

Sholden Hall Residential Home

Sholden Hall Residential Retreat

Inspection report

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21 September 2018

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

The inspection took place on 20 and 21 September 2018 and was unannounced.

Sholden Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Sholden Hall accommodates up to 27 people in one adapted building. At the time of the inspection, 22 people were living at the service.

We inspected Sholden Hall in February 2017, the service was rated Requires Improvement overall and Inadequate in the safe domain. There were breaches of Regulations and we issued warning notices relating to safe care and treatment and the need for consent. We carried out an inspection in September 2017, to check what action the provider had taken and to confirm they met legal requirements. The provider had met the legal requirements but further improvement was needed and the service was rated Requires Improvement overall. This inspection was carried out to check that the provider had continued to make improvements. The provider had made improvements and the service is now rated Good overall.

There was a registered manager working at the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and Associated Regulation about how to run the service.

Potential risks to people's health, welfare and safety had been assessed and there was detailed guidance for staff about how to mitigate the risk. Improvements had been made to the guidance when people were moved using equipment. Environmental risks had been assessed, however, the service did not have equipment to evacuate people who were not mobile from the upper floor of the service. People who were not mobile currently lived on the ground floor, during the inspection the provider purchased appropriate equipment for staff to use.

Previously when people's capacity to make decisions fluctuated, this had not been consistently assessed. Improvements had been made. People were encouraged to plan their care and express their views. 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. People were supported to make decisions about their care and support.

There were sufficient staff on duty to meet people's needs, staff had been recruited safely. Staff received training appropriate to their role, their competency was checked to make sure their work met the required standard. Staff told us they felt supported, they received one to one supervision and appraisal. Staff were trained to administer medicines and medicines were managed safely.

Staff knew how to recognise the signs of abuse and knew how to raise concerns, they were confident the

registered manager would deal with them appropriately. The registered manager had worked with the local safeguarding team when concerns had been raised. Incidents and accidents had been recorded, analysed to identify trends and action had been taken to reduce the risk of them happening again.

The provider or registered manager met with people before they moved into the service to make sure that staff could meet their needs. People's needs were assessed using recognised tools and following current guidance. Each person had a care plan, the plans contained detailed guidance about people's choices and preferences. People's end of life wishes had been recorded, staff supported people at the end of their lives according to their choices and preferences.

People were supported to eat and drink a balanced diet, snacks and drinks were available throughout the day. Staff monitored people's health and welfare and referred people to healthcare specialists as needed and followed the advice given. People were encouraged to lead a healthy lifestyle including exercise, when able. People had access to professionals such as dentists to keep them as healthy as possible.

People were treated with dignity and respect. Staff supported people when they were anxious with compassion and promoted their independence. People were supported to take part in activities. People and relatives told us they knew how to complain and were confident that any complaints would be taken seriously.

There was an open and transparent culture within the service, people knew the registered manager and were comfortable with them. The provider and registered manager completed checks and audits on all aspects of the service and any shortfalls were rectified. People, relatives and staff were asked their opinions of the service and any suggestions they may have to improve the service.

The registered manager attended local forums and registered manager meetings to keep up to date and continuously improve the service. The registered manager worked with other agencies including the local commissioning groups.

The service had been adapted to meet people's needs, improvements to the building were ongoing. The service was clean and odour free.

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 provider had submitted notifications to CQC in an appropriate and timely manner in line with guidance.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating is given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. The rating was displayed at the service and on the provider's website.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good 

The service was safe.

There were effective systems in place to protect people from abuse.

Potential risks to people's health, safety and welfare had been assessed and there was guidance in place to mitigate risks.

Staff were recruited safely. There were sufficient staff to meet people's needs.

Medicines were managed safely and people received their medicines as prescribed.

The service was clean and free from odour.

Incidents and accidents were recorded, analysed to identify trends. Action was taken to mitigate the risks of them happening again.

Is the service effective?

Good 

The service was effective.

Staff worked within the principles of the Mental Capacity Act 2005.

