

## Shawe House Nursing Home Limited

# Shawe House

### Inspection report

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### Ratings

#### Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service effective?

**Requires Improvement** 

Is the service caring?

**Good** 

Is the service responsive?

**Requires Improvement** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

We undertook this inspection of Shawe House Nursing Home on 20 and 22 June 2017 and was unannounced on the first day. The inspection team consisted of one adult social care inspector, a bank inspector and an expert by experience on the first day of the inspection. The inspection was unannounced which meant the provider did not know we were coming on the first day of the inspection.

Shawe House Nursing Home is located in Flixton, Manchester and provides nursing care for up to 33 people who live with dementia. Accommodation is provided on two floors. All bedrooms are single rooms and those on the first floor are accessible by a passenger lift. There is an enclosed garden area and parking for several cars at the front of the property.

At the time of our inspection there were 27 people living at Shawe House. The local authority had placed a temporary suspension on new admissions. It was envisaged that this suspension would be lifted once the home could demonstrate adequate improvements with regards to people's safety and the quality of care delivered.

The service had a 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.

At our last inspection in October 2016 we identified breaches of the regulations in relation to the safe care and treatment of people, person-centred care, consent, premises and equipment, staffing and the governance of the service. The home was placed in special measures as a result of the breaches identified at the last inspection and we served three warning notices.

At this inspection we found improvements had been made in all areas. We found the service was now working within the principles of the Mental Capacity Act (2005). Capacity assessments and best interest decisions were made where required. Applications for Deprivation of Liberty Safeguards (DoLS) were appropriately made. Staff offered people day to day choices about their care and sought their consent before providing support although we judged that the service needed to improve with regards to correctly recording people's consent to aspects of their care.

People received their medicines as prescribed and the nurses had received relevant medicines administration training. Protocols for the use of 'as required' medicines were in place. The temperature of the medicines fridge had not been recorded for two days as this was reported as broken. A representative from the pharmacy came out to the home and addressed this on the first day of inspection. Staff were reminded to also record the temperature of the medicines room so that the effectiveness of medicines stored there was not reduced.

People we spoke with and their relatives were complimentary about Shawe House. Relatives told us they considered their family member to be safe, the staff knew people's needs well and there were enough staff on duty to meet those needs.

There was less reliance on agency staff and staff appeared more confident and positive about their role. The registered manager had made new appointments that benefitted the home and was supported by a new deputy manager and a clinical lead.

Care plans and risk assessments were in place with guidance for staff in how people wanted to be supported and the tasks they were able to complete independently. These were written in a person centred way and had been regularly reviewed and updated when people's needs changed.

Care plans were in place for the support people wanted as they came to the end of their lives and the home had been awarded The Six Steps to End Of Life Care accreditation certificate. Relatives were kept informed about the programme.

Appropriate referrals were made to the Speech and Language Team (SALT) and dietician. Food and fluid monitoring charts were completed where required and kitchen staff were made aware of changes to people's diets. We saw referrals to other health professionals were made when needed, for example an occupational therapist, tissue viability nurse or the dementia crisis team. This meant that people's health needs were dealt with in a proactive and effective manner.

People we spoke with told us that the staff at Shawe House were kind and caring. During the inspection we observed kind and respectful interactions between staff and people who used the service. Staff showed they had a good understanding of the needs of people who used the service and this was helped as care workers were now documenting in progress notes for those people they had assisted with personal care.

We saw care plans were reviewed monthly or following any changes in people's needs. Staff documented when people refused aspects of personal care however it was not clear what actions, if any, staff took to encourage people to comply with care.

The React to Red - Safety Cross tool had last been completed in March 2017. If the tool is not used appropriately it is not obvious if any current pressure care regimes in place are working successfully. The registered manager said that this was an oversight and that use of the tool on a monthly basis would be reinstated but went on to explain that any concerns around pressure areas were identified and tracked with monthly wound management audits.

At the last inspection we had identified that people living at the home were not provided with information on advocacy services. At this inspection we saw that this had changed. The contact number for a local advocacy group was displayed on the noticeboard in the foyer.

A new activities officer was in post at the home. Regular activities included weekly entertainers and film afternoons. Information on care plans relating to life history was replicated in the activities files so that the activities co-ordinator was aware of past hobbies and could introduce activities that might be of interest to particular individuals. We were assured that people were offered appropriate activities but where participation in activities was limited staff tried to make them feel involved where possible. This meant the service to steps to ensure people were engaged in activities that were meaningful and helped with their wellbeing.

All areas of the home were seen to be clean. Procedures were in place to prevent and control the spread of

infection. Systems were in place to deal with any emergency that could affect the provision of care and the home had a business continuity plan in place to help address any unexpected emergencies.

A complaints procedure was in place. People we spoke with said the staff and registered manager dealt with any issues they raised verbally and a formal complaint we saw had been dealt with within acceptable timescales. It is good practice to include a record of the date the complaint was resolved as well as the date it was received so that the manager can audit that company policy response timescales have been met.

Audits and checks were completed on a range of areas, for example medicines, care plans, accidents and incidents, mattresses and aspects of the environment. We noted that some areas for improvement identified during an audit had not been acted upon in a timely manner, for example replacing a torn waterproof mattress cover.

The registered manager had introduced support mechanisms for staff such as a rolling rota, supervisions and staff meetings but return to work interviews following absences due to sickness were still not undertaken with staff. We will check at our next inspection to see if this support mechanism has been embedded into practice.

