Barchester Healthcare Homes Limited

Shelburne Lodge

Inspection report

Rutland Street
High Wycombe
Buckinghamshire
HP11 2LJ
Tel: 01494 440404
Website: www.barchester.com

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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?	Good
Is the service well-led?	Requires improvement

Overall summary

Shelburne Lodge provides residential, nursing, respite, palliative care and accommodation for up to 54 people. The home provides care for older people, including those living with dementia and younger adults, including people with a physical disability or sensory impairment. At the time of our inspection there were 42 people living at the home.

At the time of our inspection visit there was no registered manager in place. 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 legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, a manager for the service had recently been appointed, was in post and present throughout the inspection. They confirmed they had begun the process of registration with the CQC as required.

Summary of findings

This unannounced inspection took place on the 5 March 2015. At our last inspection of Shelburne Lodge in May 2014 we found the home met all the regulations assessed.

At the time of this inspection the newly appointed manager had only been in post for a little over a month. This had followed a period when there had been a series of management changes and arrangements. Whilst the provider had attempted during this time to provide a high level of management support, a repeated theme during this inspection, when speaking to people who used the service, their relatives and staff, was the need for a period of sustained consistency and stability.

Some people who received care and some relatives thought staffing levels were not always adequate, whilst others thought staffing had improved and was adequate. The provider used a recognised assessment tool to determine what were appropriate staffing levels taking into account dependency and occupancy levels. This however remained a contested area where different opinions were held as to outcomes achieved. The staffing in place, on the day of our inspection, agreed with the assessment tool.

We found there were systems in place to identify and eliminate or manage risks to people. Staff understood people's needs and tried to meet them in the way they wanted them. Staff said that sometimes they felt they did not have sufficient time to do so as well as they would like. People recognised staff worked very hard and were appreciative of the standard of care provided by them.

They consistently told us staff at night provided a less satisfactory standard of care than staff during the day, although some individual night staff were said to be very caring.

People received their medicines when they needed them. There was a robust system of administration of medicines and people received support from appropriately trained staff.

Staff received training in safeguarding vulnerable people. They were aware of what to do if they saw or suspected abuse had taken place. Staff had the necessary skills and knowledge they needed to meet people's care needs effectively. However, the way people's care needs were met at night was said to be less satisfactory than during the day.

People received care from permanent staff that had been subject to a robust recruitment process. This protected people from receiving care from unsuitable people. The service made use of agency staff and tried when doing so to use staff that were familiar with the service, its policies and procedures and the people who received care and support there.

People received care and support from staff that had the necessary skills and knowledge to care for them. Newly recruited staff received induction training and support from more experienced members of staff. There was a programme of on-going training and supervision support for staff to ensure their training remained up to date and that they were supported appropriately in their work.

People expressed contrasting views as to the quality of the food and activities available to them.

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.

People were not always provided with prompt care and support when they needed it, particularly at night.

People told us on the whole they felt safe and secure and were mostly positive about the care they received.

People were supported by staff that had been subject to a robust recruitment process.

Requires improvement

Is the service effective?
The service was effective.

People received the support they needed to access appropriate healthcare services either in the community or in the service in order to maintain their health and well-being.

People's changing care needs were identified through a process of regular review. This ensured appropriate adjustments could be made to their care and support so that their needs continued to be met.

People did not always experience positive mealtimes which enhanced their care and enjoyment.

Good

Is the service caring?
The service was caring.

People told us their care needs were met. They were more positive about the way this was done during the day than they were at night.

People were treated with dignity and respect. Care was provided by staff that were supported with training to do so appropriately.

People received care from staff that had the information available to them to do so in a way which was informed by their individual preferences and treated them as individuals.

Good

Is the service responsive?
The service was responsive.

People's care needs were assessed and kept under review. People were involved in decisions about how their care was provided.

People's care plans were reviewed and updated so that their care needs continued to be met.