People's needs were assessed before they came to live at the service, using recognised tools in line with best practice guidelines.

Staff received training appropriate to their roles. Staff were supported to develop their practice.

People were supported to eat a balanced diet and be as healthy as possible.

People had access to healthcare professionals when required to keep them as healthy as possible.

The building was adapted to meet people's needs.

Is the service caring?

Good 

The service was caring.

People were treated with kindness and compassion.

People were supported to be involved in their care as much as possible.

People were encouraged to be as independent as possible.

Is the service responsive?

Good 

The service was responsive.

People received personalised care that was responsive to their needs.

People and relatives knew how to complain and their complaints were dealt with appropriately.

People were supported at the end of their lives.

Is the service well-led?

Good 

The service was well led.

There was an open and transparent culture within the service.
The registered manager was visible within the service.

There were systems in place to monitor the quality of the service and make improvements.

People, relatives and staff were involved in the development of the service.

The registered manager attended local forums to continue to learn and improve the service.

The service works with other agencies to provide people with joined up care.

Sholden Hall Residential Retreat

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 checked 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 20 and 21 September 2018 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone in a care home setting.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection, we reviewed the PIR and notifications received by the Care Quality Commission. 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 spoke with 15 people and three relatives who were visiting the service. We spoke with the registered manager, deputy manager and three care staff. Conversations 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 to us.

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

We received feedback from one health professional before the inspection.

Is the service safe?

Our findings

People and relatives told us they felt safe living at Sholden Hall. One person told us, "I do feel safe here, they do come and check on me." A relative told us, "We don't have any concerns, we feel (loved one) is safe and well cared for."

Potential risks to people's health and welfare had been identified and assessed. Previously, improvement was needed in the guidance staff were given to support people who needed help to move around the service. At this inspection, improvements had been made, there was now detailed guidance for staff when supporting people to move using a hoist. People's care plans contained information about how staff should position the sling to move the person safely. During the inspection, we observed staff moving people safely using the hoist.

Some people were living with health conditions such as diabetes and epilepsy. People's care plans contained detailed guidance for staff about what signs and symptoms to look for when people were unwell and what action to take. When people had become unwell, records showed that staff had followed guidance and people had received the support they needed.

Regular checks were completed on the environment and equipment used by staff to ensure it was safe. A fire risk assessment had been completed by the registered manager and there was an evacuation plan in place. Each person had a personal emergency evacuation plan, this gave details of the support each person would need to evacuate the building safely. Most people living at the service could mobilise with support and leave the building. People who were unable to mobilise were living on the ground floor of the service. However, the registered manager had not considered how staff would evacuate people who were unable to mobilise, if they were living on the upper floor. We discussed this with the registered manager, following the discussion the provider decided to purchase an evacuation sledge. Following the inspection, the registered manager told us the sledge was in situ in the service.

Staff were recruited safely. Checks had been completed to make sure new staff were honest, trustworthy and reliable. These checks included written references and an employment history, any employment gaps had been discussed. Disclosure and Barring Service (DBS) criminal records checks had been completed before staff began work at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services.

There were sufficient staff to meet people's needs. People told us that staff attended to them quickly when they needed assistance. One person told us, "I have my call bell here within reach at all times of day or night and I would say they are top notch at answering too."

During the inspection, bells were answered quickly and there were staff with people in the main lounge. The registered manager reviewed staffing levels constantly and adjusted the amount of staff according to people's needs. Recently more people had requested to get up before 8am and night staff were not always able to meet this need. The registered manager had decided to increase the night staff so that people were

able to get up when they wanted.

Staff knew how to recognise signs of abuse and knew how to report any concerns they may have. Staff told us that they were confident that the registered manager would deal with any concerns they had appropriately. Staff understood the whistle blowing policy and their ability to report concerns to outside agencies if they felt they were not being dealt with properly. The registered manager had reported concerns to the local safeguarding team and had worked with them to reduce the risk of incidents happening again. Some people's money was managed by the registered manager, records were kept of the amount of money received and spent.

