Old Shenfield Place Ltd

Old Shenfield Place

Inspection report

2 Hall Lane
Shenfield
Essex
CM15 9AB

Tel: 01277220636
Website: www.achg.co.uk

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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

The inspection was completed on 21 March 2017 and was unannounced.

Old Shenfield Place provides accommodation and personal care for up to 31 older people. There were 24 people living at the service at the time of our inspection. The service is registered to provide nursing care but on the day of inspection there was not anyone assessed as requiring nursing care.

A registered manager was in post. 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.

Staff understood the principles of keeping people safe, but in practice these had not been followed. We found some risk assessments in place to meet their needs, but for some people relevant risk assessments were not found or up to date. This meant there were risks associated with people's care which staff were not aware of.

Staff told us they did not think there were always sufficient numbers of staff on shift to meet people's needs in a timely way. There were mixed views on staffing from people using the service. Some told us there were not enough staff and this would mean they would have to wait for support at times.

Care staff had not all had the training required, and staff had not received regular supervision of their conduct or practise.

There were quality assurance processes in place to monitor the quality of the service and to make improvements however, these were not sufficiently robust to make sure all shortfalls were identified promptly. The manager had been working to an action plan, which did not provide sufficient detail of any remedial actions taken.

Care plans were in the process of being updated and reviewed however some of the information in people's care records lacked detail. People's healthcare needs were monitored and advice and guidance was sought from healthcare professionals when needed.

Although the manager understood the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS), some staff had a limited understanding of the MCA and DoLS.

Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to raise an alert if they had any concerns.

People were supported to eat and drink sufficient amounts to meet their nutritional needs. People were able to choose alternative meal options if they did not like the choices offered on the daily menus.

People were treated with dignity and respect by caring staff. Staff knew the people they were supporting well. Although staff reviewed peoples care plans, sometimes they were not up to date or did not contain sufficient information about people's needs to be reliable for staff to follow when providing care.

An activities co-ordinator was in post who offered a range of activities to people through the activities programme in place.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of this 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 safe.

Some people's risk assessments were not reflective of their current risks.

There were not enough staff to meet people' needs.

Staff had a good understanding of safeguarding people from abuse.

People were supported with their medicines.

The service followed safe recruitment processes.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive effective or consistent training, supervision and mentoring.

Not all staff were able to demonstrate that they had a good understanding of the Mental Capacity Act 2005.

People were supported to maintain good health and had access to healthcare professionals when they required them.

People were supported to have enough to eat and drink.

Is the service caring?

Good

The service was caring

People were treated with respect and the staff understood how to provide care that respected people's right to privacy.

People were relaxed in the company of staff and told us staff were approachable.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Peoples care plans did not clearly record their support needs

People told us they could speak with staff or managers if they had any issues or concerns and were confident these would be addressed.

There was a programme of activities available at the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had a manager who was registered with the Care Quality Commission and was qualified to undertake the role.

Staff told us they enjoyed working in the service and received support from the registered manager and senior staff.

The quality assurance systems needed to be more robust to help drive forward improvements in the service. Risks to people who used the service were not always identified in a timely manner.

Old Shenfield Place

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 21 March 2017 and was unannounced. The inspection team comprised of two inspectors.

Before this inspection, we looked at all of the key information we held about the service. This included notifications the provider had sent us. A notification is information about important events, which the provider is required to send us by law.

During the visit, we spoke to seven people who used the service, two relatives, and six staff members including the registered home manager and the operations manager.

Some people could not tell us about what they thought about the home, as they were unable to communicate with us verbally therefore we spent time observing interactions between people and the staff who were supporting them. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to see that the way staff spoke and interacted with people had a positive effect on their well-being.

We looked at the care records of four people who used the services and checked files and records of five care staff members. Other documents checked relating to people's care included risk assessments, medicine records, relative and residents meetings minutes as well as health and safety documents.

Requires Improvement

Is the service safe?

