

Indigo Care Services Limited

Shevington Court Nursing Home

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?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The inspection took place on the 8 February 2017 and was unannounced. This is the first inspection since the service had been taken over by a new registered provider.

Shevington Court provides accommodation to older people or people living with a physical disability who require nursing or personal care. The service is registered to accommodate up to 46 people and at the time of the inspection there were 40 people living at the service.

The service had been without a registered manager since November 2016; however a new manager had been appointed and was in the process of registering with the CQC. 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.

During the inspection we identified breaches of 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

Bed rail risk assessments did not always consider the relevant information to determine whether these were safe and appropriate. In one example a person had fallen out of bed whilst climbing over their bed rails. The bed rail risk assessment had not been updated following this incident to determine whether they were still suitable. The falls risk assessment had been updated, however did not provide detail around the person having tried to climb over the bed rails. This meant that staff did not always have access to up-to-date information, and appropriate action had not been taken to keep people safe.

Risk assessments relating to the use of portable heaters had not been completed and therefore people could be at risk of harm. Following the inspection visit the manager completed these, and sent us a copy.

We identified that mental capacity assessments had not always been completed as required. In one example we asked that a person be referred to the local authority for review to ensure they were receiving the correct level of support. We have made a recommendation to the registered provider around carrying out their role and responsibilities in relation to the Mental Capacity Act 2005 (MCA).

Parts of the environment needed making safe when we first arrived at the service. After we raised these issues, action was taken to rectify the issues identified and these issues did not reoccur for the remainder of the inspection visit. Records showed that regular checks of the environment were being carried out, however it was evident from the issues we identified that these were not always effective.

Audit systems were effective at monitoring some areas of the service but not others. For example parts of the environment needed making safe when we first arrived at the service. Whilst checks on the environment

were being carried out, it was evident from the issues we identified that these were not always effective. Audit systems had also failed to identify issues relating to mental capacity assessments, and lessons had not always been learned from accidents and incidents.

Staff had received training in safeguarding vulnerable adults and knew how to report their concerns both inside and outside the organisation. Recruitment processes were robust which helped to ensure that those people employed were of suitable character to work with vulnerable adults. This helped protect people from the risk of abuse.

Infection control procedures were being followed by staff. During personal care interventions staff wore personal protective equipment (PPE) such as disposable aprons and gloves. This protected people from the risk of infection, and helped maintain their health and wellbeing.

People told us that they enjoyed the food and that they got enough to eat and drink. Staff were aware of people's dietary needs which ensured that people received a diet that was appropriate for them, for example low sugar, or soft food options.

People were supported to access support from health care professionals where required to maintain their health and wellbeing. Where people became ill, they were referred to their GP or paramedics for support.

People's privacy and confidentiality was protected by staff. Staff ensured that doors remained closed whilst supporting people with personal care tasks. Personal information was stored in secure cabinets and staff ensured that these were put away after use.

Positive relationships had developed between people and staff, and people were familiar with the management team and knew how to make a complaint, or raise any concerns they may have. The registered provider maintained a record of complaints that had been received, which showed these had been responded to in a timely manner.

The majority of care records contained up-to-date information relating to people's needs. These were personalised and contained information around their life histories and personal preferences. This provided information to staff on how to support people, and gave them an insight into the people they were supporting. This helped facilitate positive relationships between people and staff.

Meetings were held with staff, people using the service and their family members. This helped ensure they remained up-to-date with developments within the service, and were able to contribute to decisions being made.

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 always safe.

Bed rail risk assessments did not always include relevant information which placed people at risk of harm.

Parts of the environment that were not safe when we arrived at the service but were made safe. Records showed that checks were in place to address this issue.

Recruitment processes were robust and ensured that staff were of suitable character to work with vulnerable people.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Mental capacity assessments were not always completed as required.

People told us they enjoyed the food that was available. People who required special diets received these.

People were supported to access support from health and social care professionals when required.

Is the service caring?

Good ●

The service was caring.

People told us that staff were kind and that they treated them with dignity and respect.

People's confidentiality was respected. Records contained personal information was stored securely.

Information about advocacy services was available to people, which ensured their involvement in aspects of their care.

Is the service responsive?

Good ●

The service was responsive.

There was a complaints process in place and people knew how to use this.

A majority of records contained accurate and up-to-date information. These were personalised and contained details relating to people's preferences, likes and dislikes.

Activities were taking place, which ensured people were protected from the risk of social isolation.

Is the service well-led?

The service was not always well-led.

Audit systems had failed to identify issues identified on inspection.

