Care Quality Commission

Wright Care Homes UK Limited

Shenstone Hall Nursing Home

Inspection report

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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?	Requires Improvement

Overall summary

This inspection took place on the 26 March 2015 and was unannounced. At our previous inspection in May 2014 we found no concerns in the areas we looked at.

Shenstone Hall provides accommodation and nursing care for up to 36 people. At the time of this inspection 25 people were using the service.

There was a manager in post, however they were yet to register with us. 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.

Summary of findings

People did not always receive care that was safe within an environment that met their individual needs and from a consistent staff group who had the information they needed to keep people safe.

The Mental Capacity Act (MCA) is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so. The Deprivation of Liberty Safeguards are part of the MCA. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The provider was not always working within the guidance of the MCA and DoLS. We found that some people were being restricted of their liberty without the appropriate authorisation.

The manager and staff knew what constituted abuse and who to report it to. Safeguarding referrals were made to the local authority when there was suspected abuse.

People had access to a range of health care professionals and were supported by staff to attend health care appointments. Nutritional needs were catered for. People were supported to maintain a healthy diet that met their individual assessed dietary needs.

Assessments were carried out prior to a person being admitted into the service to ensure their needs could be met. Care plans were formulated and reflected people's individual preferences.

People who used the service and their representatives were encouraged to have a say in how the service was run through regular meetings and satisfaction surveys.

The provider had systems in place to monitor the quality of the service however there were no action plans to ensure that there was a continuous improvement.

We found a breach of a Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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. The manager could not be sure that staff were qualified and safe to work at the home. People were not always protected from the risks associated with their care.

People were protected from the risk of abuse. The manager and staff knew what constituted abuse and who to report it to.

Requires Improvement

Is the service effective?
The service was not consistently effective. The provider did not follow the legal guidance ensure people were involved in decisions about their care and were not being unlawfully restricted.

People's healthcare needs were met. Referrals to other health professionals were made in a timely manner. People received adequate nutrition and fluids.

Requires Improvement

Is the service caring?
The service was not consistency caring. People's privacy was not always respected. Confidential information was not always stored safely and people's possessions were not always respected.

Staff interacted with people in a kind and caring way.

Requires Improvement

Is the service responsive?
The service was not consistently responsive. Due to a lack of permanent staff, care was not always responsive to people's individual needs.

People who used the service and their representatives were encouraged to have a say in how the service was run.

Requires Improvement

Is the service well-led?
The service was not well led. Systems in place were not effective to ensure continuous improvement in the standards of care being delivered.

Staff did not feel supported due to a lack of consistent staff. The manager did not have systems in place to ensure that suitable checks had been made prior to staff working at the service.

Requires Improvement

Shenstone Hall Nursing 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 the 26 March 2015 and was unannounced.

The inspection team consisted of two inspectors.

We looked at the information we held about the service. This included notifications of significant events that the manager had sent us, safeguarding concerns and previous inspection reports.

We spoke with six people who used the service and observed their care. We spoke with the manager, area manager and five members of staff. We looked at five care records, staff rosters, the staff training records, three staff recruitment files and the manager's quality monitoring audits.

We spoke with three people's relatives to gain their views.

Requires Improvement

Is the service safe?

Our findings

People who used the service had a variety of needs including dementia and nursing needs. Some people were being cared for in bed. We saw that several people's bedroom doors were propped open with a variety of items, including a pressure cushion and bedside cabinets. The manager and nursing staff told us that this was because people wanted their door propped open when they were in their room. Some people were not able to tell us whether they wanted their door open or not. A recent fire risk assessment had been completed which identified that this presented a fire risk. Staff we spoke with knew that propping doors open presented a fire risk. This meant that the manager had not taken action to protect these people from the risks associated with fire.

We had received information of concern that agency staff were working at the service without suitable pre-employment checks. We found that the majority of care staff and the nurses on duty were agency staff. The manager told us that they used the same agency staff for consistency. However, the manager was unable to tell us if the staff on duty had pre-employment checks prior to working at the service. This meant that the provider could not be sure that these staff were fit to work with people at the service.

We observed people's care and saw that people did not have to wait to have their care needs met. Staff we spoke to told us they felt there was enough staff, however two members of staff told us they were concerned with the use of agency staff. One staff member said: "It's ok when we get people [agency staff] we know but when we don't it makes it hard work, harder than without them".

