CareQuality Commission

The Shelley (Worthing) Limited

The Shelley Care Home

Inspection report

54 Shelley Road
Worthing
West Sussex
BN11 4BX

Tel: 01903237000
Website: www.theshelley.com

Date of inspection visit:
24 November 2020
21 December 2020

Date of publication:
02 March 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
The Shelley Care Home is a residential care home providing personal and nursing care to 28 people with a range of health and support needs, including Parkinson's disease and people living with dementia. The service can support up to 32 people.

People's experience of using this service and what we found
People's risks were not fully assessed to protect them from the risk of avoidable harm. Some actions were taken where people were at risk of falls, but systems were not sufficiently robust to mitigate risks. Medicines prescribed for people living with Parkinson's disease were not always administered in a timely manner. Infection prevention and control systems had been implemented and were effective.

Auditing systems had not identified all the issues found at this inspection and were not effective in driving improvement to the care people received. The system used to monitor accidents did not correspond with records relating to accidents and incidents, including falls, that people had sustained. A medicines audit did not include how medicines that were required to be refrigerated had been monitored. The majority of staff had not received Parkinson's disease awareness training or in the management of falls which would enable them to support people's needs appropriately.

People were happy living at the home and felt safe. One person commented, "Yes I feel safe thank you. The staff are always courteous and kind. They are always here and if I need them I can call my bell". People could attend residents' meetings to share any concerns or to make suggestions about how the home was run. Staff told us they enjoyed working at the home and felt supported by management.

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

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Outstanding, (last report published 18 July 2018).

Why we inspected
This inspection was prompted due to information of concern received regarding infection control, staffing, and the management of the home. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that

the service can respond to coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well Led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Outstanding to Requires Improvement. This is based on the findings at this inspection.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-Led findings below.	**Requires Improvement**

Care Quality Commission

The Shelley Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was undertaken by three inspectors. We received further information of concern which necessitated the team returning to the home to undertake a second day of inspection.

Service and service type
The Shelley Care Home 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The current manager started in post on 21 September 2020, and registered with the Commission on 3 November 2020. Since the last inspection, we had received information of concern relating to infection prevention and control systems, risk management, and the way the home was being run since it transferred ownership. The provider was not asked to complete a provider information return prior to this inspection.

This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with the registered manager, deputy manager, administrator, and six care staff, two of whom were senior carers.

We reviewed a range of records. This included four people's care records, multiple medication records, falls management and accidents and incidents. We looked at two staff files in relation to recruitment. We observed infection prevention and control practices and reviewed associated records. A variety of records relating to the management of the service, including policies and procedures, were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, analyses of accidents and incidents, and the provider's policies in respect of safeguarding and visitors to the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Outstanding. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management; Using medicines safely

● Systems were not sufficiently robust to protect people from the risk of harm.

● One person was admitted to the home who was known to have had falls in their own home. Due to constraints caused by the COVID-19 pandemic, a pre-admission assessment had not been completed by staff for this person, but a relative informed the home that the person's mobility had deteriorated in recent months.

● According to the accident and incidents post-falls tracker, by 20 September 2020, a couple of months after admission, the person had experienced 28 falls, eight of which resulted in them hitting or injuring their head. It was only then that it was decided to place a sensor mat by the person's bed, so that staff would be alerted of any movement from this person to offer assistance. Although, the implementation of the sensor mat had a positive impact and had decreasrd the amount of falls the person experienced, not enough action had been taken prior to its introduction to minimise the person's exposure to increased risk of harm.

● A review of this person's care plan stated that upon admission, this person had a low level of need. There was no reference to their risk of falls, despite it being known the person had a number of falls at home. A falls risk assessment was completed and reviewed monthly. There was no review following each fall or a number of falls to help mitigate any risks. The assessment noted there were two sensor mats insitu and that the risk of falls had been reduced because staff would be alerted to this person's movements. However, the risk of this person falling, for example, in a communal area, had not been assessed.

● Documentation confirmed that this person had experienced 52 falls from admission until this inspection, 13 of which involved the person either hitting or injuring their head. There was no guidance or information for staff to follow on how to support this person when they injured or hit their head. The 'New Early Warning System' (NEWS) tool was completed, but it was not evident this was compatible for use in a care home as it provided prompts and advice for registered nurses who do not support people in the care home as nursing care is not provided. This is a system for recording and assessing clinical observations of people to promote safe and effective clinical care. There was no clear direction for staff as to what they should do. According to the training plan, it was not clear what support staff had received in using NEWS or how to determine if any further action was required. When this was raised with the registered manager, they told us they would seek further advice and guidance from external medical professionals on the appropriate use of the NEWS tool.

● Although monitoring checks had been completed when this person hit their head, these were just visual checks of the person in their room. On some occasions there was no evidence that a GP had been contacted or medical advice sought when the person had hit their head or when there were changes in the person's condition. This put the person at significant risk. Insufficient action had been taken to assess or mitigate

this person's risk of falls.

