They did not have to wait for everyone else to finish, so everyone could eat at their own pace without being rushed or unduly delayed between courses.

People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments to be seen by health professionals such as chiropodists, opticians, dentists and GPs. The GP told us the service was quick to identify changes requiring their attention, for example, when someone was losing weight to request the support of a dietician. All appointments with health professionals and the outcomes were recorded in detail and included any actions that staff needed to take to support people's wellbeing. Where health professionals had requested changes to people's care we saw that the changes had been implemented.

Some people had been identified as being at risk of not eating or drinking enough and required ongoing monitoring so that the effectiveness of the support they received was kept under constant review. These people had charts recording their food or fluid intake which showed they were supported appropriately.

Some people required regular re-positioning in order to relieve pressure on their skin. However, we found that staff were not always recording how they had re-positioned people, for example, what side they had been positioned on when in bed.

Good

Is the service caring?

Our findings

Throughout our inspection we saw that staff spoke with people in a cheerful and caring manner. One person told us, "The staff are friendly. It is good here…lovely." Another person said, "I can have a laugh and a joke with them here." A relative told us, "All the staff seem very caring. Even when they walk past people they'll acknowledge them, touch them on the shoulder and call them by their name." Another relative said, "I'm happy with how [my family member] is treated here. Staff are very kind. No matter how busy they are I always know [my family member] is cared for."

The home had received a number of cards and letters thanking staff for the care their relative had received at the home. Comments included; "Thank you to all staff for the kindliness and care given to [family member] and the ongoing support given to me." "Thank you to the staff who we consider as our large family at the home."

Where they were able to people were involved in making decisions about planning their own care and their choices were acted upon. One person who was at risk of falling out of bed had low rise bed rails. They told us staff had explained about different types of equipment that could be used to help prevent them from falling out of bed and reduce injuries from this. They told us, "I decided to have these as I feel safer with them as they stop me falling in the first place."

There were two rooms in the home that were in shared use. We were told this was discussed in advance with the people, their relatives and the placing local authority to ensure that everybody was happy with any arrangement proposed. One person's care needs had changed recently and they had been asked if they wanted to move to their own room. They said they did not want to and wished to remain sharing with the other person whom they had become friendly with. The person's wishes were respected and staff were working with them to support this person with their increased needs without infringing their dignity or privacy.

Staff we spoke with were knowledgeable and were able to give good examples of how they supported people in a way which maintained their dignity, for example when assisting with personal care.

One relative was waiting at the home for their family member to be admitted to the home from hospital. They were concerned that their family member would miss out on lunch. Staff assured them that they would make sure that food was available to them. When the person eventually arrived they were very distressed. They were gently helped in to the home, offered a chair and a cup of tea was provided for them and their relative. Once the person had relaxed and had the time they needed to chat with their relative both were offered something to eat. Staff had been patient and kindly in supporting both the person and their relative with the person's admission to the home.

When staff were assisting people with their mobility it was at the person's pace. People were not rushed despite staff having other calls on their time. People knew that when staff supported them they would have their undivided attention. Staff were calmly focussed on the person they were supporting at any one time.

Requires improvement

Is the service responsive?

Our findings

The service was not always responsive to people's social and emotional needs. Two people we spoke with were independent and able to come and go from the home as they pleased. They told us they followed their hobbies, for example fishing, when they left the home. We observed that most other people living in the home were unable to do this and were reliant upon staff support to pursue their hobbies and interests within the home and give purpose to their day. The service was advertising for staff to support people with this as the post holder had moved to a care role two months previously. An entertainer came in to sing on a monthly basis and people were supported with their faiths, but there was little else for people to do.

A few people read papers or magazines. However, the vast majority had nothing to occupy their time with and sat in chairs sleeping, watching others or walking about the communal areas of the home. Some people required staff input to help motivate them to interact with others and maintain their cognitive skills. Other people were displaying anxious or repetitive behaviours but staff were often not available to support people with this. One person was repeatedly wrapping their leg in toilet tissue. Another person was constantly walking up and down the corridor asking people if they had seen their relative. A third person wanted someone's arm whilst they walked about. Staff were aware of the lack of social stimulation and limited emotional support but had little time available to support people with this as they were busy elsewhere.

People's care was not planned in a person-centred way designed to meet all of their needs. Whilst people's physical needs had been planned for and were being met people's social and emotional needs had not been planned for and were often unmet. There were personal histories in people's care plans, but little information on how people liked to spend their time, what their interests were or how people could be supported with this in the home. Some people living in the home with dementia exhibited anxious and repetitive behaviours. We found that there was no guidance in care plans for staff about how they could support people with anxious or repetitive behaviours. The service was heavily reliant on agency staff who would not know the people they were supporting. The care plans being used would have been of little value to new or agency staff in relation to meeting people's social or emotional needs.