The home is no longer in special measures due to the improvements found during this inspection. The registered manager felt fully supported with the restructured management team and on-going assistance from the operations manager and recognised that the improvements to the service now needed to be fully developed and sustained.

## 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.

Risk assessments had been completed for some aspects of care. However people did not have access to call bells due to the increased risks. There were no assessments on file to reflect these risks.

There were now sufficient numbers of suitably qualified, skilled and experienced care staff to support people living in the home safely. There was less reliance on the use of agency staff.

The home had recruited additional staff to deal with maintenance issues and cleaning. The home environment was much improved and was cleaner.

**Requires Improvement** 

### Is the service effective?

The service was not always effective.

The home was operating in line with the Mental Capacity Act. Best interest decisions were now recorded in the care files that we looked at and applications for DoLS authorisations made. The home needed to improve with regards to gaining and recording consent.

The atmosphere at mealtimes was relaxed and appropriate music was on in the background. Staff need to be more mindful of where residents sit during meal times based on their dietary requirements.

Improvements had been made to the physical environment to make it more dementia friendly.

**Requires Improvement** 

### Is the service caring?

The service was caring

Staff attitudes had improved. We observed staff treat people with kindness and respect and interactions between people and the care staff were warm and positive.

**Good** 

The service was signposting people to advocacy services and was therefore helping to promote their rights and independence.

The home had been awarded the Six Steps to Success in End of Life training. The service was involving relatives and informing them about the process and planned to update them further at the next relatives meeting.

### Is the service responsive?

The service was not always responsive.

We saw care plans were reviewed monthly or following any changes in people's needs. Staff were documenting when people refused aspects of personal care however it was not clear what actions, if any, staff took to encourage people to comply with care.

Care workers were now documenting in progress notes for those people they had assisted with personal care.

Relatives meetings were held monthly and were attended by a core group of relatives. There had been a suggestion at the last meeting to hold these meetings every three months and relatives were happy with this arrangement.

**Requires Improvement** ●

### Is the service well-led?

The service was not always well led.

Audits and checks were completed on a range of areas, for example medicines, care plans, accidents and incidents, mattresses and aspects of the environment. Some areas for improvement identified during audits had not been acted upon in a timely manner.

The registered manager had introduced support mechanisms for staff such as a rolling rota, supervisions and staff meetings. Return to work interviews following absences due to sickness were still not undertaken.

The registered manager felt fully supported with the restructured management team and recognised that the improvements to the service now needed to be developed and sustained.

**Requires Improvement** ●

# Shawe House

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 20 and 22 June 2017 and was unannounced on the first day. The inspection team consisted of one adult social care inspector, a bank inspector and an expert by experience on the first day of the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of services for older people. One adult social care inspector returned for the second day of the inspection.

We did not ask the provider to complete a Provider Information Return (PIR) on this occasion. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We contacted the local authority commissioning team for feedback on the service. They shared with us recommendations that had been made by commissioning support officers following monitoring visits made during 2017 and actions taken by the home. We had received a report from the local Healthwatch board following an enter and view visit undertaken to the service in January 2017 that detailed their findings.

During the inspection we observed interactions between staff and people who used the service. As some people were not able to tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI) during the lunch period in the lounge areas of the home. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with three people using the service, seven of their relatives and 15 staff including the registered manager, the deputy manager, a registered nurse, the activities co-ordinator, eight care workers and three ancillary staff. We observed the way people were supported in communal areas and looked at records

relating to the service. These included six care records, four staff recruitment files, daily record notes, medication administration records (MAR), maintenance records, audits on health and safety, accidents and incidents, policies and procedures and quality assurance records.



# Is the service safe?

## Our findings

People living at Shawe House were not able to tell us whether or not they felt safe as they were living with a diagnosis of dementia. Relatives we spoke with considered people were safe and told us, "Oh yes, he is very safe here" and "He doesn't fall as much now since he has lived here." Staff told us people were kept safe as they were never left alone as lounges were always supervised. We saw that this was the case during the two days of our inspection.

As part of the inspection we checked to ensure that medicines were administered, stored and disposed of appropriately. We saw a monitored dosage system was used for some of the medicines with other medicines supplied in boxes or bottles or refrigerated when necessary. We observed people receiving their medicines, administered by nurses. We checked the medication administration records (MAR) and we saw that there were no gaps. Refusals of medicines were documented and the medicines disposed of in a safe manner.

Fridge temperatures should be recorded daily to ensure medicines which require refrigeration are stored safely. We checked the fridge temperature and found it had not been recorded for the previous two days because the fridge 'was broken' but the fault had been reported and was awaiting repair. For previous days we saw fridge temperatures had been recorded within the recommended limits. Fridges to store medicines should maintain an air temperature of 2-8°C. A representative from the pharmacy came out to the home and addressed this on the first day of inspection.

The medication room temperature had not been recorded and the deputy manager told us, "We don't record it – just the fridge." On the day of the inspection, which was an extremely hot day, the thermometer was found behind the fridge and was reading a temperature of 31°C. A senior member of staff has the responsibility for ensuring that the room and fridge temperatures are monitored and recorded using the appropriate documentation on a daily basis. This had not been completed at Shawe House which meant the effectiveness of the medication stored in the room may have been greatly compromised.