Our findings

Risks to people's health and wellbeing were not consistently identified, managed and reviewed. Peoples' risk assessments were not all up to date and some lacked sufficient information and guidance to keep people safe. Some care plans contained risk assessments specific to health needs such as environment, falls, mobility and skin integrity. However not everyone's health, safety and wellbeing had been assessed appropriately or contained sufficient guidance for staff to follow. For example, we observed two inappropriate manual handling manoeuves involving one person. On the first occasion, we observed staff transferring them into a chair by holding the person under the arms and holding onto their trouser belt to complete the transfer. Later we observed that the person had slid from their chair, and during the subsequent hoist transfer, we had to intervene, as the person did not have their sling positioned correctly. When we questioned staff, they were not aware of what size sling they were using or if it was appropriate for this person.

We checked the person's care plan and found that the manual handling risk assessment stated the person was usually able to transfer with two staff, it did not contain any detail about how this transfer should happen or what to do if the person slid from their chair to the floor. When we discussed this with the registered manager, they told us that their mobility had deteriorated and they had referred the person to an occupational therapist. However, the service had not demonstrated that they had fully assessed and mitigated the risk while they were waiting for the occupational therapist to visit. The registered manager did send us an updated risk assessment for this person and the outcome of the occupational therapist visit following the inspection.

Another person who used the service was at risk of skin damage. We saw that their care plan had completed a Waterlow assessment which scored the person as being at risk for developing a pressure sore, the care plan did not contain any information or guidance about what staff should do to reduce the risk.

These failings are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback from people regarding staffing levels. One person told us, "I've fallen so have bed rails up at night, if I am taken short at night I call for help they don't always come, the other night it was embarrassing I had an accident because no-one came; they badly need more staff." Another person told us, "Some people need a lot of care so we could always do with more staff." A third person told us, "They mainly come but at busy times it can be up to 15 minutes." Other comments included, "They come quickly when I call them", "If I use the call bell, they come pretty quickly" and "There seems enough staff." A relative told us, "Sometimes people press buzzers and wait a long time, not sure if there are enough staff."

We observed that three people were sat in a small lounge area. We were in there for 40 minutes and no one checked on them. One person had started to slide from their chair and the other person had dropped their call bell, the third person did not have access to a call bell. Staff did then arrive to provide support for the person that was starting to slide from chair. We supported the other person to access their call bell and they

told us, "I normally call the staff but I would have shouted if they had started to fall."

Staff views were also mixed about staffing. One member of staff told us, "We do have enough staff but it seems less as now we have more people but the same amount of staff. Only two carer's afternoon and evening and one senior so we are finding it more difficult. Last week [person] was on the floor and someone else was buzzing." Another staff member told us, "They are getting there with staffing but we need more staff." A third said, "There is enough staff, we have time to talk to people."

The manager told us they used a dependency tool to calculate the level of people's needs and used this information to determine staffing levels. This was recorded within care plan and reviewed monthly. However, in one care plan we noted that the score had been calculated incorrectly. This meant we could not be assured that there was always enough staff to meet people's individual needs.

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

Following this inspection the operations manager informed us that this was not the latest dependency tool and they used a different one to calculate staffing. They also added that they had identified that short term absences had not always provided sufficient cover and would be addressing this with a recruitment drive.

Staff had a good understanding about the different types of abuse that could happen to people. The staff also knew how to report concerns about people at the home. The staff told us they were aware of whistleblowing policy and would approach the registered manager if they were ever concerned for someone. One staff member told us, "I would report to senior or the manager."

People told us they felt safe living at the service, comments included; "Oh yes I definitely feel safe here." And, "I feel very safe here."

There were suitable arrangements for the safe storage, management and disposal of people's medicines. Each person had a completed medicine administration record (MAR) which recorded the medicines that people were prescribed and when to administer. The temperature of both the medicines room and fridges was monitored which ensured that people's medicine were stored within safe temperature limits. Where stocks were received and disposed of, accurate records were maintained. Medicine audits were carried out regularly.

We saw that appropriate checks had been regularly undertaken by the registered manager or by other external professional's persons, in order to provide people with a safe environment in other areas. For example, various fire safety checks were carried out on a weekly or monthly basis. However, records showed that staff had attended fire drills monthly but only up until September 2016. Water temperature checks were also not up to date. The operations manager told us following the inspection that a drill for day staff was carried out and a drill for night staff was planned. They had told the responsible person to undertake a fire drill during the day once a month and at night every three months with immediate effect and must be documented and they would monitor this. They also told us the maintenance person had been checking water temperatures but had not recorded their findings, this was now being checked by the registered manager. Other safety tests included electricity and gas checks, bathroom and mobile hoist checks and legionella checks.