Quality monitoring systems were in place to monitor other aspects of the service and ensure that quality was being maintained.

People using the service, their family members and staff were kept up-to-date on developments within the service through regular meetings.

Requires Improvement ●

Shevington Court Nursing Home

Detailed findings

Background to this inspection

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

The inspection was unannounced and took place on the 8 March 2017.

The inspection was completed by two adult social care inspectors.

Before the inspection, we asked the registered provider to complete a Provider Information Return (PIR). 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. Due to technical problems a PIR was not available and we took this into account when we inspected the service and made the judgements in this report.

Prior to the inspection we contacted the local authority safeguarding and quality monitoring teams. They shared some information with us relating to the provision of care, and support given to people during meal times. We followed up on this information during the inspection visit.

During the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke with six people who use the service and four family members. We spoke with eleven members of staff as well as the manager and area manager. We looked at the care records for six people. We looked at the recruitment records for three members of staff. We made observations on the interior and exterior of the premises and looked at records relating to the day-to-day management of the service, for example audits and training records.

Is the service safe?

Our findings

People told us that they felt safe within the service. Their comments included, "Yes I am more than safe here", "They (staff) treat me very well indeed and keep me safe and secure", "I've no worries at all" and "Yes I get my tablets on time". Family members told us they had no concerns about their relative's safety. One family member said "[My relative] is very safe here I am not a bit worried about their safety".

Bed rail risk assessments were in place for people; however these did not always reflect information given to us by staff. One person was laid in bed with the bedrails partly in place. However a member of staff told us that this person was at risk of climbing over the bed rails to get out of bed. The risk assessment stated that the use of bed rails was appropriate, however did not include the information given to us by the member of staff. This meant that relevant information had not been considered as part of the risk assessment process. There was no information around whether other precautions had been considered, for example lowering the bed and putting a mattress on the floor to reduce the risk of injury in the event of a fall. In another example a falls audit stated that one person had climbed over their bed rails and had a fall. This had not resulted in an injury. The falls risk assessment had been updated, but this did not include the information relating to the person climbing over their bed rails. In addition, the bed rail risk assessment had not been updated following this incident and still stated that bed rails were appropriate. We raised these examples with the area manager for review.

Some bedrooms had free standing heaters. There was no risk assessment in place to ensure that they were safe and suitable for the person for whom they are intended. It is important that risks are considered as these can be a trip hazard, and present as a trip hazard. Following the inspection the area manager sent confirmation that these had been completed.

At the time of the inspection the service was in the process of being refurbished. Some rooms contained equipment which was being used by the contractors. The door to one room was unlocked and we found a chop saw, power drill and a hammer along with other tools and equipment. The door to an activities room was unlocked and held open. Inside the room were step ladders and a cleaning trolley with various bottles containing cleaning fluid and solutions such as carpet cleaner and sanitisers. Activity items such as a glue gun and paints were also stored in the room. These doors had a pad lock facility fixed to them however the pad locks was missing. This meant that people would be at risk of harm if they gained access to these rooms. We raised this immediately due to the health and safety implications of people accessing these rooms. These doors were secured and remained locked throughout the day when not in use. A risk assessment had been completed around the building work that was being carried out which adequately considered the risks and put protective measures in place. Workmen were reminded of their responsibilities to ensure the door was kept locked at all times.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's safety had not been maintained.

Equipment used to help people with their mobility was not always stored safely. We saw examples where

wheelchairs and hoists obstructed external fire doors and pathways in a communal area. This posed a fire hazard as people would not be able to leave the building via the escape route. These also placed people at risk of slips, trips and falls. We raised this with staff who immediately acted to move these out the way.

In a majority of examples risk assessments were in place and up-to-date regarding people's care needs. For example, nutritional and weight-loss risk assessments were up-to-date and appropriate action had been taken to refer to the appropriate health professionals. In other examples where people were at risk of developing pressure ulcers, appropriate equipment had been put in place and there was on going monitoring by staff. Where, required people had been referred to the tissue viability service for specialist support. This protected people from the risk of declining physical health.

In a majority of cases, accidents and incidents records were being maintained which provided clear details of the event and measures taken to ensure people's safety and prevent issues from occurring again in the future. In one example the medicines fridge had gone above the recommended temperature. The manager had taken action to contact the GP and pharmacy to ensure that medicines would still be safe for people to take. In another example, one person had been referred to the falls team for support after they had had a number of falls.