Good

Summary of findings

Healthcare professionals were positive about the standard of care they observed when individuals were referred to them.

Is the service well-led?

Requires improvement

The service was in a process of transition and had not been consistently well-led.

Recent changes were generally welcomed by people. There had not however been sufficient time for these to provide sustained evidence of improvement.

The provider took steps to monitor quality and performance. People were asked for their views about the service and how it could be improved.

Staff had the opportunity to discuss issues with their line manager or the manager of the home, formally or informally.

Shelburne Lodge

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 unannounced inspection took place on the 5 March 2015.

The inspection team included an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case older people's services.

Prior to our visit we reviewed all of the information we had about the home. This included any concerns raised with us on behalf of people who lived in Shelburne Lodge and any notifications received. Notifications are information about important events which the provider is required to tell us about by law.

We also contacted social care and healthcare professionals with knowledge of the service. This included two GPs, the speech and language therapy service, people who commission care on behalf of the local authority and two social care professionals responsible for people who lived in Shelburne Lodge.

During the visit we spoke with ten people living at the home, five relatives and seven members of staff including nurses, care staff and catering staff. We also spoke with the newly appointed manager and a senior manager for the provider.

We observed care and support in lounges and dining areas and with their permission people's rooms. We looked at six care plans, five medicines records, four recent staff recruitment files and summary records of staff training and supervision undertaken by all care and nursing staff. We also looked at quality monitoring processes and reports undertaken by the provider.

Following our inspection visit we received additional feedback from one healthcare professional and further information from the service in response to requests we made for clarification or to provide additional evidence where that was needed.

Requires improvement

Is the service safe?

Our findings

People's experience and assessment of staffing levels varied. Some people experienced a delay in receiving support; others were supported quickly and effectively. People were significantly more positive about the staffing during the day than they were about staffing at night.

One person told us they made allowances for staff because; "They are so very busy". Another person said; "I don't think there is enough staff on at times…they take them from another floor…sometimes they start with two staff and then more come".

People said staffing on the first floor at night time was variable; "At night it's one carer and one nurse, sometimes its two carers and one nurse". "The staff are pushed at night, they (staff) said one night, "there are only two of us". Another noted "You do tend to wait for ages it has been three quarters of an hour," whilst another person thought the longest wait they had experienced to a call bell was twenty minutes. We were told by the manager that the staffing level at night on the first floor was one nurse and two care staff.

Staff told us that on occasion they had worked without a break and as a result were; "Exhausted by the end of the shift." They said in the past, the lack of staff numbers had; "Definitely" affected care. "You don't have the time to sit and talk to people" and "no quality time with people".

Although we were told by some staff the service had; "Lost a lot of good staff" recently, several staff told us there had; "Been some improvement recently" and they thought staffing levels were improving. In contrast to this view, another member of staff contacted us after the inspection and suggested staffing levels and use of agency staff had recently been reduced as a "cost cutting measure". On the day of our inspection, the staffing in the home agreed with the set staffing level and included the use of agency nurses and care staff.

We saw minutes of a relative's meeting held in January 2015. This had included discussion about staffing, staff turnover and how staffing levels were calculated. Relatives were told staffing was 'over and above the requirements for current occupancy'. They were also told staffing levels were calculated using an industry wide tool, which took account of people's dependency levels, the home's layout and staff skills. It was stated that pre-admission assessments were always undertaken and staffing always reflected dependency and occupancy. The outcomes for some of the people we spoke with and the views of some of the staff we spoke with did not always agree with this assessment.

Where agency staff had been used, it was always attempted to use staff familiar with the home and to the people they supported. One relative commented that where there was a high turnover of staff this could confuse people as they were not familiar with the people caring for them.