Safe recruitment processes were in place for the employment of staff. Relevant checks were carried out as to the suitability of applicants before they started work in line with legal requirements. These checks included

taking up references, obtaining a full employment history and checking that the member of staff was not prohibited from working with people who required care and support.

Requires Improvement

Is the service effective?

Our findings

At this inspection, we found that staff had not all received training to enable them to carry out their role. We looked at the training plan and found this was not up to date. The registered manager had started a new system with a training log for all staff but this had only been completed for three staff so far. In the staff files we looked at we could find no evidence of up to date manual handing training or practical competencies, we could find no evidence of any specialist training to meet the needs of people that use the service. For example, pressure care, dementia, epilepsy, learning disabilities or Mental Capacity Act training. However, all of the staff we spoke with said they had previously had face to face training in manual handling, first aid and health and safety.

During this inspection, we observed two manual handling transfers that were not of the required standard. We discussed this with the home manager and following this inspection they sent us a copy of an updated staff competency form with guidance that senior staff had to follow to assess staff competency in this area and informed us the staff members involved had received additional training.

Staff had not all received training in how to support people at the end of their lives. At the time of inspection we saw that one person was receiving end of life care. Records showed that staff had checked on them regularly during the day and overnight and had provided mouth care to keep them comfortable. However, we saw one entry in the night record log which stated, "Still breathing." which demonstrated a lack of respect. The registered manager told us they would deal with this immediately.

Records we looked at showed that staff had not received appropriate or consistent supervision or annual appraisals. Annual appraisals are used to review a staff performance and identify any areas that could be improved on as well as looking at the person's aspirations and future training needs. Failure to provide staff with appropriate levels of support can lead to opportunities for their development being missed and lead to staff feeling unvalued. Staff told us that the registered manager had tried to address this since they started. Staff comments included, "I have just had first one in a long time", "Last time I had training was when I joined. I have just had one supervision", "No I have never had a manual handling observation to check my competency" and "I've been here 18 months and didn't have any supervisions, I've had my first one now; it was good as gave me a chance to speak about things, I had it with the registered manager."

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

There were monthly staff meetings where the team could share information and discuss issues together, the staff we spoke with appeared well informed about developments in the service. At one recent staff meeting, we saw in the minutes staff had discussed confidentiality, professionalism and prevention of pressure sores.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of the inspection applications to deprive people of their liberty had been made.

Staff we spoke to were not aware of having training in MCA and we could find no records of this however, staff were able to demonstrate how they supported people to make choices who had difficulties making decisions or communicating. One staff member told us, "I will always ask people no matter what, I will open the wardrobe and show them clothes." Another staff member said, "Some people's rooms have pictures with stories, it talks about what people like, what they used to like when they were independent, which helps us know what people would choose, otherwise we can ask a colleague or someone who knows them well." A third staff member said, "[Person] can't speak, we write things down and get them to write, they have a sheet of paper with letters on it and they point to them to spell things out."

Care plans included information about the person's capacity and most we looked at stated the person had capacity. However, not all care plans were signed and in one person's care plan the mental capacity assessment included several day to day activities and the best interest process lacked detail. Mental Capacity Assessments must be time and decision specific and followed by best interest decisions. We discussed this with the registered home manager who told us that during their reviews of looking at care plans they would review all mental capacity assessments and ensure care plans were signed.

People were complimentary about the food. They said the food provided was nutritious and that they were always given a choice. Comments included, "I am satisfied with the food, they come round with the menu and we get to choose what we want" , "The food is very good, we get a good choice" , "The food is excellent, always fresh and lots of choice" and "You can have red or white table wine with your meal and If you have a friend stay for a meal you can buy a bottle of champagne, my nephew came for a meal, we had a lovely time."

We observed that food was well presented and served hot. We looked at the kitchen, which was clean and well organised. We saw that sufficient food stocks were available. We noted that records were completed in relation to temperature checks, cleaning schedules and meals served each day. We spoke with the chef and they were able to tell us about the dietary requirements of the people that used the service. The chef showed us their list of people's food likes and dislikes as well as if they required specific diets such as soft or pureed diets. The chef told us menus were developed in consultation with people that used the service during meetings. These menus would then be reviewed and changed every three months or on demand if people wanted changes. We found that people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. The Chef told us that breakfast was cooked to order and available daily and people had access to hot and cold drinks throughout the day.

