Derbyshire County Council

Florence Shipley Residential and Community Care Centre

Inspection report

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

Summary of findings

Overall summary

This inspection took place on 12 January 2018 and it was unannounced. It was the provider's first inspection at this location.

Florence Shipley Residential and Community Care Centre is a large purpose built building which provides a range of facilities including advice, information, day respite, rehabilitation and health support services. They are registered to provide residential care to 32 people within the 'care home'.

People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates 8 intermediate care beds in the 'Bailey' unit. The aim is to facilitate discharge form acute settings, and to support people to return home or to prevent hospital admission or long term care. It also has 16 spaces for longer term care across two units called 'Woodside' and 'Coppice' which are on different floors. They specialise in providing care to people living with dementia. Each of these units has separate communal facilities. At the time of our inspection they were providing support to 24 people; 8 in each of the three units described. A fourth short stay unit which is registered to accommodate a further 8 people was not currently open.

There was a registered manager in place. 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.

There were not always enough staff deployed in some units to meet people's needs safely. This also impacted on the fact that there was not always enough support for people to pursue interests and engage in activities.

Staff received training and support to enable them to fulfil their role effectively and were encouraged to develop their skills. They understood their responsibilities to identify and report abuse. They felt supported by the registered manager and received regular supervisions.

Staff had caring relationships with the people they supported. They understood how people communicated and supported them to make choices about their care. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. They knew people well and provided care that met their preferences. People's privacy and dignity were maintained at all times. They were supported to have important family relationships.

People were supported to maintain good health and had regular access to healthcare professionals. Their care plans were regularly reviewed to correspond with changing support needs and they were personalised and accessible. Risk was assessed, actions were put in place to reduce it and their effectiveness was

reviewed. Medicines were administered as prescribed and they were stored safely.

Quality monitoring systems were effective in highlighting errors and implementing actions to ensure that they were addressed. This included infection control measures and processes which demonstrated that lessons were learnt when things went wrong. There was a procedure in place for people to complain; and although no complaints had been received the registered manager resolved all concerns in line with it.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.
There were not always sufficient staff deployed to ensure that people were supported safely. People were supported to take their medicines safely and there were systems in place to store them securely. Staff knew how to keep people safe from harm and how to report any concerns that they had. Risks to people's health and wellbeing were assessed and plans to manage them were followed. Lessons were not always learnt from when things went wrong. Safe recruitment procedures had been followed when employing new staff. The environment was clean and hygienic.

Is the service effective?

Good

The service was effective
Staff received training and support to enable them to work with people effectively; in line with best practise guidance. They understood how to support people to make decisions about their care and if they did not have capacity to do this then assessments were completed to ensure decisions were made in the person's best interest. The environment was planned to meet their needs. People were supported to maintain a balanced diet and to access healthcare when required.

Is the service caring?

Good

The service was caring.
Staff developed caring, respectful relationships with the people they supported. They were supported to make choices about their care. Their privacy and dignity were respected and upheld. Important relationships with families were supported.

Is the service responsive?

Requires Improvement

The service was not consistently safe
People did not always have enough support to pursue interests or engage in activities. Peoples care was based on their preferences and care plans were up to date and regularly reviewed; including in preparation for when people may reach the end of their life. There was a complaints procedure which people knew how to use.

Is the service well-led?

Good

The service was well led.
Systems were in place to assess and monitor the service to improve the quality of care and support for people. Staff were given guidance and support to fulfil their roles and responsibilities.

Florence Shipley Residential and Community Care Centre

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 12 January 2018 and was unannounced. It was completed 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 who uses this type of care service.

We used information the provider sent us in the Provider Information Return. 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. However, they had completed the information eight months previously and so we gave them the opportunity at the inspection visit to update us.

We used a range of different methods to help us understand people's experiences. People who lived at the home had varying levels of communication. We spoke with four people and also observed the interaction between people and the staff who supported them throughout the inspection visit. We also spoke with two people's relatives about their experience of the care that the people who lived at the home received.

We spoke with the registered manager, two deputy managers, two senior care staff, two care staff, one apprentice and one domestic member of staff. We also spoke with one visiting health professional. We reviewed care plans for four people to check that they were accurate and up to date. We also looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and

reviewed to drive improvement. We reviewed audits and quality checks for medicines management, fire risk assessments, health and safety checks and infection control. We reviewed staff training records, minutes of meetings and the dependency tool used. We looked at complaints and two staff recruitment files.

We asked the provider to send us additional information after the inspection visit to demonstrate that action had been taken to reduce risk of harm to people and they sent this to us within the agreed time span.

Requires Improvement

Is the service safe?