People told us on the whole they felt safe and secure and were positive about the care they received. "I feel I get top quality care" and "Most of the staff are very good" were typical comments

Potential risks to people's safety had been identified, assessed and kept under review. For example risks from falls or damage to the person's skin from pressure. There were control measures in place to eliminate or manage risks where that was possible. For example, falls risk assessments identified the number of staff required to move the person safely. Pressure relieving equipment and care regimes were identified and put in place to protect vulnerable skin areas.

Training records showed staff had received training in safeguarding adults from abuse. The provider's safeguarding policy and procedures were readily accessible to staff. Staff demonstrated a good understanding of what could constitute abuse and how it might be recognised. They knew what to do if they had any concerns about people's safety or welfare.

People were protected from the risks associated with acquired infections. Staff training records showed staff had received training in infection control. We saw they followed good practice, for example in wearing appropriate protective clothing when providing care and support.

The home had a fire evacuation plan which was kept under review. There were fire extinguishers in place which had been regularly serviced and fire alarm tests had been carried out to ensure they were operating as they should. The provider had a business continuity plan in place to provide for the safety and welfare of people and staff in the event of an emergency.

People were protected from risks associated with faulty equipment or services. Maintenance records were kept

Requires improvement

Is the service safe?

which confirmed equipment was checked and serviced regularly to protect, people who used the service, staff and visitors from harm. Records showed safety checks, for example on lifts; legionella water testing and gas safety had been carried out.

People received their medicines safely. People had no concerns about their medicines and the support they received with them. They said staff seemed to have good communication with their doctor and were able to make any changes to their medicines as directed. One person said there had been an occasion when a dose of a twice weekly medicine had been missed. We found this had been identified and appropriate action taken to address it. There were systems in place to identify any errors and staff involved with medicines told us they would immediately report any discrepancy they found. We looked at medicines records and found they were accurate. We looked at the arrangements for the storage and disposal of medicines and found they were safe.

People were safeguarded from the employment of unsuitable care and nursing staff to provide their care and support. We found there were effective staff recruitment processes in place. We looked at the recruitment files for four recently recruited staff. We found appropriate checks had been undertaken before they commenced work.

Good

Is the service effective?

Our findings

People's health and care needs were being met. People were generally quite positive about care and nursing staff. One person told us; "Whole team pretty good here". They did, however, contrast their experience between day and night staff. "Some care staff are very good, some not so good, one or two of the night staff are terrible". "Most of the staff are very good", "Staff are a bit of a mixture, the night staff are off-hand."

People received support from a range of specialist health and social care professionals. Care plans included details of the involvement in people's care of GPs, specialist nurses and community mental health nurses for example. One specialist community nurse told us that in their experience staff had been very careful to follow advice. Another health professional noted that communication was not helped by the frequent changes in staff; "Staff have always been helpful and very caring on an individual basis, but….when speaking on the phone or in person, I have often spoken to different nurses who are unaware of the client's status or our previous input".

People's care needs were assessed. Care plans included evidence of pre-admission assessments to identify people's individual care needs. This enabled, for example, any specific equipment required to be provided before they moved in and ensured their needs were effectively met from the outset. The initial assessment included a nutritional assessment which identified any known risk factors, for example a history of weight loss and swallowing difficulties. It also identified any known specific dietary requirements. This could include, for example, where people were diabetic or who needed their food thickened to assist them to swallow food safely. Assessments identified those people at risk of malnutrition or dehydration and records were in place to ensure staff supported those people to eat and drink sufficiently. Reviews of people's weight and other indicators of health indicated where action was required to promote weight gain or support hydration. We noted whilst most people had fluids within their reach in their rooms, in some cases these were not easily accessible.

Staff told us whilst they were very busy, they felt they were able to meet people's needs effectively. The staff we spoke with knew the people they provided care and support to, even when they were relatively recently appointed staff. They felt they were competent and had the skills they needed to carry out the tasks assigned to them. This was supported by the mostly positive comments people who received support and their relatives made. "Excellent, efficient and effective" was one relative's assessment of the care staff supporting their relative.