Records showed health and social care professionals visited the service as and when required and that requests for their support were noted. Care records held feedback from GP's, speech and language therapists, social workers and occupational therapists. Staff identified people's needs and involved health and social care professionals appropriately.

Good

Is the service caring?

Our findings

Interactions between the staff and people who used the service were positive and relaxed. Staff showed kindness towards people spoke to them respectfully and smiled and engaged in friendly banter. People said staff were kind and caring, comments included, "The nicest thing about living here is how friendly it is", "I am happy here", "Most of the carers are caring and careful; I get everything I need" and "They're very good, kind staff."

People told us that staff knew them well, knew their preferences and listened to them. One person told us, "They know me here; they know I don't drink tea or coffee so they bring me lemonade." Another said, "They know me well, they know what I like." A third person told us, "They will always ask what I want, I get to choose when I get up and when I go to bed but that's because I can do it by myself."

At lunch some people were offered wine with their meal. Staff were chatting to people about their day, and people chatted with each other creating a nice sociable atmosphere in the dining room. One person told us about the history of the home as they had always lived local. They said, "I know quite a few people here, it is a very nice place the whole place is always warm." We observed a staff member putting a fork into a person's hand who was unable to see, the person was then able to eat independently although the staff member continued to sit with the person to support them.

Staff were able to demonstrate that they knew people well and knew how they liked their care and support. One staff member said, "[Person], at 7 pm they like to have their high tea before they go to bed; when they wake up they like their room tidied immediately everything in their room has its place." Another staff member said, "[Person] likes their hair and makeup done in a very specific way they like their hair to be right and their lipstick on before breakfast."

People were treated with dignity and respect. One person said, "We respect each other here, it's a mutual thing, they always knock before entering my room." Staff told us how they promoted peoples dignity, privacy, and independence. One staff member said, "I cover people with a towel, will give a flannel and encourage them to do what they can."

People told us that they were involved in making decisions about their care their care and that they were confident in making their views known. A recent coffee morning had taken place and regular meetings were held, one person told us, "There are meetings once a month for us with management, there is going to be one for visitors as well, a separate one."

We saw people's rooms were personalised to meet their needs and preferences. This included family photos and mementos. People we spoke with told us that they liked their bedroom where they could spend time with their family and friends.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care could be supported by staff and the local advocacy service. Advocates

are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local lay advocacy service on display. There were no advocates being used by people at the time of our visit.

Requires Improvement

Is the service responsive?

Our findings

The registered home manager had started to review and replace care plans with a new format. Some of the care plans we reviewed included care needs assessments, although the care plans varied in the amount of information they contained. Sometimes there was clear information for staff to follow and at other times there was not. In some cases, information recorded about people's needs was not up-to-date to help ensure staff met people's needs effectively. For example, one person's care plan had recorded in one section that they no longer used their buzzer so a bed sensor had been put into place, but in other sections the care plan had not been updated and still stated the person would use their buzzer. Each section of the care plan was evaluated monthly but staff completing the evaluations had not noticed the conflicting information within the care plan. We also saw that some evaluations had not been completed since December 2016.

The new version of the care plan did not always contain the level of detailed required. One person had recently had a pressure sore which had subsequently healed, and the new care plan did not contain sufficient detail about how a reoccurrence of this might be prevented in the future, the Waterlow assessment was left blank. An updated skin integrity plan was sent to us following this inspection.

Staff we spoke with understood the importance of providing a person-centred approach and providing care and support that was tailored to each individual. A staff member said, "Everyone is different and like things done in a particular way."

The activities co-ordinator told us they completed a questionnaire for peoples preferences, this was shared with staff and put in care folders. Staff knew peoples preferences and tried to respect them. A person told us, "They are very helpful if they can do anything for you they will." Another person said, "They know I drink tea though not how many sugars I take." A third person said, "I once had a male carer I sent him away and asked for a female and they sorted this out."

The service supported people to maintain routines that were important to them. One person told us, "They don't mind what time you get up, you can choose; if you want breakfast in bed you can have it." However, where people required help and support from staff to maintain their routines people's personal preferences were not always respected. One person told us, "Depends on staff available as to what time I go to bed, I like to go after tea but I have to wait until someone is available to help me."