These concerns constituted a breach of Regulation 9(1)(a)(b)(c)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to moving in to the home people's needs were assessed by the manager and the head of care to determine whether the service was able to meet their needs. The person was involved in this process as were their relatives when appropriate. The service intended to formally review people's care with them and a relative on a three monthly basis, but this had not yet been implemented. People's care records were due for review on a monthly basis but this wasn't always being done. Some people's records had last been reviewed in full three months ago. However, where people's needs had changed care plans had been reviewed and updated accordingly and people had been involved in discussions about the changes to their care. We also found that people had continued to be weighed to ensure that any risks to their welfare in relation to nutrition were identified and acted upon promptly.

A system was in place to manage complaints. Information on how to complain was displayed in the home. No formal complaints had been received in the last 12 months. People and their visitors knew how to make a complaint. They were confident that if they had any complaints their concerns would be taken seriously and acted upon. One person told us, "If things go wrong they [staff] just come round and gently put things right." A relative said, "I've no reason to complain. But If I had any complaints they would be quickly attended to here."

Requires improvement

Is the service well-led?

Our findings

Management checks were not identifying areas requiring improvement. The issues we identified in relation to the management of medicines had not been identified by the service beforehand despite a recent audit. Accidents and incidents were not properly analysed. For example, information wasn't analysed to show where and what time of day accidents were occurring so that patterns could be identified and service provision reviewed when necessary.

There was no schedule of what audits were required and how often they needed to be carried out. There were no premises or infection control audits to establish whether the systems in place in the

home protected people from inappropriate or unsafe practices. A 'management daily walk around check' had not been implemented as intended. It was often not carried out because the management team were frequently providing care for people and did not have time to complete it.

The staffing issues had meant that the manager and head of care had little time in recent months to devote to the management and improvement of the service. The manager told us that they had made a decision to prioritise 'hands on' care, staff recruitment and supporting and training staff. This had meant that monthly reviews of people's care had not been carried out and management audits, where they existed, had been sporadic.

In February 2015 the provider had engaged the services of a consultant to help identify and drive improvements within the service. We noted correspondence over several months to the provider regarding requests for urgent improvements to the premises and the need to review staffing provision. However, little action had been taken to address this at the time of our inspection seven months later.

The last residents and relatives meeting had been held in April 2015. The July meeting had been cancelled as staff did not have the time to organise this. No survey had been organised to obtain the views of people living in the home or their representatives. Whilst people were comfortable to raise any specific concerns with the home's managers, their views had not been sought by the service to help evaluate and improve the service people received.

These concerns constituted a breach of Regulation 17(1)(2)(a)(b)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not monitored the service to ensure that the necessary maintenance could be carried out within reasonable timescales. We saw that the maintenance staff had a very heavy workload for the hours they were employed. As well as urgent improvements being required to the premises to improve safety and hygiene there was a lot of general maintenance and updating to the premises required which had not been carried out. We observed that some light fittings were broken, a bathroom tap dripped, woodwork had rotted due to water ingress. The main bathroom had a water stained ceiling, an unoperational thermostat and a flat roof had standing water on it. It was a poor environment for people living in the home, their visitors and staff.

The provider contacted us shortly after the inspection and advised us that they would 'bring forward' the refurbishment of the premises.

The manager had fostered an open and responsible culture in the service. Staff were positive and felt well supported by the manager and told us that that their concerns were listened to, and where necessary, acted upon. One staff member told us how the manager had taken action when a previous staff member had referred to people in a disrespectful manner. The standards the manager expected of the staff were clearly understood.

Both the manager and the head of care had a sound knowledge of the day-to-day workings of the

service and we observed both assisting people using the service during our inspection. Their practical support was recognised and appreciated by other members of staff. People and their relatives were supportive of the home's management team and staff and felt that they were always helpful and approachable.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider had not deployed enough staff to ensure people's needs were met. Regulation 18 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not ensured that the premises were safe. Regulation 12(1)(2)(d)(e)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider had not ensured that people's social and emotional needs were assessed, planned for or met. Regulation 9(1)(a)(b)(c), (3)(a)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Adequate systems were not in place to identify risks to people's welfare or improvements required to the service. Where they were in place, action was not always taken to make the necessary improvements. Feedback from people on the quality of the service was not always sought.** **Regulation 1717(1)(2)(a)(b)(e)(f)**