We saw that for people who were prescribed 'as required' medicine (PRN), appropriate protocols were in place to support staff to recognise when to administer these. We identified a person who received PRN medication. We checked the daily count record and found the number recorded did not tally with the actual number in stock. There were eight more tablets in stock compared to the amount recorded on the count record. The deputy manager said a monthly medication audit took place but was unable to explain why the count was incorrect but confirmed they would 'look into it immediately'. We identified that in this particular instance there were recording errors with the numbers on the sheets, compounded by nursing staff not physically checking stock on every occasion that PRN medicines were offered to the individual. The deputy manager told us that this would be addressed with all nursing staff.

We also checked that the controlled drugs were being stored and administered correctly. Controlled drugs are medicines where strict legal controls are imposed to prevent them from being misused, obtained illegally or causing harm. We saw that access to controlled drugs was limited to nursing staff only. We saw

they were stored securely and that two staff members signed when controlled drugs were administered, as per the home's medicines policy. Controlled drugs were prescribed for one person at the time of our inspection. We saw that another person's epilepsy rescue medicines were also stored in the controlled drugs cabinet for safe keeping. This was so staff knew where to find them in the event of an emergency. We were confident that controlled drugs were being stored and administered safely.

Adults who live in care homes may not be able to make decisions about their treatment and care and may need to be given their medicines without them knowing (known as 'covert administration'), for example hidden in their food or drink. One person living at Shawe House received covert medication. We saw a care plan was present in their file and authorisation had been received from the person's GP, which suggested how best the medication should be administered. We saw a best interest discussion had taken place and had been recorded in the person's care file for easy reference. This helped ensure the person's health and welfare was maintained and the medication was administered safely in line with requirements.

At our last inspection in October 2016, we judged that there were insufficient numbers of suitably qualified, competent, skilled and experienced care staff to support people living in the home safely. Following that inspection the provider had increased daily staffing levels by one care worker. We looked at staff rotas and noted that these were now clearer with an established rolling rota in place for staff employed at the home. A new chambermaid position had been created to assist domestic staff maintain the cleanliness of the home and to ensure that care staff were free to provide care and support. The registered manager was now supported by a deputy manager and a clinical lead, one of whom was always supernumerary when on shift. At the last inspection we had identified an over-reliance on agency staff but at this inspection we noted all of the care workers rostered for duty were permanent members of staff and were included on the staff rota for that day.

At the time of this inspection there were 27 people living at Shawe House, with two residents identified as needing one to one care during the day. One to one support is commissioned when a person has complex needs or behaviours that require constant monitoring and supervision to ensure that they, and others around them, are kept free from harm. The local authority had placed a temporary suspension on all new admissions to the home in March 2017. It was envisaged that the suspension would be lifted once the provider could demonstrate that the necessary improvements had been made by the service.

We saw on the first day of inspection there were six care staff on duty, one nurse, the deputy manager and the registered manager for the care and support function. The agency had failed to supply a second nurse on the morning of the first day of our inspection however, the deputy manager was able to fill this role until a second nurse arrived. On our arrival at the home at 8am we were told that one care worker had also rang in sick earlier that morning. The agency had been approached to supply a care worker in order to maintain staffing levels and the rota updated to reflect the sickness absence.

Relatives and staff we spoke with did not express concerns about staffing levels and said there were enough staff on duty to meet people's needs. Our observations throughout the inspection confirmed this. We saw there was always a staff presence in the lounge areas on the ground floor. Staff also walked between the lounges in the home and provided support when required for any people who liked to walk in the corridors around the home. This showed there were sufficient staff employed by the service to meet people's needs.

At our last inspection in October 2016 we identified numerous potential environmental hazards for those people who were mobile and able to walk around the ground floor of the home. At this inspection we saw that the provider had resolved many of the identified issues with coded locks fitted to the wheelchair storeroom and to a door in the foyer, which led to the nurse's office and to an outside space at the back of

the home. The registered manager told us there were plans to fit a coded lock onto the door that allowed access to the lift, although we did not see people trying to access the lift alone during this inspection.

Problems identified with the lift's internal doors during the previous inspection had been dealt with soon after that inspection and we saw that the lift was fully operational with no gap between the doors when closed. We were assured that this was now a safe environment for people with dementia.

The service had recruited a maintenance man and duties associated with this role were now being addressed. We could see that areas identified as requiring redecorating had been done and rooms were being prioritised for repair, redecoration and replacement furniture. The environment within the service was now maintained and secured in a way that ensured the safety of people with dementia.

We looked at six people's care files. Risk assessments had been completed in areas related to falls, mobility, pressure areas and nutrition using the Malnutrition Universal Screening Tool (MUST), which helped ensure people's care needs were delivered in a safe manner.

These were reviewed monthly and updated as required. Where people had been assessed as potentially displaying behaviour that challenge, a plan was in place to guide staff of the potential triggers and how to distract the person to diffuse the situation. Appropriate action was taken to reduce identified risks. The service was identifying risks and taking action to mitigate these.

We noted that people did not have access to call bells in bedrooms as these were not in situ in any rooms we looked in. The registered manager explained that due to people's complex needs call bells were not appropriate and could pose more of a risk to people, for example from possible strangulation with the cord wire; however we saw no risk assessments on care plans to this effect. We asked how the safety of people was met if they could not alert staff for help and the registered manager told us regular observational checks were done on everyone, day and night. The use of equipment such as sensor mats alerted staff if people were out of bed or a chair and the use of low profile beds and crash mats further minimised the risk of injury and helped keep people safe. The manager told us they would review each person and formulate a risk assessment around access to a call bell. We will check on this at our next inspection.