People received care and support from staff with the necessary skills, knowledge and experience. Staff confirmed they received regular training. New staff had been given an appropriate induction which reflected nationally accepted best practice standards. This meant they knew what was expected of them and were given the necessary support to carry out their specific role. For example, domestic staff confirmed they had received infection control training and training about the storage of chemical cleaning materials which could be hazardous to people's health.

We found training records included periodic updates where this was judged necessary by the provider. For example, moving and handling and safeguarding vulnerable people along with others. The provider monitored staff training and we were provided with details of the numbers of staff who had completed which training. There had been significant staff turnover, with a number of new staff recruited. Despite this, we found there had been an overall improvement in most areas of training between September 2014 and March 2015. We confirmed that training was continuing to be provided and monitored.

Staff had different experiences about formal supervision, although they told us they felt able to seek advice or guidance at any time from their line manager or the newly appointed home manager. There had been a number of changes in management within the home over a period of approximately a year. This had been disruptive of some formal, structured supervision which had not always been at regular intervals. This was improving and staff said they did feel supported. We saw records of formal supervision that had taken place and was planned for the future. This was being monitored by the senior management responsible for Shelburne Lodge

Staff received training in the Mental Capacity Act 2005 (MCA) and understood the need to assess people's capacity to make decisions. The MCA provides the legal framework to assess people's capacity to make specific decisions at a given time. Where people are assessed as not having the capacity to make a decision themselves, a decision is taken

Good

Is the service effective?

by relevant professionals and people who know the person concerned. This decision must be in the 'best interest' of the person and must be recorded. We saw that the initial assessment process included an assessment of people's mental capacity.

The requirements of the Deprivation of Liberty Safeguards (DoLS) were being met. The DoLS provide legal protection for vulnerable people who are, or may become, deprived of their liberty in order to keep them safe. We were informed that 25 DoLS application had been made to the local authority at the time of the inspection. At that time, none had yet been processed or approved.

People were not very positive about the quality of food provided for them. This was not so much about the nutritional value as the menu and style of cooking. It was described very forcefully as; being; "Not appetising to look at…horrible…disgusting…hard to tell what it is and tough to eat". The majority of people appeared to have their meals in their own rooms. Those we talked with said they preferred to do that as they found the dining area of the home noisy and unconducive to having a relaxed meal.

We observed a lunch during the inspection. We saw people were offered choice, and appeared to be able to change their mind at the point the meals were served. Staff were busy collecting meals from the kitchen to take to people in their own rooms, and this 'traffic' was not very restful for the people who were eating in the dining area.

When we observed meal times, there appeared to be sufficient staff available overall. However, it was not always clear who was responsible for the organisation of people's support during meal times, which meant staff were not always as effectively deployed as they could be. We observed the chef and the activity staff were very active and provided positive support to people in making choices. They were at pains to engage with people and find something they liked from those choices available. Unfortunately, on the day of the inspection, two of the choices available contained pork, which restricted a realistic choice if people did not like it.

We saw minutes of a relative's meeting held in January 2015 which included discussion about food, nutrition and catering arrangements. An offer was made to relatives to become involved in meetings from time to time about nutrition and catering.

We discussed people's comments and our observations with the manager and a senior manager from Barchester Healthcare during the inspection. Immediately after the inspection the manager carried out an extensive survey over four weeks, to assess people's view about the food in a structured and systematic way. The analysis showed the majority of people found the food very enjoyable or enjoyable, with the proportion of people who found it poor decreasing each week.

We were also informed as a result of the issues raised during our that there was to be a fortnightly meeting with the activities team, relatives and people who live in Shelburne Lodge to discuss food and menus.

Good

Is the service caring?

Our findings

People told us that the majority of staff treated them with dignity and respect. They confirmed staff knocked on their doors before entering, used their preferred name and asked permission in most instances when providing care and support. The most positive views of staff behaviour and attitude referred to daytime staff; "They really care", the more negative to night staff. "They can be a bit short with you, and one of them I dread, the tone of (their) voice!" "They haven't got the time to talk."