Our findings

There were not always enough staff deployed to meet people's needs safely. We saw that some people who had a history of falls and had been assessed at risk of falling again were left unsupervised while staff needed to support other people. For example, in a handover meeting we heard that staff were advised to monitor one person because they needed staff support to mobilise safely and they had tried to stand independently on several occasions earlier in the day. We saw that when two staff assisted another person with personal care, this person was left unsupervised for fifteen minutes in the communal area. On the day of our inspection one member of staff was unwell and the agency that the home used had been unable to replace them at short notice. This had an impact on how quickly people's needs were met; for example, we saw that one person sat at a table for two hours after finishing a meal. On another occasion a trainee member of staff was left alone with six people for half an hour. This member of staff had not been fully trained and we were told that they should only be observing other staff. Although they had a phone system to request emergency support they had not been trained to immediately support people in an emergency situation which put people and the member of staff at risk of harm. We raised this with the registered manager who ensured us after the inspection visit that all staff were informed that this situation should not happen again.

When we spoke with staff about staffing levels they told us that they did not think they were always sufficient staff available to meet people's needs. One member of staff said, "I feel like people are unsafe. For example, if someone needs help from two staff it means that there are no other staff to help others". Another member of staff said, "There are three carers on at night which means that there is one on each floor. When someone who needs two staff to assist them requires assistance, a member of staff needs to leave a floor resulting in people being alone. Some of those people are able to get up independently and staff would not know until they returned to the floor".

We spoke with the registered manager who told us that the provider used a tool to assess people's needs and plan staffing to meet them. However, they said that the complexities of the building were not taken into account. They had tried to remedy this by implementing a call system across the floors. However, they also recognised that this was not always effective. They also told us that a fourth unit on a different floor was not open because of being unable to recruit staff while an organisational restructure took place which impacted on this service recruitment of staff. People on the Bailey Unit told us that they did have enough staff to meet their needs in a timely manner. This demonstrated to us that the provider was not effectively deploying staff across different units to ensure that people's needs were met.

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

Risk was assessed and managed to keep people safe from harm. We saw that people were supported to move safely and when we reviewed records we found that this was in line with the risk assessments. For example, when people were moved using equipment, we saw that guidance was followed to ensure that there were enough staff and that the equipment was correctly attached. A health professional we spoke with told us, "The staff are good at assessing if people have sore skin and will ensure that they use

equipment such as cushions to prevent it". Other risks to people's health and wellbeing were also considered; for example, there were plans in place to assist staff to support people to calm during episodes of distress. Records that we reviewed showed that risk assessments were regularly reviewed.

There were procedures in place to learn lessons when things went wrong and to record what action was taken to avoid it happening again. For example, we saw that when people had accidents or fell that these were recorded and analysed. Some actions were taken to reduce the risk; such as, using technology in people's rooms to alert staff when they got out of bed and referral to other professionals for advice. However, we also saw that people continued to be at risk because there were not always staff available to monitor people who were at risk of falls.

People received their medicines as prescribed and when needed. One person said, "The staff give me my medicines. They check what they are and also check that I have taken them; which is a good safeguard". We observed that people were given their medicines individually and that time was taken to explain what it was for and to allow some people to do it more independently; for example taking the medicine from a pot themselves. Some people had medicines prescribed to take when needed; for example, for pain relief or to reduce anxiety. Staff we spoke with knew when people required additional medicines and could describe this to us. We saw that there was also clear guidance available to support them. Medicines were securely stored on each unit and records were maintained to manage them safely to reduce the risks associated with them.

Staff understood how to recognise and report suspected abuse. One member of staff said, "If I suspected any abuse I would report it to the senior or the manager. If I was still worried I would report to the local authority". We reviewed safeguarding concerns with the registered manager and saw that when needed they had conducted a thorough investigation in partnership with the local authority.

Infection control procedures were in place to ensure that people were kept safe from harm. One healthcare professional we spoke with told us, "This home is immaculately clean and they have had no infection outbreaks. If staff support us they always use the correct protective equipment and this is always readily available". We observed that staff used the correct equipment when they supported people or served food. We also saw that there were domestic staff available to clean and respond to any concerns. There was a five star hygiene rating from the food standards agency which demonstrated that food was managed well as this is the highest award possible. The food standards agency is responsible for protecting public health in relation to food. There were also regular infection control audits and reviews in place.

The provider followed recruitment procedures to ensure that staff were safe to work with people who used the service. One member of staff we spoke with told us that they had asked for references and completed DBS checks before they started work. The DBS is the national agency that keeps records of criminal convictions. Records that we reviewed confirmed that these checks had been made.

Good

Is the service effective?