Incidents and accidents had been recorded and analysed. The registered manager had identified any trends or patterns. Action had been taken to reduce the risk of them happening again. Some people had been referred to health care professionals, their medicines had been reviewed and this had reduced the number of falls they experienced. Another person had displayed behaviour that challenged, the incidents had been analysed and guidance had been put in place for staff to follow. The guidance had been successful, as staff reported less incidents of behaviour that were challenging.

People's medicines were managed safely, people received their medicines when they needed them. Staff received training to administer medicines and their competency was checked. We observed medicine rounds, staff were patient and spoke to staff in a compassionate way, giving them time to take their medicines.

Staff recorded when they administered medicines accurately. The temperature of the rooms and the fridge where medicines were stored were recorded, to ensure that they were stored within the recommended temperature for medicines to remain effective. Liquid medicines are effective for a limited period once the bottle is opened, all opened bottles had an opening date on them.

Some people were prescribed 'as and when' medicines, such as pain relief and medicines for anxiety. There were protocols in place for staff to follow about when to give the medicines, how often and the maximum dosage.

The service was clean and fresh. There were sufficient domestic staff to keep the service clean, there were cleaning schedules for staff to follow. Staff used personal protective equipment such as gloves and aprons when required. There were infection control boxes in each person's room, containing gloves, bags and aprons. The registered manager told us the stock in each box was checked regularly and had been introduced so the equipment was available for staff where they needed it.

Is the service effective?

Our findings

People and relatives told us they thought the staff were well trained and that they enjoyed the food. One person told us, "The food is wonderful, we get plenty of it and a wonderful choice." A relative told us, "They are definitely well trained, I see it first hand when I am visiting."

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 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 applied for DoLS authorisations when appropriate and these had been authorised. The registered manager had a system in place to identify when the authorisations were coming to an end and had made new applications in a timely manner. At the last inspection, when people's capacity fluctuated, there had not been clear documentation about the decisions they were able to make. At this inspection, improvements had been made. The registered manager and deputy manager had assessed and documented capacity assessments at the time when decisions had to be made. When people had been assessed as not having capacity to make the decision at that time, a best interest decision had been made.

When best interest decisions had been made, there was a record of the actions considered and the reason why they were discounted. This process showed that the final decision had been the least restrictive for the person. People were encouraged to make day to day decisions such as how they wanted to spend their time and what they wanted to eat. Staff respected people's decisions, when people made decisions about their healthcare, staff discussed the decision with them to make sure they had capacity to make the decision. For example, when one person decided not to have a blood test, this decision and the consequences of not having the test were discussed. Staff assessed that the person had capacity to make that decision and respected this, the person later decided to have the blood test.

People met with the provider or registered manager before they came to live at the service to assess if staff would be able to meet their needs. The pre-admission assessment covered people's physical and mental health needs, however, more detail about people's cultural or spiritual needs were needed, though this was discussed once people had moved into the service. We discussed this with the registered manager who agreed that this would be added to the pre admission assessment.

The assessment was used to complete people's care plans. People's needs were assessed using recognised tools such as Waterlow scale, to assess if people were at risk of skin damage. The results of the assessments

were used to develop people's care plans and equipment was put in place to meet the need identified.

People were supported to eat and drink a healthy, well balanced diet. People had a choice of meals, they were asked what they would like to eat and shown the meals to help people decide. The kitchen staff were aware of people's choices and preferences and any special dietary requirements they had. When people were at risk of losing weight, their meals were fortified with cream and butter and offered high calorie snacks.

We observed a lunchtime meal, people were supported to be as independent as possible, some people used plate guards and special cutlery to eat their meals. When people required assistance, staff supported people in a respectful way, people were given choice and could take their time.

Staff monitored people's health and when changes occurred action was taken and people were referred to healthcare professionals to support their changing needs. When people had difficulty swallowing, they were referred to the Speech and Language Therapist (SaLT). Staff followed the guidance given, we observed people being given drinks as directed by SaLT. Staff requested a review of people's medicines when they were unable to swallow tablets and their medicines had been changed to liquid form.