We looked at the recruitment procedures in place to help ensure only staff suitable to work in the caring profession were employed. When we checked the records for four members of staff we saw that all had a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and aims to prevent unsuitable people from working with vulnerable groups. Each of the staff files we saw contained an application form, two written references obtained before the staff started work, and copies of photographic identification. This meant that the service undertook pre-employment checks on new staff in order to keep people safe.

Staff we spoke with told us they had received training in safeguarding adults and they were clear about how to recognise and report any suspicions of abuse. One care worker explained the forms of abuse that people using the service could be vulnerable to. The service had taken the necessary steps to help ensure that staff were competent and aware of how they would keep people safe from harm. Potential safeguarding incidents referred to the local authority had also been notified to the Care Quality Commission and we discussed the outcomes of these with the registered manager where these were known.

We saw incidents and accidents were recorded and reviewed by the registered manager. The registered manager told us that a person's care plan might be reviewed following an accident or a specific action taken, for example a referral to the falls clinic or dementia crisis team. This meant the service responded to incidents when they occurred to reduce the risk of them re-occurring.

Personal emergency evacuation plans (PEEPs) outline the level of support each person needs to be relocated to another area of the home or completely evacuated in the event of an emergency. We saw PEEPs were present within the care files we looked at, with copies also in a 'grab file' which helped ensure the safety of service users if any form of emergency occurred which required evacuation from the home. We highlighted to the registered manager that a colour co-ordinated system, for example red, amber and green, would provide a more effective system for recognising those service users who are more dependent in the event of an emergency and would help to further ensure their safety.

We looked at the records for the lift, gas and electrical safety checks, portable fire fighting equipment and manual handling equipment checks. Records showed equipment in the home had been tested and serviced in line with the manufacturer's instructions. A business continuity plan was in place with contact information and guidance for staff to deal with any emergency situations such as a gas or water leak, heating failure or evacuation of the building. There was a large, yellow 'grab bag' stored in the nurses office. This contained information and equipment relevant in the event of an emergency. We saw that this contained wind up torches, blankets, high visibility jackets and information relating to residents, for example copies of PEEPs, GP details and medicines information.

At the last inspection we had identified concerns around the cleanliness of the home in both communal areas and people's bedrooms. There had been on going concerns raised since that inspection by the local authority and the home had organised a deep clean to the premises in February 2017. An infection control audit carried out in May 2017 awarded a score of 70%. One recommendation from this report was to store individual slings in large bags when not in use, as this would protect the slings, extend their life and reduce the risk of contamination. We saw that sling bags had been purchased, were stored in a locked cupboard and had individual names on them. When we checked the store room we saw four slings were bagged but two other slings were hung up and had not been returned to the bags after being used. This was done immediately we brought it to a care worker's attention.

On the days of inspection we noted the home was much improved. The home was cleaner in all areas. On the first day of inspection we identified a malodour in the foyer area. By the second day of inspection a new piece of carpet had been fitted near to the front entrance and the odour had gone. We spoke with the head housekeeper and spent time with the chambermaid and observed what cleaning regimes they followed to maintain the cleanliness in the home. This meant that people were protected from potential infections as the standards of cleanliness had improved.

## Is the service effective?

### Our findings

At the last inspection in October 2016, we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to a lack of supervision and training of staff. At this inspection, we saw that the home had taken steps to address this issue.

We saw the service's training matrix. The home had teamed up with a local home owned by the same company and staff attended training sessions held there, run by the company's qualified trainer. Examples of mandatory training included moving and handling, safeguarding of children and adults, fire safety, health and safety, record keeping, food hygiene and infection control. All staff were signed up to the Qualification Credit Framework (QCF) level 3. We saw that people had completed aspects of refresher mandatory training identified as outstanding at the last inspection.

Other training for staff was available in the form of flexible, distance learning courses. This was on going since the last inspection and staff had completed workbooks on topics relevant to the caring role at Shawe House, for example end of life, pressure sore awareness, behaviours that challenge and dementia awareness. Fifteen staff had recently completed and received an NCFE level 2 certificate in Understanding Behaviour that Challenges. This meant that staff had received the right training in order to manage behaviour, which would assist them to respond effectively to the triggers, signs and symptoms of challenging behaviours. This also demonstrated that the service provided additional training to help ensure that its staff could meet the needs of the people using the service.

New staff told us they received induction training when they started working at the service, including shadowing experienced members of staff, being introduced to people and having time to get to know them and their needs. New staff were also enrolled on the care certificate. The care certificate is a nationally recognised set of standards that health and social care workers adhere to in their daily working life. This showed us that the service made sure that staff received a thorough introduction to home before being offered employment on a permanent basis and people could be confident that they were being effectively supported by staff.

We saw that the provider had changed to a different agency for the supply of nursing and care staff. The registered manager told us there was less reliance on the agency for the provision of care workers, although it was envisaged that more agency nurses might be required in the future. At the time of our inspection two nurses were known to be leaving and a third handed their notice in. The registered manager told us that recruitment of nurses was a priority for the company.

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 make 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 to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application procedures of this in care homes and hospitals is called Deprivation of Liberty Safeguards (DoLS).

A capacity assessment considers whether a person can make decisions for themselves; sometimes a person's capacity to make decisions can fluctuate so a capacity assessment should determine which decisions a person can make, which decisions they need help to make and which decisions must be made on their behalf. When decisions are made on behalf of a person under the MCA they are called 'best interest decisions'; documentation for best interest decisions should show who was involved in making the decision, what options were considered and why the preferred option was selected.