Our findings

Staff had training and support to do their jobs well. One member of staff told us about their induction when they started work. They told us that they attended some training courses such as moving people safely. They also said, "I did two shadow shifts in the home before I started which was good to get to know people and see how things are done here". Other staff told us how their skills were continually developed. One member of staff said, "Before I started administering medicines I did a one day course in it. I was then observed afterwards to make sure I was doing it correctly". In the PIR the provider told us, 'Some staff including domestics and laundry assistants have attended five day Person Centred Dementia Care Training'. One member of staff we spoke with told us that they had attended this training although their role was not directly in caring for people. They said, "The dementia training was very good and helped me to understand how to interact with people". Records that we reviewed confirmed that staff's competency was checked and that they had completed all of the training required.

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 the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff understood about people's capacity to make decisions for themselves and could describe how they supported them to do so. We saw that, when needed, people had mental capacity assessments in place which described what decisions they could make. For example, we saw that people had capacity assessments around medicines and personal care. When they did not have capacity to make decisions, these were made in their best interest with guidance from healthcare professionals and in consultation with people who were important to them. We saw that some DoLS authorisations had been granted to legally restrict the person's liberty to maintain their safety and that further applications had been made. When there were conditions on these authorisations staff were knowledgeable about them and what they needed to do to comply with them. We saw that this was reinforced because DoLS information was recorded as part of the daily handover.

People had enough to eat and drink and there were systems in place to monitor them if they were at risk. One person told us, "The food is always good here". A relative we spoke with said, "The food is excellent". We saw that people were offered a choice of meals and that different methods were used to enable them to choose. There were photographs of the meals that people could look at in advance to make a choice. They were also shown the two meals and asked to choose at mealtime if needed. Some people required specialist diets and staff we spoke with were knowledgeable about this. When people required support to eat this was given in a respectful manner. People were offered drinks throughout the day of the inspection

visit. One person said, "There is always plenty of tea". This meant that the provider ensured that people had enough to eat and drink and maintained a balanced diet.

People had their healthcare needs met. One relative told us, "The staff are on top of things for my relative's care; for example, they call the doctor when they need to". One healthcare professional we spoke with said, "The communication is very good and they always let us know if they are concerned. We also have a communication book where they write anything they want to ask and we sit down and review that every two weeks. They are very good at following any plans we put in place". On the Bailey unit the staff team worked with other health professionals on a daily basis to assist with people's rehabilitation. One member of staff said, "We work closely as a team and support each other". Records that we reviewed showed that people's healthcare was monitored and reviewed. This meant that people were supported to maintain good health and to access healthcare services.

People's needs were assessed and outcomes were clear, including working to best practice. For example, there was guidance for staff about supporting people who took warfarin so that they understood the impact this could have on their health or in an emergency. The provider worked in partnership with other organisations to ensure that people's needs were met. One member of staff said, "The district nurses check the person's blood and we follow the amended plan and dosage that they put in place for taking the warfarin". We saw that this was being followed and recorded in line with national guidance.

The environment was planned and adapted to meet people's needs. In the PIR the provider told us that the building had been designed with specialist advice to meet the needs of people living with dementia. We saw that there was signage around the building to help people to orientate. One member of staff said, "The garden was designed with a figure of eight path so that people could walk for as long as they needed without coming to the end of the path". There were rooms for activities, for people who smoked to use and space for families to visit. In the Bailey unit there was a training kitchen that had adapted surfaces that people could reach from their wheelchair. People spent time here being assessed and re-learning skills in order to be able to move home after a period of rehabilitation. In the larger building there was also a restaurant and additional facilities; for example, a hairdressers. This demonstrated to us that the provider ensured that the environment was adapted for people.

Good

Is the service caring?

Our findings

People had caring relationships with the staff who supported them. One person told us, "The staff are all very caring and I have never been treated with such respect. They take the time to explain things to me and this makes me feel secure". One relative we spoke with said, "The staff are marvellous and my relative is very happy". We saw that the staff knew people well and we observed that they comforted people. For example, when people were less able to communicate they smiled and reassured them; for example, we saw them stroking one person's hair.

People were involved in making choices about their care at different levels depending on their ability to do so. People who were staying on the Bailey unit decided how their care was planned with staff; for example, staff prioritising their morning support so that they could go out with family. Other people also made choices; for example, we saw that one person chose to stay in their room and were supported by staff in there.

People's dignity was promoted and they were treated with respect. We saw a member of staff ask one person if they could have the key to their room so that they could hoover it. The person greeted the staff member warmly and agreed that they could enter their room. At other times during the inspection we saw staff knock on people's doors before entering. One healthcare professional we spoke with told us, "The staff think about people's privacy and always draw curtains and close doors before an examination".

Staff knew people's life histories and their families. One person told us, "My family can visit anytime, including the children. When some friends visited with a takeaway the staff laid the table in the training kitchen and set it up so that we could enjoy our meal together privately. It's a home from home". A relative told us, "I can visit whenever I want to". Staff understood how to support people's human rights; for example, one couple lived at the home. They said, "They look after us and we always get to sit together". This demonstrated to us that attention was given to supporting people to maintain important relationships.