People were supported to be as active and healthy as possible. People were supported to walk around the building and the grounds. Staff encouraged people to move their arms and legs when sitting in the chair, to keep them active. People were referred to the dentist, optician and chiropodist when needed.

Staff received training appropriate to their role. New staff completed an induction programme, this included shadow shifts, to learn about people's choices and preferences. Staff completed the Care Certificate, this is a set of standards that care staff need to achieve to be deemed competent. The registered manager assessed staff competency during their induction.

Staff received training in topics to enable them to support people and keep them safe. The training was updated regularly. Training was completed online and face to face for subjects such as moving and handling. Staff received training in topics specific to the people they supported including diabetes and dementia.

Staff received regular one to one supervision and yearly appraisal, to discuss their performance and any concerns they may have. Staff told us they felt supported by the registered manager and could speak to them whenever they needed.

Sholden Hall had been adapted to meet people's needs and improvements continued. The gardens had been improved, there was now a quiet, sensory area where people could spend time and relax. The provider had a maintenance plan, which included changing flooring in the main corridors and redecoration to improve the environment for people.

Is the service caring?

Our findings

People and relatives told us that staff were kind and caring. One person told us, "I would say all the staff are more than caring." Another told us, "The staff are tip top." A relative told us, "I would say that the staff are most caring. They can't do enough to make my (loved one) comfortable and happy here."

Staff treated people with compassion and understood how to support them when they became anxious. One person was walking around the service, they were confused and upset. Staff gently took their hand explaining that the lounge was a nice place to sit until lunch. They distracted the person with a puzzle for them to concentrate on and a cup of tea. The person became more relaxed and spent time completing the puzzle.

People appeared to be comfortable in the company of staff. One person called to staff and requested a hug and kiss. They were smiling and laughing, telling the staff that they loved them and the staff told them that they loved them as well.

People told us that staff respected their privacy and dignity. Staff were observed knocking on people's doors and respecting people's dignity by closing curtains and doors during personal care. One person told us, "I can have my door open or shut in my own room and they always knock before entering."

People were supported to be as independent as possible. People were supported to use walking aids safely, so they could move around the building. When people needed to be accompanied by staff to mobilise safely, pressure mats were used to let staff know when people were up, so their privacy was maintained.

People were encouraged to be involved in their care whenever possible. One person told us, "They keep me in the loop, so I know what I need to know about my care and what I feel I need." Each person had a keyworker, who would discuss their care plan with them or their relatives. Relatives told us they were involved in the care of their relative and felt they were kept informed.

People were supported to maintain relationships that were important to them. One person told us, "I like to come back to my room for a bit of privacy and chat to my visitors undisturbed." People could personalise their rooms, we observed and people told us they had brought in pictures and other important items. One person told us, "I have my own belongings and my room feels like my own space."

People religious and spiritual needs were discussed and people were supported to attend services when they wanted. Representatives of people's faith were invited into the service to support people.

People's confidential information was kept safe and secure. The registered manager understood their responsibility to keep people's information safe. When people needed additional support from an advocate to make decisions this was arranged. An advocate is an independent person who can help people express their needs and wishes, weigh up and make decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

Is the service responsive?

Our findings

People and relatives told us they knew how to complain and that they would be listened to. One person told us, "I feel most confident in raising a concern and being listened to." One relative told us, "I would not think twice about raising a concern if I had one, but they do not occur too often."

Each person had a care plan that contained detailed information about people's choices and preferences. Staff had guidance about how to support people and how they communicated with staff, including people's use of hand gestures. There were details about how people liked to be supported to wash and dress, eat and drink and be supported when they were anxious. Staff knew people well and described how they supported people, this confirmed what had been written in the care plan.

People's care plans were reviewed regularly and any changes were recorded. People and their relatives were involved as much as possible. The deputy manager reviewed care plans with the person or their relatives and this was recorded. When people or their relatives requested changes, these were made and staff were informed at handover. Some changes had been made following guidance from health and social care professionals such as the safeguarding team. Where possible this had been discussed and agreed with the person or their relatives.