At the previous inspection, we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as best interest decisions were not being documented appropriately and therefore the home was not operating in line with the MCA. At this inspection we saw that this had been rectified. Best interest decisions were now recorded in the care files that we looked at, for example, decisions taken on behalf of people refusing care, allowing specific preferences in care and for the covert administration of medicines. These detailed the decisions made, the people involved in making them and guided staff on how to support the person or what action to take in these instances.

We noted that the majority of people living at the home lacked capacity which meant they required constant supervision or would be prevented from leaving unaccompanied, so applications for DoLS authorisations were necessary. We saw that appropriate applications for DoLS had been made by the service to the local authority and that CQC had been notified when these were authorised. A laminated poster was displayed in the reception area informing relatives about the need for DoLS and when this would apply. The need for a DoLS was conveyed in a sensitive way and reassured relatives that people were not unnecessarily restricted.

We noted one particular area which had not been completed as required, this being consent forms. The only consent form we saw was for photographs which had been signed by family members as the person lacked capacity. However, we did not see any evidence that the family member held an authorised Power of Attorney. It is important to note that families may, and usually should, be consulted about the proposed care and support, and their views taken into account, but this is not the same as consent. They do not have automatic legal authority to provide permission for the proposed care or treatment.

Only people who have a Lasting Power of Attorney (LPA), or have been appointed by the Court of Protection as a deputy, have legal authority to give consent on behalf of a person who lacks capacity to do so. It is also good practice to gain consent for the administration of medication and the sharing of information which would address any concerns related to confidentiality. We discussed with the registered manager the use of a combined consent form which would then require just one signature. We will check on progress of this at our next inspection.

We noted improvements had been made to the building environment to make it more dementia friendly. Memory boxes were in place at bedroom doors, signage was in use at the home to indicate rooms that were toilets and bathrooms and there were two activity boards at either end of the corridor. The two large arched mirrors that we had voiced our concerns about at the last inspection had been removed from the 'green lounge'. The décor was fresher and lighter and bedrooms had colourful mural transfers depicting various scenes from a window.

Eating well is vital to maintain the health, independence and wellbeing of people with dementia. However, for many people with dementia, eating can become challenging as their dementia progresses. People using the service were seen by the inspection team to be enjoying the food served at the home and relatives we



spoke with were complimentary of the food prepared and served in the home.

During the second day of inspection we sat in the conservatory dining room and observed lunch. People were allowed to sit where they liked and some chose to sit at the table or took lunch on a small table whilst sat in a lounge chair. We saw on two occasions residents taking food from other people's plates. On the first occasion staff saw this and were able to distract the person however on the second occasion we alerted staff as one person removed the top from a piece of sandwich from another person's plate. As the person was eating soup we were not sure whether the individual's dietary requirements meant that they were unable to chew or swallow a sandwich, and may therefore be at increased risk of choking. Staff were able to remove the piece of bread once alerted to this. We brought this to the registered manager's attention and suggested that as staff might not be able to observe everybody eating due to helping other individuals and the layout of the room, they should consider people's seating arrangements at mealtimes. We will check on this at our next inspection.

A health professional had identified concerns after a monitoring visit to the home in March 2017 having observed a person being assisted to eat with the use of a syringe. This method of administering food and fluids is only on the recommendation of a Speech and Language (SALT) professional due to the increased risk of aspiration. Breathing a foreign substance into your airways is called lung, or pulmonary, aspiration. The substance could be food, liquid, medicine, mucus, or saliva. Aspiration can cause choking. It can also cause a problem called aspiration pneumonia, which is a serious infection in the lungs.

During our two days of inspection at the home we saw no staff or relatives using syringes to assist people to eat or drink. The dietary requirements document available in the kitchen and to care staff detailed those individuals who required a pureed diet and 'teaspoon sized' mouthfuls of food due to the risk of choking. We saw minutes of a staff meeting that reflected staff had been informed that this practice had to cease unless authorised by a relevant health professional. We were satisfied that the use of syringes in relation to assisting people with eating and drinking had been stopped.

A food hygiene rating result is given to a business to reflect the standards of food hygiene found on the date of inspection by the local authority. We saw the service had been awarded with the maximum score of 5 in the Food Hygiene Rating Scheme and this was correctly displayed at the front entrance to the home.

At lunchtime, we sat in the dining room to observe practice. Ten people were in the dining room and four staff members supported them. Most people required support to eat their meals. We saw a written menu was displayed on the wall but because of the level of cognitive impairment of the people present, this did not serve any purpose and we suggested to the registered manager that the use of picture menus would provide people with the opportunity of making their own meal and drink choices.

Soup and sandwiches were on the menu and whilst we did not observe any choice of soup or sandwiches, staff did say if residents had a preference then they could have it. We saw a person declined the soup on offer and was immediately offered an alternative. We saw a choice of two meals were available at dinner time. We did not always observe table cloths on tables and condiments were not routinely offered to people, which may have improved the mealtime experience for the service users, however the atmosphere was relaxed and appropriate music was on in the background. Staff were responsive to people's needs and we observed several staff members supporting some service users to eat their meals in a calm and caring manner.

When people lost weight we saw appropriate referrals were made to the Speech and Language Team (SALT) and dieticians. Food and fluid monitoring charts were completed where required and kitchen staff were made aware of changes to people's diets. We saw referrals to other health professionals were made when needed, for example an occupational therapist, tissue viability nurse or the dementia crisis team. Care plans

contained a log of professional visitors. This showed us that people were supported to maintain good health and to access other healthcare services.