Requires Improvement

Is the service responsive?

Our findings

People were not given enough opportunities to pursue interests and get involved in activities. We saw that people sat in chairs for the majority of the inspection visit watching television. Staff told us that they found it difficult to spend time with people because they were so busy. One member of staff said, "We don't get enough time to spend with people and most of them are bored". Another member of staff told us, "The facilities here are brilliant but we don't often get the chance to use them. For example, two people enjoy the Jacuzzi bath but it is on another floor and so it is not easy for us to take them there and have cover on this floor". We saw that one person was unsettled and pointed to the door. A member of staff said, "They enjoy going out to the shops or to the garden but as I am the only member of staff keeping an eye on people in the communal area I am not able to take them". In the PIR the provider told us that people were involved in an inter-generational project with a local education establishment. When we spoke with staff about this they told us that only a couple of people from the residential units were involved and it was mainly working with people who attended the separate day service. The people on Bailey Unit told us that their days were busy working with physiotherapists and seeing family.

Staff understood people's preferences and supported them in line with it. For example, we saw that people chose when to get up and that their care was planned around this. People had care plans in place which staff were familiar with. Some people had diverse support requirements and we saw that these were assessed. For example, one person spoke two languages and as their dementia progressed they often used their birth language more. We saw that this was considered and that some signs in the building had been translated for them. When people were staying on the Bailey unit their plans were focussed on goals and time specific. One person told us, "I know what the plan was. I am walking again and I can get in and out of bed better now. I am visiting my home this morning to assess what I will need there when I go back". We saw that their care plan reflected this.

There were good communication systems to ensure that staff monitored people's wellbeing and altered their care when it changed. One member of staff said, "We have a handover at the end of the shift where we discuss how everyone is". We observed the handover meeting and saw that there was a record kept of the discussions. It included any changes in people and appointments etc. that they had.

There was nobody being supported at the end of their life when we visited. However, people's last wishes had been considered as part of their care plan, including religious requirements. The registered manager told us, "We work closely with our doctor's surgery to plan people's support when they are assessed as being at end of life. This will include theirs and family's wishes about hospital admissions, pain relief and other last wishes". We saw that some people had orders in place which stated that they did not wish to have resuscitation and these were discussed with them and families. This demonstrated to us that the provider was prepared to support people in a personalised way when they were at the end of their life.

People and their relatives knew how to complain if they needed to. One person told us, "I know how to complain but I wouldn't want to". We spoke to the registered manager who told us that they hadn't received any formal complaints. They said, "I have reviewed and responded to concerns in line with the

complaints procedure though as I think it is good practise". We saw the action that had been taken was recorded and that whoever had made the complaint was satisfied with the response.

Good

Is the service well-led?

Our findings

There was a registered manager in post. They ensured that there were quality audits in place to measure the success of the service and to continue to develop it; for example, audits of medicines demonstrated when records were not fully completed. When external agencies had made recommendations they had followed these to improve their rating. The registered manager told us, "When we received a low food standards rating we reviewed the circumstances that contributed to it. We put plans in place and followed the recommendations; such as improving the labelling of fridges. The catering manager also conducted a lot of observations of practise. We were delighted to achieve a very good rating on re-inspection".

The registered manager developed relationships with external agencies. In the PIR we were told, We plan to improve the communication between visiting doctors and people and their family by re-evaluating the routine of visits to include more contact time with residents'. When we spoke with the registered manager about this they told us that there was now a regular two weekly meeting where each person was discussed and reviewed. We also saw that a multi-disciplinary team collaborated to ensure good outcomes for people on Baily unit.

The provider had an oversight of the home and the registered manager ensured that they reported regularly. They said, "I am asked to complete and report on a different audit on a monthly basis; for example, I have recently reported on our infection control processes". We saw that the provider reviewed some audits; for example, a health and safety specialist had reviewed the internal audit. The registered manager said, "All of the information leads to a service improvement plan".

Staff felt that they were well supported and able to develop in their role. One member of staff told us, "The manager is supportive and does listen and we all work well together as a team". There were opportunities for them to share their ideas and any concerns; for example, through team meetings and one to one support sessions with line managers.

There were processes in place to receive feedback from people who lived at the home and their relatives. The registered manager told us, "We have a quality questionnaire but it is difficult to complete with people who are living with dementia. We organised a meeting for family and friends but unfortunately it was not well attended. We have found the best way to get people to interact is informally though quizzes and activities in 'lounge meetings' and we will continue to develop these".

The manager ensured that we received notifications about important events so that we could check that appropriate action had been taken.

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 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were always sufficient staff deployed to meet people's needs.