● One staff member told us there were times when a senior member of care staff might go off duty at 18.00hrs, leaving less experienced care staff on their own for two hours. They explained that if a person fell, this might take them away from other residents. They said, "We all feel on edge, praying like nothing happens". This staff member added, "Once someone fell and I didn't do the paperwork. I was then contacted by the carer who said she had so much to do the next day".

● When we asked this staff member about fire drills, they told us, "It's been a while; they were on a regular basis, but seems to be reduced recently".

● Some people at the home lived with Parkinson's disease. This disease puts people at higher risk of falls. One person was not consistently administered their medicines for their Parkinson's disease at the prescribed times. According to the medication administration record (MAR) for this person, their prescribed times for taking a specific medicine were 08.00, 12.00 and 16.00hrs. However, according to a member of care staff, the person should receive this medicine at 06.00, 12.00 and 18.00hrs; a conflict of information.

● Online advice from The Parkinson's Foundation and other sources states that if people do not take their medicines consistently and at the time recommended by the prescriber, this can have a detrimental effect on their health, to the point their Parkinson's disease becomes uncontrolled, thus increasing their care needs considerably.

● There were numerous occasions when this person's medicine was not administered at the time prescribed. For example, a review of records in September 2020, showed that on 13 occasions, this person's medicine was given between 56 minutes late and over 2 hours late.

● Two other people who received medicines to treat their Parkinson's disease did not always have these administered at the time recommended.

● Neither staff nor the registered manager had identified that all three people were not having their Parkinson's medicines administered according to the prescribed times. They were first made aware of this when it was identified as part of our inspection. Following the inspection, the registered manager advised us they were seeking advice and guidance to improve the timely administration of Parkinson's medicines to better-meet people's assessed needs.

The provider had failed to take sufficient action or implement systems to protect people from the risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other aspects of medicines management were managed safely.

● One person said, "The staff bring me my pills". Another person confirmed they received their medicines on time and told us, "Staff just bring it; they do what they can for you".

● Where people administered their own medicines, risk assessments had been completed. Their medicines were stored securely in their rooms.

● There was at least one staff member on each shift that had been trained in the administration of medicines. Medication administration records were kept electronically.

● We observed a senior member of staff administering medicines to people appropriately on the first day of inspection.

Preventing and controlling infection

● We were assured that the provider was admitting people safely to the service.

● We were somewhat assured that the provider's infection prevention and control policy was up to date. Policies supported IPC within the home and were specifically related to COVID-19. Cleaning protocols and the use of PPE is in line with government guidance. On the second day of inspection, the home had begun to use lateral flow testing (LFT) for visitors to be tested. The registered manager has sent through an

updated visiting policy which now takes government guidance into account.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was using PPE effectively and safely. There were IPC stations around the home for staff and people to use.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

We have also signposted the provider to government guidance to develop their approach.

Staffing and recruitment
● Staffing levels were sufficient to meet people's needs.
● People felt there were enough staff on duty. One person said, "I haven't had to wait. I can hear them [staff] running down the corridor to help others. If I needed them and pressed my bell, I know they would be doing that for me".
● Care staff confirmed staffing levels were adequate. One staff member told us, "Yes, there are enough staff. There are four on the floor in the morning, plus one senior, a deputy and a manager. The afternoons are quieter; there's always three on. If there were any more staff on shift they'd be bored". Staff commented that they had time to spend individually with people. Another staff member said, "There is enough time to give care and have 1:1 with people, spending time getting to know them".
● Recruitment systems were robust. A review of two staff files showed that all necessary checks had been made. References were obtained, checks made with the Disclosure and Barring Service to ensure new staff were safe to work in a care setting, and employment histories were verified.

Learning lessons when things go wrong
● There was a developing culture of learning from incidents.
● The registered manager explained, "There's nothing formally written down at the moment, but it's 'falls' in a nutshell. Falls started to increase and I started to look at it and the way we were reviewing falls. That's why I put a falls strategy in place. I did this at my last home and it did reduce falls. There were no sensor mats here when I took over. I bought two in September and have since bought another two". There was a falls policy in place.
● The registered manager sent us a copy of their 2020 accident tracker for people living at the home. This identified who had sustained the fall, the time it occurred and in which part of the home. This helped the registered manager to identify any reoccurring features or issues, so that actions could be taken to address these. For example, people with a high frequency of falls had sensor mats in their rooms to monitor their movements so staff could offer assistance. Referrals to local falls prevention teams had also been completed.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Outstanding. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

● The registered manager was aware that any concerns of a safeguarding nature should be raised with the local safeguarding authority. However, they did not understand the need to notify CQC of any abuse or allegations of abuse as well as the local safeguarding authority.