# Is the service caring?

## Our findings

We asked relatives if they considered staff to be caring and respectful. The relatives we spoke with were all complimentary of the care people received. One relative told us, "I can't fault the care. They're really on top." Another relative told us, "It's much improved. They're good to me as well." This showed us that the service provided support to relatives as well as people living in the home.

At the last inspection in October 2016, we saw instances where care staff did not treat people with dignity or respect, as staff were indiscreet when communicating amongst each other about people's personal care needs. During this inspection we saw that staff attitudes had improved. We spent time observing the interactions between staff and people living at Shawe House in communal lounge areas on the ground floor, as people were not able to tell us about their experiences themselves. We observed staff treat people with kindness and respect, interactions between people and the care staff were warm and positive. Staff responded to people's needs in a timely manner.

We observed care in one lounge using the Short Observational Framework for Inspections (SOFI), which is a way to help us understand the experience of people using the service who could not express their views to us. During the observation period we noted positive interactions between care workers and people sitting in the lounge. Interactions between staff and residents were focussed on support needs but we also heard staff making pleasant remarks based on what people liked or what they knew about the person.

The care plans we saw for people who had lived at the service for some time included information about people's personal history. This included family members and details of their hobbies, interests and life history, for example previous jobs they had done and things they had achieved throughout their life.

Staff knew the people they were supporting. We spoke with one staff member who recognised the importance of judging people's mood before offering support with personal care. They told us, "If they're not in the mood I don't push it. I just try and encourage them as much as possible." This meant staff would offer people support with their personal care when they judged them to be in a more receptive mood.

Memory boxes were in place outside most rooms and contained photographs of the person, often showing important milestones in their life, such as a wedding, the birth of a child or a grandchild. Some bedrooms had been personalised according to people's tastes and preferences, with their own furnishings, ornaments and family pictures. Doors to bedrooms contained people's first names on them. We saw one room with a colourful personalised doorsign of "grandma" made by a younger family member. The home encouraged people to maintain family relationships and relatives we spoke with told us they always felt welcome in the home.

At the last inspection we had identified that people living at the home were not provided with information on advocacy services. At this inspection we saw that this had changed. The contact number for a local advocacy group was displayed on the noticeboard in the foyer. Advocacy services help people to access information, to make decisions and to speak out about issues that matter to them. Signposting people to

access advocates meant that the service was helping to promote their rights and independence.

The home had been awarded the Six Steps to Success in End of Life accreditation certificate. The Six Steps to Success programme aims to enhance end of life care through supporting staff to develop their roles around end of life care. The aim is to ensure all patients at end of life receive high quality care provided by care workers supported to develop their knowledge, skills and confidence to deliver quality end of life care. We saw that care staff had also undertaken a distance learning course on the end of life.

Relatives had been made aware of the Six Steps programme and had expressed an interest in knowing more about it. The registered manager told us there were plans to have a representative at the next relatives meeting planned for September 2017 so that relatives could be fully informed about the programme. This showed us that the service was involving relatives and informing them about the process, whilst preparing to meet the needs of people who were at the end of their lives. We saw a record of people's wishes for the end of their life in care plans. The person's GP and family, where appropriate, were involved when a decision not to attempt resuscitation had been made.

## Is the service responsive?

### Our findings

During the inspection, we looked at six care files. The files we looked at had been written in a person centred manner and made reference to a person's choices and preferences. In some cases, because of the service user's cognitive impairment, some information had been provided by family members which showed they had been involved in the care planning process. A pre-admission assessment had been completed within the files we looked at which helped ensure their individual care needs could be met by the provider.

We noted there were still some gaps with regards to the completion of individual personal care records for people, indicating for example when people had their teeth brushed, nails cleaned or had a bath. Some care workers had documented when aspects of personal care had been refused, for example when people had refused a bath or refused assistance with brushing their teeth. We noted that people often refused oral care and did not have their teeth brushed regularly. Whilst the refusal of care was documented it was not clear what actions, if any, staff took to encourage people to brush their teeth and care plans did not reflect this either. We brought this to the registered manager's attention who was able to outline ways in which staff encouraged people to have their teeth brushed and participate in care and assured us this would be documented in future. We will check on this at our next inspection.

We saw individual care plans had been reviewed on a monthly basis with the involvement of family members. Within one person's file, we saw there was a risk of a breakdown in pressure areas because of the time being spent and cared for in bed. The care plan included a requirement for the person to spend two hours in the lounge area in the morning and afternoon. There was an added requirement for the person to be turned every two hours of a night time.

On the day of the inspection, we observed the service user spending time in a communal area during the morning and afternoon. We also checked the turning chart in the service user's room and saw that all turns had been completed in line with care plan requirements. This helped ensure that any identified risk of tissue breakdown was minimised and that care was focussed on meeting this person's specific needs. Similarly, another service user required a dressing to be changed every other day on a leg wound and we saw records that showed this had been completed as required. Another service user had lost weight in consecutive months and we observed a referral had been made to the dietician which helped ensure the person's health and welfare was maintained.

Detailed care plans and risk assessments were developed as staff got to know the person. We observed that the staff had a good knowledge of people's individual needs. Staff explained to us people's individual's needs. For example one person required support with pressure relief, another was receiving treatment from the podiatrist and staff were aware of those people who had a soft diet due to the risk of choking.