People were supported to take their medicines as prescribed. Topical application charts were available which showed staff where to apply medicated creams, however we observed that 'when required' (PRN) protocols were not always in place to show under what circumstances these should be given. We looked at a sample of people's medication and found that the quantities being stored matched the recorded quantities. We observed an evening medication round taking place. The member of staff dispensed medicines directly from packaging into a plastic cup before giving this to the person to take. This prevented the risk of cross contamination and protected people from infections. The member of staff waited with people to ensure they had taken their medication, before signing medication administration records (MARs) to show that medicines had been given as prescribed.

People's medication was stored correctly and in line with manufacturer's guidelines. For example some medication needed to be stored in a refrigerator to ensure their continued efficacy. The registered provider had a refrigerator in place for this purpose, and the temperature was being monitored on a daily basis to ensure these did not become too hot or too cold.

Staff had received training in safeguarding vulnerable people and were aware of the different signs and indicators of abuse. Staff had a clear understanding of how to report any concerns they may have, either inside or outside the organisation. The registered provider had a whistleblowing procedure in place which staff were aware of. Whistleblowing is where staff can raise concerns to management, or report concerns to outside bodies without fear of reprisals.

Staffing levels were sufficient at the time of the inspection. Staff reported that there were times they felt additional staff were required so that they could spend more time with people. They confirmed that this did not impact upon people's safety, for example in the event of an emergency. The registered provider had a dependency assessment tool in place which was used to calculate the number of staff required. We looked at staffing rotas which showed that consistent numbers of staff were in post during each shift.

We looked at the recruitment records for three members of staff, which showed that recruitment processes were robust. Staff had been required to provide a minimum of two references, one of which was from their most recent employer. Staff had also been subject to a check by the disclosure and barring service (DBS) prior to employment. The DBS carries out checks to ensure that applicants are not barred from working with

vulnerable groups of people. This helps employers make decisions around the suitability of applicants for the role, and helps ensure people's safety is maintained.

Checks had been completed on equipment and other aspects of the environment. A legionella risk assessment had been completed and the water was being monitored to ensure it was free from harmful bacteria. Hoists had been serviced to ensure they were in working order and electrical equipment had been tested to ensure it was safe. Personal emergency evacuation procedures (PEEPs) were in place which outlined to staff what support people needed to remain safe in the event of an emergency. Fire drills were being completed which did not highlight any issues with the fire evacuation process.

Infection control procedures were being followed by staff. Staff wore personal protective equipment (PPE) such as disposable gloves and aprons. The registered provider had an infection control policy in place which staff had signed to show they had read this. Equipment and bathrooms were clean, and we observed domestic staff cleaning parts of the service.

Is the service effective?

Our findings

People commented positively on staff, and told us they were skilled at carrying out their role. One person commented, "They all seem skilled", and complimented a member of staff on the support they gave.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been made for people who required them and were in the process of being authorised by the local authority.

Care records contained details around people's cognitive ability and mental health. However mental capacity assessments had not always been completed as required. In two examples we observed that bed rails were in place, however mental capacity assessments had not been completed to determine if the person could consent to this, or if it was in their best interests. In another example one person had been deemed not to be able to self-medicate and frequently refused their medication. Information within their care record suggested that their mental capacity could fluctuate, however a mental capacity assessment had not been completed to determine their capacity to refuse medication, or outline what measures were in place to ensure staff acted in their best interests. This situation was being managed by staff returning at a later time, which resulted in this person taking their medication as required. In another example, one person was subject to constant supervision however care records did not contain any information to show they had been consulted about this and daily notes showed that they had objected to this. A mental capacity assessment had not been completed and their care record stated they were "able to make decisions for [themselves] with help and support from staff". We asked that this person be referred to the local authority for a review of their needs.

We recommend that the registered provider seek advice and guidance from a reputable source about meeting the requirements of the Mental Capacity Assessment 2005.

Staff had completed training in the MCA and were aware of their roles and responsibilities in relation to the Act. Staff gave appropriate examples where they would offer people choice over their own care, for example choosing what they want to wear for the day, or their preferences during meal times in relation to food and drinks. This showed that staff acted to promote people's choice and control as required by the MCA.

Staff had completed training in areas required for them to carry out their role effectively. For example, fire safety, first aid training and moving and handling. Training had been delivered via a mix of e-learning and classroom based training. Some staff had also been supported to achieve nationally recognised

qualifications in health and social care. An induction process in place for new members of staff, which consisted of a period of shadowing experienced members of staff and completing training in areas such as those outlined above. New staff were also required to complete the Care Certificate, which is a nationally recognised set of minimum standards that care staff are required to meet.