● A safeguarding alert was notified by the inspector to the authority in October for one person who had sustained 32 falls by the time the alert was raised. Another person who had suffered a serious injury, had previously experienced multiple falls, but a safeguarding alert had not been raised by the registered manager, as they had not understood that this was a potential safeguarding issue according to local authority guidelines.

● We discussed with the registered manager when and who to notify and advised them of their responsibilities in this regard.

● We looked at audits relating to how the care delivery and management of the home was monitored. We reviewed the medicines audit. This had failed to identify issues found at inspection, for example, the disparity of timings when Parkinson's disease medicines were administered. The audit did not include how medicines that were required to be refrigerated were checked. We were told by a senior member of staff that these checks were undertaken, but not recorded. The staff member provided assurances this would be rectified and the medicines audit updated, and this was actioned.

● The registered manager had recognised the need to monitor accidents and incidents, in particular, to record and analyse falls people had sustained in the form of an accident tracker. This tracker was completed monthly, with a quarterly and planned annual analysis showing spikes in falls, so these could be looked into and investigated as to any potential cause. However, the tracker did not include the possibility that medicines inconsistently administered for Parkinson's disease might be a contributory factor for falls. It is recognised that the registered manager only commenced the accident tracker in October 2020, so any falls before this were not included. Some information within the tracker does not appear to correlate with accident or post-falls observation forms we reviewed. For example, in October 2020, it was noted that one person had fallen once in that month, but the accidents and post-falls records showed they had experienced six falls. For November 2020, the tracker recorded the same person had seven falls, but the records showed they had fallen nine times.

● Despite the high number of falls at the home resulting in four notifications of serious injury to people, no staff had received falls management training.

● The plan which showed training completed by staff to enable them to carry out their roles and

responsibilities was reviewed. Only one member of staff had received Parkinson's awareness training. As some people living with Parkinson's disease did not always have their prescribed medicines within the correct timeframe, this indicated there was a lack of awareness and understanding from staff regarding the importance of adhering to the prescribed times.
● After the inspection, the registered manager sent us a copy of a letter sent to staff who had not completed all their required training. This advised that any training not completed by the end of December 2020 could result in disciplinary action being taken.

The provider had failed to implement robust auditing systems to identify areas in need of improvement. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager told us of the changes that had occurred since they took over. They explained their strategy for marketing the home. They said, "Getting the right staff is important. If you get the right staff you can build the right team, keeping staff happy and supporting them. The activities are excellent and we work closely with activities staff. There is a WhatsApp group and people keep in touch via Zoom. Good food is really important too and we've recruited another chef, as well as our existing chef. We haven't sent any surveys out yet to people or relatives. With surveys I think you have to give it a bit of time really. It's on my radar, but we do have quarterly residents' meetings".

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● We asked the registered manager about their responsibilities under duty of candour and the need for good communication. The registered manager explained they wanted to, "Build a culture that is open and honest with good communication between management and staff. If staff come to me with any issues, they can be quickly sorted and my door is always open. Some staff have not adjusted to the change of management/ownership, so they took the decision to leave. Duty of candour is about being honest, open and transparent, with CQC, safeguarding and the local authority, about things happening at the home and with relatives".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People and staff told us of a number of changes that had been implemented under a new management team after a change of provider.
● People told us they were happy living at the home. One person said, "I have nothing to raise, no complaints, but if I thought something was amiss I would mention it". Another person said, "I have nothing to worry about. It's quite comfortable here".
● Some people said they did not know who the registered manager was, but others had met them. One person told us, "Who is it? Is it the tall chap? Oh yes, I know him". Another person commented, "I don't think I know the manager, I haven't had to. If I need to speak with someone, I can speak to the carers".
● Residents and staff meetings were organised and provided opportunities for people to come together to discuss anything and make suggestions. When asked about residents' meetings, one person said, "I haven't needed to say anything. I'm quite happy here".
● Staff enjoyed working at the home. One staff member said, "I feel supported and valued, it's nice. There may have been a change in management, but it's still a nice place to work". Another staff member told us, "The manager is lovely, a really nice man, very approachable. He sits and talks with the residents. The residents see us as their family. There's a real bond between the staff and the residents; the staff are really

close knit".
● Records confirmed that staff meetings were organised. Any issues or matters pertaining to the running of the home were discussed, and staff suggestions were documented and acted upon.

Working in partnership with others
● The service worked in partnership with others.
● District nurses supported people at the home, and GPs or nurse practitioners were consulted as needed.
● The registered manager had joined local forums and told us, "I think networking with local registered managers is important, to share best practice for example".
● People had access to hairdressing and the services of a chiropodist.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to take sufficient action or implement systems to protect people from the risk of harm. Regulation 12 (1) (2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement robust auditing systems to identify areas in need of improvement. Regulation 17 (1) (2)(a)(b)