One person told us: "I've been given the wrong medication before". We looked to see how the provider managed people's medication. We saw that it was stored securely in a clinical room and only trained nurses administered it. Agency nurses were regularly used due to staff vacancies and we saw that not everyone had photograph ID to be able to support the nurses to ensure that the right person was given their prescribed medication. There were no protocols for people when they were prescribed as and when (PRN) medication such as pain relief and inhalers. We asked a nurse how they knew when people required their PRN medication and they told us they would ask them. Some people would not be able to tell them due to their dementia. This meant that these people were at risk of not having their medication at the times they needed them.

People who used the service and their relatives who we spoke told us they felt safe at Shenstone Hall. One person said: "Yes I feel safe here, I have no problems". A relative told us: "It's generally pretty good. I have no real worries about my relative's safety". Staff we spoke to knew what constituted abuse and told us that they would report any signs of abuse to the nurse or manager. The provider had implemented a staff concern email for staff to use if they had concerns about any care practice at the service. Staff had previously used the whistle blowing policy and informed us of concerns they had about the service. The manager and provider had alerted the local authority safeguarding team when they had suspected abuse had taken place and cooperated with the investigations.

Requires Improvement

Is the service effective?

Our findings

Some people were being cared for in bed due to their illness. One person had recently become unwell and now remained in their room all the time. A member of staff told us that they felt that this person would benefit from being supported to sit downstairs in the lounge area as they enjoyed the company of others. However, they were left in bed because it was difficult to bring them downstairs because of the use of agency staff. Because of this person's illness they lacked the capacity to communicate whether they were happy with being cared for in their room. The nurse told us that they felt that this person was being deprived of their liberty by being left in bed. A referral had not been made to the local authority DoLS team to seek authorisation. The Mental Capacity Act 2005 (MCA) is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so. The Deprivation of Liberty Safeguards are part of the MCA. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

Another person was also being cared for in bed and lacked the mental capacity to decide whether they wished to remain in bed. We saw in this person's care records that this person should be sat out in a chair. We saw that this person remained in bed all day and was not given the option to sit out of bed. When we asked the manager about this they were not able to tell us why this person remained in bed all day. The provider had not followed the principles of the Mental Capacity Act by ensuring that people were not being unlawfully restricted of their liberty.

These issues were a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

We saw several people had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order. This is a legal order which tells a medical team not to perform CPR on a person. CPR is a first aid technique that can be used if someone is not breathing properly or their heart has stopped. We saw that the orders had been completed with the GP and the person's representative when people had been assessed as lacking capacity to be involved in the decision making process.

People we spoke with and their relatives told us that the staff were good. One person told us: "Most of the staff are very good". The majority of staff on duty were agency staff. The manager was not able to tell us what training they had completed, however we observed that they knew people well and were aware of their needs. For example we saw people being supported with their mobility with the use of specialist equipment; staff were competent and knowledgeable throughout the process. Permanent staff told us they had a period of induction and received regular training to fulfil their role.

We saw that people had a choice of meals and there was fresh fruit and cakes offered throughout the day. Some people required pureed food and we saw that this was available to them. One person told us: "The Sunday lunches are lovely. The roast chicken last week was the best I've ever had". Another person said: "The food is excellent at times". When people had been identified as having lost weight, nursing staff made referrals to a dietician for nutritional support. One person who had been assessed as requiring regular food intake confirmed that they received regular snacks throughout the day.

People's health care needs were met. We saw people were supported to see their GP, dietician, optician and community nurses. When a change in a person's health was identified we saw that referrals to the relevant health professionals were made in a timely manner and staff followed their recommendations.

Requires Improvement

Is the service caring?

Our findings

We saw that some people who were being cared for in bed had their bedroom doors propped open. One person was being supported with an Percutaneous endoscopic gastrostomy(PEG)feed, PEG feeding is used where patients cannot maintain adequate nutrition with oral intake. We saw this process was taking place whilst the door was open and another person kept lifting their legs up over the bed rail compromising their dignity. This meant that the provider was not considering these people's privacy by ensuring care was delivered in a manner that respected people's right to privacy.

People's confidential care records were left around the service and not with the person or in a private place. Confidential information was at risk of being seen by visitors. We discussed this with the manager who told us that staff had been reminded to record all care interventions, however they were now leaving people's confidential records around the service rather than in a secure location.

In the bathrooms we saw that people's toiletries had been left there. They were not labelled as to whose they were and had not been returned to people's rooms following their bath or shower. We asked a member of staff whose toiletries they were and they were unable to tell us. This meant that people's possessions were not being respected and confidentiality was not being maintained.