The manager was in the process of completing supervisions with staff. The manager explained that she had conducted formal one to one supervisions with some staff and acknowledged that other staff still required this. The manager was in the process of developing a system so that other senior staff could take on the role of formally supervising junior staff. Staff confirmed that they felt supported and that the manager was available to offer support where needed.

People told us that they liked the food and got plenty to eat and drink. Their comments included 'I am really satisfied with the food' and 'I get three square meals a day and more in between'. The kitchen was clean and well organised. There was a good stock of food which included tinned, frozen and fresh items. The chef was held information about people's dietary and was knowledgeable about them. For example people who had diabetes and required a low sugar diet, those who were at risk of malnutrition and needed high sugar content and those at risk of choking who needed their meal texturizing. There was a good stock of full fat products including milk and cream which the chef used to fortify meals.

People's care records contained information which showed that they had been supported to access their GP or other health professionals where required. This helped ensure that people's health and wellbeing was maintained.

The registered provider was in the process of refurbishing the environment. We had a discussion with the area manager who gave assurances that adaptations would be included to meet the needs of those people using the service, for example people living with a sensory impairment or physical disability.

Is the service caring?

Our findings

People and family members told us that the staff were kind and caring and that they were respectful of their privacy. Their comments included, "They (staff) are ever so nice and very kind", "I have no complaints about the staff, they all are very caring and very polite" and "They (staff) are spot on. They look after [My relative] better than I could have imagined".

Action was taken by staff to offer reassurance or seek support where people became distressed or were at risk of becoming distressed. We saw examples where staff responded in a timely manner to people's needs, in one instance rushing to support someone who had a fall. In another example we heard a discussion between staff and an external health professional, where staff were able to provide clear and relevant information. This helped the professional to carry out their assessment of this person's needs, and ultimately the best course of action to take.

Positive relationships had developed between people and staff. During the inspection we observed laughter and chatting between them. One person commented, "This nurse is very good. They are one of the best" whilst being supported to take their medication. We observed another example where one person gave a member of staff a hug. Family members told us that they were made to feel welcome when visiting the service and were offered refreshments such as tea or coffee.

People's privacy and dignity was maintained by staff. Staff knocked on doors before entering bedrooms and they ensured doors to bedrooms and bathrooms were closed when assisting people with personal care. Care records and other files containing confidential information were stored securely in locked cabinets. Staff closely supervised files when they were taken out for use.

People had the choice to personalise their bedrooms with items such as photographs, pictures and other personal belongings which were important to them. Staff spoke exclusively to people and avoided any interruptions from others. Staff sat next to people when holding conversations with them and they maintained eye contact and listened carefully to what the person had to say.

People's care records contained details around their life history and their preferences, for example their favourite/ least favourite foods. This showed that there had been some involvement of people in developing their care. However, there was no evidence to show that people, or where appropriate their family members, had been involved in review processes to show continued involvement.

At the time of the inspection visit there was no one who required an advocate. However, Information about local advocacy services was available to people and the manager demonstrated a good understanding around where it would be appropriate to seek advocacy support. An advocate offers independent support to people to ensure that their wishes and feelings are taken into account where decisions are being made regarding their care needs.

People received the support they required at the end of their life. People's GP were involved in planning to

ensure that people remained as comfortable as possible. Care records had an end of life care plan in place, and where required end of life medicines were stored in preparation to ensure that these were available to people when they needed them. People who did not wish to be resuscitated, or where it had been determined this would not be in their best interests, the appropriate documentation stored clearly at the front of their care record.

Is the service responsive?

Our findings

People family members knew how to complain and they said they were not fearful of complaining. Their comments included, "I have no hesitation in telling them if I was unhappy", "Yes I would most definitely complain if I needed to, no worries on that score" and "I have no concerns but if I did I say so". The registered provider had a complaints policy in place which was available to people in the service user guide, which people had been given. There was also a copy available on the notice board at the entrance to the service.

A complaints form was made available to people should they wish to make a written complaint. A complaints log was kept, which detailed complaints made and the response to them. This showed complaints were dealt with in line with the registered provider's complaints procedure. Complaints were monitored each month to ensure they were appropriately responded to and lessons were learnt from them.

Initial assessments had been completed prior to people moving into the service. This had been to ensure that the service was able to meet their needs. This process included reviewing information from health and social care professionals. Information gathered was used to develop people's care records. These contained information relating to such matters as personal care needs and both physical and mental health. Where people were at high risk of developing pressure ulcers, protocols were in place, for example frequent support with altering position to minimise the risk of these occurring. In one example detailed information on a person's physical health condition was included in their care record. This provided staff with the information they required to ensure people receive the support they needed.