The registered manager told us that where possible they wanted to support people at the end of their lives, as Sholden Hall was people's home. Staff had received training about how to support people at the end of their lives.

At the time of the inspection, some people were being supported at the end of their lives. People had specific end of life care plans that covered all their needs including spiritual and religious. There was guidance for staff about when to administer pain relief to keep people comfortable. Staff worked with the district nurses to support people and respond to their changing needs. End of life medicines were stored at the service to be used when needed.

People had the opportunity to take part in activities that they enjoyed. Staff supported people in the communal lounge to make things, read magazines and discuss their memories. There were regular visits to the service by musical acts and twice weekly arts and crafts. People appeared to be engaged and happy when they were involved in activities.

The provider had a complaints policy, this was displayed in the service. There was also a simplified pictorial version on display to inform people that they could go and see the registered manager whenever they were worried or upset.

There had been no written complaints since the last inspection. The registered manager understood that complaints needed to be recorded, investigated and responded to. During the inspection, we observed a relative speak to the registered manager about an issue and the registered manager dealt with this immediately. One relative told us, "Little things have been quickly sorted."

Is the service well-led?

Our findings

People and relatives told us they thought the service was well led. One person told us, "Yes, I feel this home is well led and the manager is very approachable."

At the last inspection, we identified that further improvement was required relating to assessing people's mental capacity and guidance for staff when using equipment to move people. At this inspection, these improvements had been made.

There was an open and transparent culture within the service. The registered manager was known by people and relatives. People stopped to talk to the registered manager and give them a hug, people appeared to be relaxed in their company. Staff and relatives told us the registered manager was approachable and they could talk to them at any time about any concerns they may have. The registered manager and deputy manager were on call when they were not at the service, staff told us they were available when they needed advice.

The registered manager had a vision for the service. They wanted people to lead happy lives and feel part of a family and to continue to adapt the premises to enable people to be as independent as possible. This vision was shared by staff and the improvements to the service were working towards the goal.

There were effective systems in place to monitor the quality of the service. The provider completed a monthly audit of the service and any shortfalls identified were reported to the registered manager for action. The registered manager completed their own weekly, monthly and quarterly audits. The registered manager devised action plans when shortfalls were identified and recorded when the action had been taken. These were checked by the provider.

Staff understood their roles and responsibilities, the provider had policies and procedures for staff to refer to. When changes were made to these policies staff were asked to read them and sign to say they understood.

Resident and staff meetings were held, these had not been as regular as the registered manager wanted. A staff meeting had been planned on the first day of the inspection. The meeting was used to inform staff of changes and ask them if staff had any concerns or comments. People and relatives felt that they always had the opportunity to express their views. One relative told us, "I don't see the point of meetings when the staff are open to chat when we come in."

Quality assurance surveys had been sent to people and relatives. The results of the surveys had been analysed. The results and the actions that were going to be taken in response, were displayed in easy read format in the main reception. People and relative's responses had been mainly positive but felt that the environment needed improving, the provider had plans in place for improvements. Professionals had been asked for their opinion of the service and the response had been positive. Staff survey had been sent out but had not yet been analysed at the time of the inspection.

The registered manager and deputy manager attended local registered managers forums, to kept up to date with any changes. The registered manager showed us the plan they had put in place to improve the service following a forum meeting about changes to the Care Quality Commission inspection process. Actions from the plan had been completed and the outcomes seen at this inspection. Staff, including the registered manager, attended training by the clinical nurse specialist, to improve their clinical skills and support people with ailments such as skin tears until the district nurse could attend.

The registered manager worked with other agencies including the local safeguarding authority and local commissioning group. One social care professional told us the registered manager did listen to advice and kept them informed about any incidents in 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 an appropriate and timely manner and in line with guidance.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating is given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. The rating was displayed at the service and on the provider's website.