We carried out an observation over lunchtime and saw that staff spent time with people encouraging them to eat in a kind and caring manner. People were able to eat where they liked. A new dining area had been introduced and we saw some people chose to use it. We saw one person became distressed in the company of others and they asked to leave the table. The staff supported them to eat in a place they were comfortable instead. However we saw that a few people had been left with a drink in front of them that they were unable to drink without support. Drinks of tea had gone cold and staff did not take the time to sit and encourage the person to drink.

A relative told us: "All the staff are lovely, they always make time for us when we visit, we get offered refreshments and a private place to visit". Relatives and visitors were free to visit at any time. A relative told us: "We've got the code to the front door so we can just let ourselves in". We discussed this with the manager who told us that they wanted people's relatives to feel free to visit at any time and that they were happy with the security arrangements. Regular resident and relatives meetings were held where they talked about things such as planned changes to the home and staff recruitment and we saw a plan of future meetings were visible on the notice board.

People were encouraged to personalise their own rooms. A relative told us: "Staff have asked me to bring in some old photographs and they wanted to know all about my relative so they could put it in their care plan". The nursing staff told us that they were currently working on personalising all the care plans to ensure that reflected people's individual preferences using the information gained from people and their relatives.

Requires Improvement

Is the service responsive?

Our findings

A pre admission assessment was completed prior to the manager agreeing to offer the person a service. This was to ensure that the provider could meet the individual needs of the person. We saw information was gathered from the person themselves and their representative. A relative told us: "I have been fully involved in my relative's care planning, I know what is in the plans and agree with them". However some staff were concerned that people did not always receive the care that had been agreed due to the use of agency staff. One staff member said: "I want to see [person who uses service] get up but they need continuity of staff who know how to manage them". A person also expressed concern about the agency staff, they told us: "Some staff don't know my routine, it was midnight before I got to bed the other night and I like to be in bed by 10.30pm".

Three people who used the service told us that staff did not always respond quickly to the call bells when they used them. Two people told us: "Staff say they will be with you in a minute, but then you don't see them for ages". We observed one person ask to use the toilet, a member of staff asked them if they could wait a minute and it was 10 minutes before the staff came to support them.

People who used the service and their representatives were encouraged to have a say in how the service was run through regular meetings. Following a recent relatives meeting we saw that the manager had said that they would use the staff photograph board so that people knew who was on duty. We saw that the photo board did not reflect the staff on duty on the day of our inspection. This meant that the manager had not responded and actioned what they had said they would at the meeting.

We saw a list of planned entertainment for people. Some people enjoyed some singers on the day of our inspection. However other people sat for long periods with little or no stimulation. One person told us: "There is not much to do". The activity coordinator worked 12 hours a week in the afternoons; we saw that people's records had large gaps in when they had not been involved in any kind of activity.

The complaints procedure was visible on the notice board. A relative told us that they felt confident that if they had a complaint it would be dealt with. Staff we spoke to told us that they would refer any complaints to the manager.

Requires Improvement

Is the service well-led?

Our findings

People who used the service, staff and relatives we spoke with told us that there had been a lot of staff changes recently. Staff told us that this had affected their moral and meant because of the use of agency staff that they could not always deliver the care at the standard they should. Relatives we spoke with also expressed concern that several staff who they had confidence in had recently left. The manager told us that changes to staff working hours and routines had meant that some staff had been unhappy with their working conditions and had now left. Nurse and care staff vacancies were being advertised.

Nursing staff are required to re-register with the Nursing and Midwifery Council every year to ensure they maintain their professional registration. The manager was unable to tell us whether the two permanent staff had current registrations and when we looked at staff records we saw that one person's registration was out of date. On speaking to both nurses they told us they were registered. However the manager had not been aware and there was no system in place to monitor and record the status of the nurses registrations.

We saw that the manager completed several audits to assess and monitor the quality of care but there was no system to collate the information. The manager told us that no action plan had been implemented to ensure that the identified improvements had been made. Areas throughout the building required refurbishment. Some equipment was old and worn and we saw several small maintenance tasks had not been completed. For example, some toilet roll holders were not attached to the wall and one toilet was missing a toilet seat. There was no maintenance plan. This meant that the provider could not be sure that these issues would be dealt with in a timely manner.

The manager and provider had notified us of all significant events which had occurred in line with their legal responsibilities.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Service users must be protected from abuse and improper treatment.**