The interactions we saw between staff and people who lived in Shelburne Lodge were positive.

People appeared relaxed and calm when receiving care and support. We saw staff gave assurance to people as they provided support. For example, we saw one transfer from a wheelchair which was carried out in such a way as to reassure the person and maintain their dignity. People told us their privacy and dignity was respected, they said their doors were closed whilst personal care was given and we saw staff knocked on people's doors before entering.

During our visit one person suffered a fall. Staff responded immediately, a 999 call was made and we noted paramedics attended within 10 minutes. Staff were with the person at all times following the fall, offering support and encouragement and ensuring they were warm and as comfortable as the circumstances allowed.

The relatives we spoke with felt the care provided was of a reasonable standard overall and in some cases very good. They told us their views about their relative's care were taken into account and met in most cases. There were differing views about how involved they were with their relative's care plans; however they agreed they could access them if they wanted to.

Those care plans we saw included evidence people were involved in the assessment and review process and included details of people's wishes at the end of their life, where these had been ascertained. When it became appropriate to do so an end of life care plan put in place. Additional specialist advice and support was also accessed. This ensured people at the end of their lives received care and support which met their needs and was in line with their wishes. Staff had access to specific end of life training to support this process.

A series of changes in management had made the building of effective relationships more difficult for people who lived in Shelburne Lodge and their relatives. People told us the degree of their involvement with activities and food, for example, was variable. We saw minutes of a relative's meeting held in January 2015 where an offer was made to relatives to become more involved in nutrition meetings with relevant staff, perhaps on a monthly basis.

The manager confirmed people had access to advocacy services if these were required. In most cases however people either self-advocated or relatives advocated on their behalf. Those people we spoke with were happy they could speak with the manager at any time they had issues or concerns to raise. They all told us there were no restrictions on their visiting and they felt able and welcome to visit as they pleased.

Good

Is the service responsive?

Our findings

People's needs were assessed before they moved into Shelburne Lodge. We saw monthly care profile reviews had been completed and re-assessments undertaken, including assessments of risk. For example, we saw one where the risk of a person's call bell being out of their reach was assessed and action proposed to address it. We checked during our visit and found their call bell was well within their reach. This provided evidence people's care needs and risks to their health, safety and welfare were reviewed regularly to take account of any changes or developments.

Although it was harder for newer staff to have a detailed knowledge of people they provided care and support for, staff told us they had access to and read people's care plans and tried to ensure they met people's needs in the way they preferred.

One person said; "The staff are quite capable, they ask how I want to be looked after". When we talked with agency staff, we found that where they had been to the home on a number of occasions, they had a good basic understanding of people's needs and in some cases a very detailed one. Those staff we spoke with demonstrated an understanding of the needs of the people they supported. Staff showed in the interactions we observed and in the conversations we had with them, they knew how individuals liked their care to be provided.

From what people, their relatives and staff told us and from what we observed during the inspection, including our lunchtime observation, people were offered choice. They could, within reason, determine how their care and support was provided. For example, we saw the chef and activity staff when supporting people with their lunch were very considerate and patient with one person who was finding it difficult to understand the choices available to them. One person, however, told us they did not always have the opportunity to get up at the time they wanted, as staff came too early on occasions.

A programme of activities was displayed in the home. For the week 2-8 March 2015 this included an organised activity twice a day, in the morning and afternoon. We spoke to the activity co-ordinator who was relatively new in post. They discussed their induction week and the support they received from other Barchester Healthcare services. They had shadowed a more experienced activity co-ordinator at another home and told us they shared ideas and experiences when developing activities. They confirmed they were booked on a special training course for activities in residential care settings.

The activities co-ordinator told us they tried to go into every room, every morning and undertook one- to- one sessions with people as often as they were able. Part of their role was to develop and inform the drawing- up of people's life histories, which were included in people's care plans. These enabled care staff to understand some of the interests and significant events and people in the lives of those they cared for.