At the time of the previous inspection care staff were not involved in documenting within care plans about aspects of care they delivered to individuals. We highlighted to the registered manager at that time that as care workers did not have access to care plans it was unlikely they would read the information about the person contained in it. This might result in inappropriate care being delivered to a person, especially when

changes in need had been identified. At our inspection in June 2017, we saw that this practice had changed and care workers were now documenting in progress notes for those people they had assisted with personal care. People were more likely to receive the right care and support because care staff had access to care plans and was contributing to them.

It was apparent that staff knew people's preferences in relation to care and support, but also in regards to social activities such as music and the environment. One person preferred to sit in the green lounge as this was a quieter environment and staff respected this choice. A visiting relative was complimentary about the care given to their relative and told us, "They know him so well." They told us staff played the kind of music their relative enjoyed and removed them from noisy environments as this caused distress to the individual. Care plans were made available for care workers to read and staff we spoke with felt they were given sufficient information to be able to support people living at Shawe House. Staff told us there had been improvements in the communication of relevant information and care staff were now involved in the handover process and in writing in daily progress notes. Information discussed during handovers was also documented and retained by the service. A visitor told us how they were kept regularly updated with regards to their relative's changing needs and said, "Communication is great. They keep me updated." Another relative visiting told us, "I've asked for things to happen and they've been done." They told us they had requested a move for their relative from the first floor to the ground floor and this had been accommodated by the home.

We saw that there was a board displaying activities on offer during the week. There were regular activities such as a weekly entertainer and a film afternoon. At the time of this inspection there was a gazebo in the rear garden and relatives told us residents had been outside and had enjoyed the recent spell of hot weather. The activity co-ordinator held a painting session which three people participated in. We observed good interactions between everyone engrossed in the activity.

Information on care plans relating to life history was replicated in the activities files so that the coordinator was aware of past hobbies and could introduce activities that might be of interest to particular individuals. We saw one individual's file noted they had previously had animals and included the names of the animals. This meant that staff were able to ask the person about the animals and enter into a conversation with them.

We spoke with the activities co-ordinator who was relatively new to the role. The co-ordinator demonstrated a good understanding of the different needs of people who were living with dementia and had ideas to promote the wellbeing of people who lived in the home. They showed us the family tree residents were making in one of the lounges. This was an on-going activity and we saw residents involved in cutting out leaf shapes and these being placed on the wall. The aim was to make a large family tree collage on the lounge wall with all residents featuring in this. One person was accompanied to the hairdresser's on a weekly basis as their preference was to go out to have their hair done. This was documented in their activities file.

A relative we spoke with flagged up a concern to us regarding a lack of participation in activities by their family member and told us, "I am concerned. They don't encourage [person] to do anything." We queried this with the activities co-ordinator and looked at the person's weekly activity record for the three weeks prior to our inspection. We could see that if the activity did not seem suitable for the person or they were unable to physically do it this was noted, however it was explained to the person what was going on. There were occasions when staff had tried to involve the person as much as possible and this was documented. For example, when others had been planting flowers staff had wheeled the person to the table in a wheelchair to watch. During a food tasting activity the person had been given only those foods appropriate to their diet, due to associated risks. Visits by family members were also recorded. We saw a narrative by the

co-ordinator which detailed a manicure and a hair style provided to the resident. The activity co-ordinator had written, "Hopefully this made [person's name] feel better about themselves." We were assured that people were offered appropriate activities but where participation in activities was limited staff tried to make them feel involved where possible.

We were shown the complaints log which contained one recorded complaint that had been managed in a satisfactory manner. It is good practice to include a record of the date the complaint was resolved as well as the date it was received. This should help to ensure complaints were resolved in line with the provider's policy requirements, for example within 28 days. We saw the complaints procedure was displayed on the entrance hallway. We did not see any service user handbooks given to people and their relatives on admission to the home although the manager did show us a copy of a service user guide. The complaints procedure should be included within a handbook or guide so that people and their relatives know who to contact in the event that they want to make a complaint. Two relatives we spoke with told us they had never needed to make a formal complaint and one said that the staff and registered manager dealt with any issues they raised verbally. One relative told us they had raised a concern about missing items of laundry and this had been addressed.

We saw that the service had received compliments in the form of thank you cards from the relatives of people that had spent time at the home, which were on display in the corridor. They were complimentary of the service and thanked the staff for the care and support their family member had received.

We saw monthly residents meetings were held and were attended by a core group of relatives. There had been an agreement at the last meeting to hold these meetings every three months. One relative had offered to take a lead role in producing the minutes from the meetings. Relatives we spoke with confirmed that they had been asked for feedback and had completed a survey, although they were not clear exactly when this was.

## Is the service well-led?

### Our findings

At the last inspection we identified breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems in place to assess and monitor the quality of care at Shawe House were not effective in identifying, assessing and managing all the risks relating to the welfare and safety of people living in the home. At this inspection we judged that improvements had been made and the quality of care had improved as a result.

As a result of the last inspection we served three warning notices to the provider for breaches in regulations. At this inspection we found that the areas identified within these warning notices had been remedied satisfactorily.

At this inspection we saw that audits and checks were completed on a range of areas, for example medicines, care plans, accidents and incidents, mattresses and aspects of the environment. External audits had also been completed by the local authority for compliance, infection control and environmental health in the kitchen. Action plans had been agreed to address shortfalls identified in these external audits which had been signed when updated or completed.