Care records contained personalised information such as people's likes and dislikes. For example one person's care record stated that they "dislike pasta and spicy foods". Whereas another person's care record stated that they preferred to be supported by female care staff. People personal histories were also outlined which included aspects of their life that had been important to them, for example war time experiences. This helped staff gain an insight into the people they supported and helped facilitate the development of positive relationships.

Care records had been reviewed on a regular basis, which ensured that in a majority of cases information remained up-to-date and accurate. However we found some examples where important information had not been included or considered as part of the assessment process. We have reported on this under the safe domain.

Daily records were completed by staff which outlined the support that had been given to people, along with any important developments in their care. Monitoring charts in relation to pressure relieving mattresses did not always state what setting these should be on, however on checking mattresses we found they were on the correct setting. Fluid balance charts were being completed which outlined the amount of fluid people had consumed throughout the day. These were used to monitor and to a judgements regarding the needs of those people at risk of dehydration. However, the charts did not include the amount of fluid people should have each day. This meant that meant that staff could not be sure if someone had drunk enough. We raised this with the manager so this information could be included in the future.

During the inspection visit we did not see activities taking place, however there were photographs and examples of previous activities. For instance arts and crafts, sing-a-longs and Valentine's Day activities. Staff told us that fund raising events were due to take place to raise money for a sensory garden. People and family members were fully involved and encouraged to put forward ideas for fund raising events.

Is the service well-led?

Our findings

Throughout the inspection visit management were visible and people's family members approached them to speak about their relative's care. We observed the area manager speaking to people who used the service, some of whom knew him by name which demonstrated a relationship had been developed. Staff commented positively on management and told us that they found them to be approachable.

The service had been without a registered manager since November 2016. A new manager had started and was in the process of registering with the CQC. There were clear lines of accountability within the service and staff knew who to report to. The manager reported to an area manager, and beneath the manager was a deputy manager. This ensured that people and their family members were able to access support where the manager was not available.

Audit systems had failed to identify that relevant information had not always been considered around the appropriate use of bedrails. This meant that action could not be taken to ensure people's safety, and had placed people at risk of injury. In addition, action was not always taken in response to incidents to show that appropriate learning had taken place. We have reported further on this under the 'safe' domain. Audits had also failed to identify that mental capacity assessments were not being completed as required by the MCA.

We raised concerns in relation to the storage of equipment, and the securing of rooms which contained hazardous tools. Whilst immediate action was taken to address these issues, and these did not recur for the remainder of the inspection visit, this demonstrated that checks on the environment were not always effective.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because audit systems were not always effective at identifying and addressing areas that required improvement.

Audits were carried out in other areas such as the monitoring of those people who had developed pressure ulcers to ensure their condition did not continue to worsen. This process also ensured that people had been referred to relevant health professionals where required. Audits were completed around the changing of invasive devices to ensure this was being carried out as required. Invasive devices can include catheters which need to be changed periodically to prevent obstructions and maintain the catheter's functionality. An infection monitoring audit was also completed to monitor those people who had been diagnosed with an infection, and check that they were receiving the proper care and treatment. This ensured that good practice was maintained in these areas, which impacted positively upon people's wellbeing.

Quality monitoring checks were carried out by the registered provider. This included a dining experience observation which had identified issues with the décor, which would be resolved after the refurbishment. This also looked at staffing levels, recruitment and safeguarding concerns. This had helped to ensure there were no issues in relation to these areas.

Team meetings took place so that staff could meet as a group and discuss their work and the people supported. The manager facilitated a staff meeting in January 2017 to introduce herself as the new manager of the service. Prior to the meeting an agenda was made available to staff which listed the main topics for discussion. Staff were invited to add to the agenda any other topics they wished to discuss. The minutes of the meeting was made available to all staff so those who were unable to attend were updated with the discussions which took place.

Meetings with people using the service and their family members had been completed. The last meeting had been held in February 2017, during which discussions had taken place around plans for the service, the refurbishment, decoration and menus. A survey had been completed with people which showed that overall people were satisfied with the service being provided.

By law the registered provider is required to notify the CQC of specific incidents that occur within the service. Prior to inspecting we reviewed our system and found that these notifications were being sent through by the registered provider.

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
Treatment of disease, disorder or injury	The registered provider needs to ensure that people's safety is being maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered provider needs to ensure that systems are effective at identifying and addressing issues.