People were supported to maintain relationships that were important to them and visitors were made welcome. One visiting relative said, "We recommend this place to others, it's always a lovely atmosphere and we are always made very welcome." A person told us, "My visitors can come more or less when they like here."

We received mixed views about whether there was enough to do, comments included, "We have plenty to do as there is a programme every week" , "We go out on a Friday, a quiz this morning and we are going on a coach this week" , "We have entertainment, we have it at the end of the month and some of us go out once a month to a tea dance, you get a timetable of what's happening each week, we get quizzes, sing hymns etc."

However other comments included, "I would like more to do", "We could do with a bit more entertainment", "I've been here for two years, it is an alright place to live but it's so boring, that's why we all go to sleep" and "They don't ask us what we would like to do, they do painting, flower arranging but I am not into that."

On day of inspection we observed seated exercises during the morning. We spoke to the activities person who said, "We ask people what they want to do". They also told us that they tried to meet people's spiritual needs and organised weekly hymn services, which people enjoyed. They told us, "We have a clothing company that comes in a few times year. I do quizzes, pitched to meet various abilities, music quizzes, card games, board games, and armchair exercises. There is a man comes in fortnightly to do seated exercise." They also said they did artwork, adult colouring and 1:1 for an hour to see people who chose not to join in group activities. External entertainment was also booked every two weeks, guide dogs came in, theatre trips were organised, and some people were going to the garden centre on Friday.

There was a complaints policy in place and it was available for visitors to access. We saw that complaints had been documented and responses sent. One person said, "I've never had to make a complaint, but I would speak to the manager if I needed to." Another person told us, "I have no complaints, I would talk to the lady in the office, and she would take it seriously." A relative said, "I have met the new manager, she seems very approachable."

Requires Improvement

Is the service well-led?

Our findings

There were systems in place to monitor the quality of care practices in the service. However, these were not sufficiently robust to make sure all shortfalls were identified promptly. For example, we found that care plans did not always contain up to date or relevant information, training and supervision for staff and health and safety records were not up to date. Other audits included medication, bed rail audits, staff management and finance, the registered manager had an action plan in place but this did not contain any information about progress made or actions taken.

This inspection highlighted shortfalls in the service that had not been resolved by the monitoring systems in place. The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services was a breach of Regulation 17 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they felt the team was largely effective and that staff worked and communicated well together. People living in the home told us that they felt the home was short-staffed and staff sometimes rushed about. This impacted on people negatively as they said they often had to wait for staff. There had been recent increases to the occupancy of the home that staff told us they were still getting used to the increase in admissions.

The home had a registered manager who had only been in post for a short period of time. Staff were positive and said that the registered manager was very approachable and knew what was happening in the service. One staff member told us, "I'm getting to know [registered manager], she seems quite good." Staff also said they felt supported by the registered manager. One staff member said, "I love her [registered manager] I feel is a human being, she has a heart, she is approachable, she listens and is accessible." Another staff member said, "It's much better here now, before was a closed door and we felt shutdown. We have staff meetings once a month but with the [registered manager] the door is always open." A third staff member said, "There have been lots of different managers very confusing for us and the residents."

The registered manager and operations manager talked with us about the progress that had been made and accepted that there were still improvements required in service delivery. They told us, "There have been a lot of changes. Staff morale has improved. We have updated some care plans but have more to do." The operations manager told us that they intended to introduce a more detailed provider's audit that was used in their other services to monitor the standards within the home. The registered manager and operations manager had responded very positively to the concerns identified in this inspection, sending us updated information following the visit. This showed that the service was able to identify ways in which improvements could be made and was acting quickly and responsively to resolve issues.

The registered manager encouraged open communication with staff and people using the service through regular meetings and annual surveys. One person told us, "They always ask us for our feedback on the food at residents meetings." The registered manager held monthly meetings with staff to discuss any issues. In addition, staff told us daily handover meetings were useful for discussing people's progress and addressing

any concerns.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Some people's risk assessments were not reflective of their current risks and did not guide staff on how to care for people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have in place effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity

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 sufficient numbers of staff were deployed to ensure people's needs were met at all times. Regulation 18 (1) and People who use services were not protected against the risks associated with insufficient training for staff. Regulation 18 (2) (a).