We saw copies of activity evaluation plans. These recorded, for each relevant activity, the number of people who attended and the level of participation/response against six areas. (Mood/well-being, interaction, communication, engaged/attentive, physical activity and orientation). These assessments included one to one sessions and hand massage, external entertainers and a 1940's style lunch which was held on; 'Dignity Day'. These records showed, for example that 19 people had a one to one hand massage on the 20th February, and 18 people took part at some point in the 'dignity day' events on the 1st February.

When we spoke with people about the activities available, we received mixed messages. Some people said they did not join in as the particular activities were not of interest to them. "I don't join in often with the activities, there isn't anything for me really". Others were more positive and told us they thought activities had recently improved. This suggested the home's activities were in a period of transition, which would be informed by residents' and relatives' meetings and analysis of the activity evaluations of activities carried out. We saw minutes of a relatives' meeting held in January where activities were discussed, including information about plans for additional trips out from the home in the future.

Staff confirmed people were able to maintain their religious observance if they chose to do so. For example, the activity programme for the week commencing the 2 March, included a Methodist led service and a Christian fellowship group. The programme did not include any other faiths, however we were told where people had specific requirements related to their religious observance, these would always be facilitated.

Good

Is the service responsive?

There were mixed responses to the home's complaints process. People were aware there was a policy in place; however they felt it was more likely they would address any issues with staff or the manager informally as they arose. Some people were confident their concerns would be addressed whilst others were less so, based on their experience in the past. The CQC had previously monitored some specific complaints. We found these were dealt with in accordance with the service's complaints policy and procedure, even when the outcome may not always have been entirely satisfactory to the complainant. When this was the case, the policy included details of where people could take their complaint further, if they chose to do so.

Requires improvement

Is the service well-led?

Our findings

The service had experienced a number of changes in its management over the previous nine months. We were told by some staff this had led to staff morale being low. When we spoke with staff they were looking forward to a period of stability with the 'new' manager who had only taken up their post shortly before the inspection visit.

The registration process with the CQC was in its early stages. We confirmed with the manager and the senior support manager assisting with the service, that manager's registration would be processed without undue delay.

At each of the recent changes in management, support had been provided into the service from senior and experienced managers from Barchester Healthcare in order to provide guidance and some stability. CQC had recently been contacted by some staff that had raised concerns about staffing and staff issues arising from the frequent changes in manager over a relatively short period. The new manager told us they were committed to working closely with staff to manage the necessary changes in the home's operation effectively and fairly.

Those staff we talked with were mostly supportive of the manager although they also recognised as they had only been in post a short time, further changes and adjustments were inevitable.

Comments from one healthcare professional suggested the recent lack of consistent management had contributed to poor attendance at some courses they had organised and also some difficulty with communication over periods where management changes were occurring.

We saw minutes of relatives' meetings and we were provided with details of a range of audits and evaluations carried out by the service in order to obtain feedback, monitor performance, manage risks and keep people safe. This included a manager's quality assurance tool which monitored performance over a range of areas of the homes operation every six months.

The manager told us the results of these audits and quality monitoring were being analysed and used to inform how the provision of care was organised. We saw a "Quality First" action plan and further action plans derived from an assessment of the "lived experience". This identified, for example, the need to improve the external appearance of parts of the home to make it "more loved" and demonstrate respect for the people for whom it is home.

The consistent theme of relatives and people who lived in the home we had contact with was that recent changes in management had been unsettling. There was also a consistent hope and expectation the new management team would be able to achieve improvements in the way the service operated. For some people there were signs this progress had already started, for others they were not yet sure how consistently improvements would be maintained.

Staff also told us they had found the series of changes in management of the home unsettling. They were however committed to the values of the provider and told us they always put the people they provided support and care for first. They were also looking forward to a period of stability under the newly appointed manager.