We saw examples of completed accident reports and a corresponding accident log had been implemented by the registered manager which summarised when, where and how the accident had happened. We saw that the individual however, was not identified on the log by name but by a reference, for example resident 17. We pointed out this would make analyses and trends of accidents more difficult as it was not immediately obvious who had been involved in each incident or accident. We discussed this with the registered manager who agreed to implement recording the person's name immediately. The registered manager also indicated that the log would be recorded with each month on a separate page, again to make the analysis easier and more meaningful.

Following a safeguarding concern raised by a health professional in January 2017 the local authority and clinical commissioning group had raised concerns with regards to the home's approach to pressure care. We saw documentation in the home in relation to the React to Red skin campaign. This campaign is the latest pressure ulcer prevention campaign to be held by NHS Trust Tissue Viability Nurses. The main message of the campaign is that by reacting to red skin over bony areas and asking for help and advice from a healthcare professional this can stop red skin becoming a serious wound.

We saw that the clinical lead had started to monitor the occurrence of pressure areas using the React to Red - Safety Cross tool, a daily audit of how the home is doing in reducing pressure ulcers. We saw that this tool had last been completed in March 2017 and meant that the home was not fully aware if pressure ulcers were increasing or decreasing. If the tool is not used appropriately it is not obvious if any current pressure care regimes in place for individuals are successful and the home cannot respond to people's individual changing needs. The registered manager explained that any concerns around pressure areas were also identified and tracked with monthly wound management audits.

Mattress checks were documented and a mattress cover from a specific room was identified as having a small tear to one side. We saw that this had also been documented the week before the inspection but had not been acted upon. Audits are only meaningful when appropriate action has been taken. We brought this to the registered manager's attention and a new mattress cover was ordered immediately and arrived the following day. We were assured that processes for reporting faults, repairs and required equipment were in place and that staff would be reminded of these in supervisions. The head housekeeper told us they completed and recorded daily environmental spot checks to ensure standards were being maintained and we saw these being carried out at the time of the inspection. We were assured that the service had improved the systems in place to maintain the cleanliness of the home and relatives we spoke with confirmed this and told us, "I've seen lots of improvements recently, definitely" and "My mum's room used to be dirty. It's not now, it's lovely."

There was a rolling rota in place which had been introduced after the previous inspection. More permanent staff had been recruited and there was less reliance on agency staff. Where agency staff were used, predominantly to fill nursing vacancies, the registered manager had introduced a first day induction checklist. We saw and staff told us that staff meetings were now held. Staff meetings are a valuable means of motivating staff and making them feel involved in the running of a service; they are a good forum to discuss incidents and good practice and help to promote the cohesiveness of the team. These meetings, along with the increase in supervisions, meant that the morale of staff was higher. A member of staff confirmed this and told us, "The home is better now. I feel supported and my supervisor supports me." The registered manager was still not conducting back to work interviews following staff sickness absences. Undertaking return to work interviews can make the member of staff feel fully supported. It also provides management with an opportunity to assess that a member of staff is fit for duty and able to undertake the role they are employed to do.

Staff we spoke with were complimentary about the registered manager. We were told they were approachable and would listen to, and act upon, any concerns raised. We saw the registered manager was visible within the home throughout our inspection. One member of staff told us, "[Manager's name] has got an open door policy. I can talk to them about anything, including any personal problems I might have."

The operations manager for the provider was actively supporting the registered manager of the service, spending one and a half days per week in the home. We saw that the registered manager provided a weekly update to the operations manager with a governance report. This report contained any significant issues happening in the home, key performance indicators and updates with regards to risk and compliance. The operations manager then added other information and submitted their own governance report to the operations director. We saw that this was a separate document and that the registered manager did not always receive a copy that included the operations director's and the director's comments. We highlighted this to the registered manager and discussed the importance of feedback from senior management. The registered manager agreed and changed the format of the document so that the comments from all managers and directors were on the same form. We will check that this has been adopted on our next inspection.

We noted staffing changes at the service which had provided the registered manager with increased support. A new deputy manager was in post and a clinical lead. During the week, one of these roles was supernumerary to the rota to provide management support. Other appointments such as the new maintenance man, a domestic staff member with chambermaid duties and the activities co-ordinator also provided support functions to the existing staff team. This additional support had a positive impact on people living at the home as it meant that care workers were available to deliver care and the physical environment was improved.

Services providing regulated activities have a statutory duty to report certain incidents and accident to the Care Quality Commission (CQC). We checked the records at the service and found that all incidents had been recorded, investigated and reported correctly.

We saw that the overall rating of 'Inadequate' awarded at the last inspection in October 2016 was displayed on the noticeboard in the entrance foyer to the home, as the provider has to do by law. Resident and staff surveys had been undertaken in June 2017 prior to this inspection. The levels of satisfaction results in a number of areas were displayed on the notice board for staff and relatives to see but due to the format of the document it was not clear what aspects of the home or the job people were or were not happy about. We brought this to the registered manager's attention.

We judged at this inspection that the registered manager did have an improved oversight of the safety and quality of important aspects of service. Overall we found improvements had been made at the service for example in relation to maintaining people's safety, the environment and the cleanliness of the home. The numbers of staff supporting people living at the service had been flexed and there was one less care worker on duty during the day, as new admissions to the home had been suspended by the local authority and the home was not operating at full capacity. The registered manager told us that staffing levels would increase once admissions were restarted. Relatives and staff we spoke with considered that there were enough staff on duty. The registered manager felt fully supported with the restructured management team and recognised that the improvements to the service now needed to be developed and sustained.